

Royal United Hospitals Bath NHS Foundation Trust

Royal United Hospital Bath

Quality Report

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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

Requires improvement



Medical care (including older people's care)

Requires improvement



Surgery

Good



Critical care

Requires improvement



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Outstanding



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Royal United Hospitals Bath NHS Foundation Trust as part of our comprehensive inspections programme of all NHS acute trusts.

The inspection was announced and took place between 15 and 18 March 2016. We also inspected the hospital on an unannounced basis on 29 March 2016.

We rated the hospital as requires improvement overall. The effective, and well led key questions were rated as good, caring was rated as outstanding and the safety and responsiveness of the hospital was rated as requires improvement. End of life care within the hospital was rated as outstanding, but critical care services were rated as requires improvement.

Our key findings were as follows:

Safe:

- We rated safety in the hospital as requires improvement. Urgent and emergency care, critical care and maternity and gynaecology were rated as requires improvement. All other services were rated as good.
- There were periods where staffing and skill mix were not as planned by the trust. This was mitigated by higher numbers of healthcare assistants and in some cases supervisory ward sisters acting in a clinical capacity. Nurse staffing and skill mix was assessed and reviewed twice a year using recognised tools to determine staffing levels, in places wards had not been fully engaged with this in the review in August 2015, but were in February 2016. Although there was awareness and systems in place to flex nurse staffing across wards, these were not clear and relied upon the judgement of senior staff rather than being grounded in clear processes. There was, however, a process in place for the authorisation of the use of agency staff and a staffing escalation policy in place. Recruitment was ongoing for nursing vacancies across the trust and the trust was training assistant nurse practitioners in order to provide additional support.
- The trust commissioned a fire safety review in November 2015. Actions were being taken to mitigate the concerns raised. However, these were ongoing and would not be complete until quarter three of the 2016/17 financial year. The trust told us about the actions they were taking and provided an action plan but this action plan did not clearly show the progress and interim mitigating actions.
- The records maintained regarding the servicing, repair and cleaning of equipment was not always clear and did not provide assurance that all equipment was being regularly maintained. Within maternity services, there were not sufficient numbers of key equipment available, for example epidural pumps.
- In some areas of the hospital, for example in critical care and maternity services, cleaning required improvement. There had also been a higher rate of infections with *Clostridium difficile* than the hospital target, and also a case of legionella colonisation on one of the wards.
- Openness and transparency about safety was encouraged and embedded across the hospital. Systems were in place for the recording, investigation and learning from incidents. Staff understood their responsibilities to raise and report concerns, incidents and near misses. There was evidence that learning was widely shared across the hospital. However, within critical care not all incidents were reported and had become 'every day events'.
- When something went wrong, patients received a sincere and timely apology. They were told about any actions taken to improve processes to prevent the same happening again. The majority of staff understood their responsibilities under the Duty of Candour requirement and could provide examples when they had been used.

Summary of findings

- Performance showed a good track records and steady improvements in safety. The morality risk was similar at weekends to that during the week within the hospital and the trust scored within the expected range. Rates of new pressure ulcers, falls and catheter acquired urinary tract infections were monitored with no discernible trends. There were techniques in place to help patients avoid harm. These included: the discrete identification of risks on the patient board, for example, their risk of falls and vulnerable pressure areas; and, comfort rounds carried out by staff.
- Medicines were managed effectively throughout the hospital, with secure storage and effective recording where appropriate.
- Records throughout the hospital were stored securely. However, there were some instances where confidential information was not secure if left unattended.
- The completion of records was variable within the hospital. In most areas records were completed and there were clear plans of care and treatment for patients. However, within the emergency department, records were not always completed in order to ensure that it was easy to identify if a patient's condition was deteriorating.
- In most areas of the hospital there was a proactive approach to anticipating and managing risks to patients. These were embedded and were recognised as being the responsibility of staff. However, in the emergency department, the time taken to triage and assess patients who self-presented at the department (not admitted by ambulance) was not consistently recorded and accurate performance data was not available. This meant we could not be assured that patients were quickly assessed to identify or rule out life or limb threatening conditions to ensure patient safety. We saw examples of patients waiting over an hour for initial assessment.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safeguarded from abuse. Staff understood the processes and there was evidence of reporting occurring as necessary.

Effective:

- We rated the effectiveness of services within the hospital as good. All services that we rate for effectiveness were good with the exception of medical care which requires improvement.
- Patients care and treatment was planned and delivered in line with current evidence-based guidance and standards. We saw good levels of compliance with recognised care pathways, including those for sepsis and stroke care within the emergency department.
- Compliance with protocols and standards was monitored through both internal and national audit. Performance with national audits was mostly in-line with or better than other trusts. For example, the trust was rated C in the Sentinel Stroke National Audit Programme, which placed them in the top 44% of trusts offering stroke care. There was evidence that audit was used to improve performance and practice, for example in the treatment of sepsis in the emergency department. However, improvement was required in the National Diabetes Inpatient Audit from 2015 and the Myocardial Ischaemia National Audit Programme from 2013/2014. Improvements were also required in the audit of compliance with guidance on the termination of pregnancy and the monitoring of rates of infection post caesarean section for learning.
- Patient outcomes were generally good, although patient reported outcome measures (PROMs) for patients receiving surgical treatment for groin hernias and varicose veins were worse than the England average.

Summary of findings

- In most areas of the hospital, staff were provided with the training and support they needed to do their job. In the emergency department nursing and medical staff received regular teaching and supervision. They were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers. However in medical services, there was not a reliable system for staff supervision, and appraisal performance in services for children and young people required improvement.
- Care was delivered in a coordinated way with support from specialist teams and services. There was close, collaborative working across the hospital, for example between the emergency department, stroke team, discharge assessment team, medical nurse practitioner (older person's unit), mental health liaison service and the alcohol liaison service.
- Staff had a good understanding of the Mental Capacity Act 2005. However, for Deprivation of Liberty Safeguards, the trust policy was not in line with the code of practice and stated that for the majority of patients, their stay in hospital would be less than 72 hours so the wider Mental Capacity Act should be applied. For those remaining in hospital for longer than 72 hours the 'acid test' for deprivation should be applied. The Deprivation of Liberty Safeguards are applicable to all patients who lack capacity, as set out within the Mental Capacity Act 2005, no matter the length of time they are in hospital.
- Patients were assessed and provided with adequate pain relief most of the time. We saw some examples of where assessed pain levels were not recorded and pain relief was not provided in a timely manner in the emergency department. Additional equipment was required to assist with pain and discomfort during labour and birth.

Caring:

- Overall, caring within the hospital was rated as outstanding. Services for children and young people, and end of life care were rated as outstanding, with all other services rated as good.
- Children and young people were treated as individuals and as part of a family. Feedback was exceptionally positive about the care they received, and praised the way staff really understood the needs of the child and involved the whole family.
- Within end of life care, patients and their families were universally positive about the way they were treated by staff. There was a strong patient-centred culture and staff across the hospital were motivated to provide high quality end of life care and support that promoted patients' dignity and respect. This was centred around an approach called the conversation project.
- Patients were treated with kindness and compassion. Staff throughout the hospital provided reassurance when patients were anxious and confused. Within services for children, staff were skilled in communicating with children and young people to minimise their anxiety and to keep them informed of what was happening.
- Patients were treated with courtesy, dignity and respect. Patients and their relatives were greeted by staff who introduced themselves with their name and role.
- Across the hospital, patients and their families were involved as partners in their care. Parents, siblings and grandparents were encouraged to be involved in children and young people's care and treatment.
- Patients understood their care, treatment and condition, worked with staff to plan their care and shared decision-making about their care and treatment. Doctors and nurses took time to explain care in a sensitive and unhurried manner.
- There was a hospital wide approach to initiating conversations with patients and relatives who were making the transition to end of life care.

Summary of findings

- However, within critical care there was limited support for patients who stayed on the unit for a long time, in order to keep them in touch with life going on around them. For example, there was not active use or promotion of using quality patient diaries.
- Improvements were required in the number of patients engaging in feedback of experience surveys in maternity services.
- Within outpatient and diagnostic imaging services, staff did not always respect confidentiality when speaking with patients at reception desks.

Responsive:

- Overall, improvements were required to ensure that services within the hospital were responsive to patients' needs. Urgent and emergency services, medical care, surgery, critical care and outpatients and diagnostic imaging were rated as requires improvement. However, services for children and young people, and maternity and gynaecology were rated as good and end of life care was rated as outstanding.
- Access and flow was an issue within the hospital. Although patients arriving by ambulance received an assessment within eight minutes of being admitted to the emergency department, the hospital consistently failed to meet the standard for 95% of patients to be discharged, admitted or transferred within four hours of arrival. There had been a worsening trend since October 2015 with the worst performance in January 2016 at 71.8%. The average for the year (stated in data in January 2016) was 86.6%. Despite this there were no patients who waited in the department for longer than 12 hours on a trolley. A, although patients did remain in the department overnight when there were no beds available in the hospital, the 12 hour standard was not breached.
- However, this was not solely an emergency department problem. The flow of patients throughout the hospital from admission to discharge was not efficient. Patients sometimes stayed in hospital longer because ward teams were not able to arrange transfer to community hospitals or to easily access packages of social care in the community.
- There were a number of initiatives ongoing in the hospital to improve the flow of patients. For example, there was a ward flow pilot project to streamline the process of transferring patients from the medical assessment unit to speciality wards. The emergency surgical ambulatory unit had reduced the need for patients referred by their GP to the hospital to be admitted to the hospital.
- There were long waiting times, delays and cancellations of operations within the hospital. Access to routine specialist treatment was greater than the 18 week standard across surgical specialties and in gastroenterology, cardiology and dermatology. From May 2015 when the standard was abolished, timely access to these services deteriorated further. The short stay surgical unit had been used as an escalation ward since December 2015, in order to accommodate the demand on services across the hospital. This had an impact on the number of elective operations that the hospital could perform.
- Within outpatient services, 14 out of 31 specialty departments were breaching the national standard for patients to receive their outpatient appointment within 12 weeks of referral, in order that treatment can start within 18 weeks. However, the trust met the national cancer waiting time standards.
- Due to pressure on services, we found that patients were being moved between wards at night. Data collected showed that the number of patient moves after 10pm had reduced between October and November 2015. This occurred in surgical and critical care services. In addition patients in critical care experienced delays in being discharged from the unit because of pressure on services elsewhere in the hospital. These delays were worse than the national average. However there were fewer urgent operations cancelled due to the lack of an available critical care bed.

Summary of findings

- Most services in the hospital were responsive to people's individual needs. There were very good facilities for patients living with dementia in all areas. For example within outpatients there was a sensory box in place to support patients using distraction therapy. There was good support for patients living with a learning disability and their families and carers in all areas. However within critical care, there were no follow up clinics or psychological support for patients following discharge from the unit, no high or low-level communication aids for patients and there were limited facilities for relatives on the unit.
- Within maternity services, there was good access and flow, although gynaecology services were affected by the access and flow issues in the rest of the hospital. There was however, room for significant improvement in the provision of specialist bereavement services for maternity patients and their families experiencing loss. Staff were not trained in this and the designated areas identified to care for bereaved women and their families lacked privacy, space and facilities.
- Services for children and young people were tailored to meet their needs and delivered in a flexible way. Although facilities within the areas of the hospital designated for children and young people were good. Other areas, including the theatre recovery rooms were not child friendly.
- The responsiveness of end of life care within the hospital was outstanding. There was an individual approach to the planning and delivery of end of life care. The trust worked with services in the local community to provide continuity of care where possible. Rapid discharge was provided for patients when the appropriate packages of care were available in the community. The trust engaged commissioners and community services in driving improvements in end of life care.
- Complaints were managed effectively across the hospital. There were no barriers to making a complaint, they were handled in an open manner and opportunities for learning and improvement were acted upon.

Well Led:

- We rated the well led domain as good. All services within the hospital were rated as good with the exception of critical care which was rated as requires improvement.
- The leadership, governance and culture promoted the delivery of high-quality person centred care. There was a clear statement of vision and values within the trust which was driven by quality and safety. Some departments, for example the emergency department, had created mission statements.
- There were effective governance frameworks throughout the hospital, risks were identified and the majority were mitigated effectively. Leaders were aware of challenges to patient care within services and identified plans for improvement. Cross department and directorate working was evident in ongoing work to improve the flow of patients through the hospital and out into the community. Partnership working was evident.
- Clinical and internal audit processes were well embedded and had a positive impact on quality governance.
- There was an open culture within the whole hospital. People were encouraged to report incidents. There was a culture of safe innovation, with staff telling us of the "Dragon's Den" approach to pitching areas for improvement to the trust board.
- Leadership within directorates was visible and staff felt supported in their roles.
- However, the critical care service lacked senior nurse leadership as there had been no matron in post for over a year prior to our inspection. Although there was support from the clinical lead, senior sister and senior manager providing temporary oversight, the unit was not performing as it should without the guidance of its most senior

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nursing post. The unit was not always benefitting from the wider experience and skills of trust-wide teams. The leadership did however, promote the delivery of safe patient care and there had been improvements in safety and quality measurement and governance arrangements. There had also been measurable and valuable innovation and change within the unit following audit, research and investigations into best practice.

We saw several areas of outstanding practice including:

- The emergency department had developed guidelines on the management of patients during periods of high demand when flow out of the department is limited. The guidelines aim to reduce the patient safety risks associated with overcrowding by minimising the number of ambulance-borne patients with undifferentiated diagnosis waiting in the corridor for assessment. The document also describes measures to maintain the comfort and dignity of patients waiting in the corridor.
- SSSU and SAU had Project Search Students. This programme provided a mixture of structured work placements and classroom learning for young people living with learning disabilities. It was evident that the students were part of the team and had a clear set of tasks and structure to their daily routine.
- The Surgical Assessment Unit operated an Emergency Surgical Ambulatory Care Unit (ESAC). As part of a Quality Improvement Project (QUIPP 5.8) it was recognised that patients waiting for emergency surgical procedures such as hernia and abscesses (category C and D as classified by NCEPOD), were not being managed properly. These patients were often starved and cancelled at the end of an emergency theatre lists due to running out of theatre time. The ESAC had two dedicated surgeons, which operated a booked emergency list, which focused on these patients and had eight spaces. It had its own dedicated ultra sound equipment, room and a Sonographer who has a dedicated inpatient clinic for two hours a day, Monday to Friday.
- The ESAC unit was run by two band seven Nurse Practitioners Monday to Friday. The Nurse Practitioners also ran a Nurse Led Clinic, which managed complex dressings, and an Accelerated Discharge Programme, which aimed to get patients home sooner but still give them the support and treatment required as an outpatient rather than inpatient.
- There was outstanding caring to children, young people, their parents and the extended family.
- Frontline staff and senior managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.
- There was excellent local leadership of the children's service. Senior clinical managers were strong and committed to the children, young people and families who used the service, and also to their staff and each other.
- The trust had run The Conversation Project, which was an initiative to improve communication between staff, patients and relatives about care for the dying patient.
- The trust had implemented new documentation called The Priorities of Care for recording a personalised care plan for the dying patient.
- We observed and heard numerous examples of outstanding, compassionate care provided by nursing, medical and cleaning staff for patients at the end of their lives from both the patients and their relatives.
- We saw some outstanding practice within the outpatients department, in how staff treated and supported patients living with learning difficulties. This included providing double appointments, rearranging appointments out of hours so patients with anxiety problems could be seen without other patients around. We saw how carers were fully involved where appropriate including working with them and the patient during potentially intimate examinations.

Summary of findings

- The orthopaedic and fracture clinic had a sensory box that could be used for patients with dementia, learning difficulties and children. The box had a range of sensory objects as well as appropriate picture books. Staff told us they use the box regularly as part of distraction therapy.

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

Importantly, the trust must:

- The trust must continue to work in collaboration with partners and stakeholders in its catchment area to improve patient flow within the whole system, thereby taking pressure off the emergency department, reducing overcrowding and the length of time that patients spend in the department.
- The trust must take steps to ensure that the emergency department is consistently staffed to planned levels to deliver safe, effective and responsive care.
- The trust must take steps to ensure that all staff in the emergency department are up-to-date with mandatory training.
- The trust must monitor and report on the time to initial assessment of patients who self-present in the emergency department.
- The trust must take steps to improve record keeping within the emergency department, so that patients' records provide a contemporaneous account of assessment, care and treatment.
- The trust must take steps to ensure that patients in the emergency department receive prompt and regular observations and that early warning scores are calculated, recorded and acted upon.
- The trust must take steps to improve recording of pain assessment scores and pre-hospital medication and ensure that patients attending the emergency department who need it receive prompt and appropriate pain relief.
- The trust must take action to ensure that staffing reviews are robust and reflect accurate and comprehensive data for all medical wards. The trust must continue to mitigate the risks associated with less than planned staffing levels to ensure safe staffing on medical wards for every shift
- The trust must take action to ensure that relevant staff are aware of the major incident protocol.
- The trust must take action to improve the safe storage of medical notes on the surgical wards.
- The trust must employ an experienced nurse to the post of critical care matron, a post that has been vacant for 15 months.
- The trust must ensure the approved operating policy for critical care is understood and followed by hospital staff when considering moving nursing staff to work on other wards. Review nursing staff levels so they meet recommended guidance for critical care to enable the supervisors/coordinators, protected staff, and clinical educators to fulfil their roles.
- The trust must review the incident reporting procedures within critical care to ensure staff are aware of what constitutes an incident, staff are enabled to report all incidents, and they receive feedback and follow-up from those they report.
- The trust must ensure all areas of the critical care unit are clean, tidy and organised to allow good cleaning to take place.
- The trust must review the equipment on the critical care unit to ensure all maintenance and servicing is up-to-date and then accurately recorded. Ensure all equipment and medicines are checked as required and stored safely, preventing the risk of tampering, and to meet legal requirements.

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- The trust must ensure the access and flow of patients in the rest of the hospital reduces delays from critical care for patients admitted to wards. Reduce the number of patient discharges at night.
- The trust must make sure policies, guidance and protocols for providing care and treatment within critical care are reviewed and up-to-date with best practice at all times.
- The trust must ensure there are specialist bereavement staff and an appropriate environment to effectively provide care and support for bereaved gynaecology and maternity patients and their families.

In addition the trust should:

- The trust should continue to develop cooperative relationships between the emergency department and other specialities within the hospital and work towards meeting internal professional standards.
- The trust should continue to work with partners to improve the responsiveness of out of hours support for adults, children and young people with mental health issues.
- The trust should continue to work with partners to improve the responsiveness of the patient transport service.
- The trust should ensure there is a reliable system of staff supervision for clinical staff.
- The trust should ensure patient records are stored securely on the cardiac ward.
- The trust should ensure staff are compliant with safeguarding children level two and safeguarding adults level two training.
- The trust should take action to improve the performance of the diabetes service, particularly with regard to prescription errors and the number of patients seen by a multidisciplinary foot team within 24 hours.
- The medical division should ensure specialty clinical governance meetings occur frequently.
- The trust should ensure improvement plans to address difficulties of flow within the medical service proceed and the impact of these changes are critically monitored.
- The trust should ensure re-assessments of risk of venous thromboembolism are consistently completed.
- The trust should ensure staff identify review dates and stop dates for antibiotics prescribed.
- The trust should ensure that actions resulting from external reviews, for example fire safety reviews, are clearly documented and acted upon in a timely manner.
- The trust should make sure chemicals and substances that are hazardous to health (COSHH) are secured and not accessible to patients and visitors on the surgical wards sluice area.
- The trust should continue with their action plan to reduce their RTT in all surgical specialities.
- The trust should continue to recognise and address issues with nursing staff shortages on the surgical wards.
- The trust should make sure medical staff on the surgical wards are up-to-date with their mandatory and statutory training and meet trust targets.
- The trust should review the chairs in the admission suite as they were of the same height, which could make it difficult for patients with limited mobility.
- The trust should reduce the number of bed moves after 10pm on the surgical wards.
- The trust should make sure a doctor prescribes all oxygen therapy before being used.

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- The trust should make sure all operations and procedures are included on consent forms prior to the start of the procedure/operation, especially for those who lack capacity to make the decision.
- The trust should make sure all equipment in theatres has the date of the last service recorded on them.
- The trust should repair all the equipment that was broken or damaged in theatres.
- The incident reporting system should be able to provide analysis of trends in incidents to staff to allow actions to be taken quickly to address any areas needing to be improved.
- The trust should display avoidable patient harm data within critical care so it shows long-term results and is meaningful to visitors.
- The trust should complete the process of otherwise good mortality reviews within critical care services to demonstrate the implementation of actions and responsibility for their delivery.
- The trust should make sure all confidential information relating to patients in critical care is secure.
- The trust should review and risk-assess the provision of the critical care outreach team service or its equivalent, which was not being provided as recommended in best practice, with appropriately trained staff for 24 hours a day. Ensure there is a formal handover between the outreach team and hospital-at-night team.
- The trust should ensure sufficient allied health professional staff are used or employed to meet the rehabilitation needs of patients in, or being discharged from, critical care at all times.
- The trust should review the use of link roles for critical care staff to better embed this practice.
- The trust should look to reference the guidance by The Law Society in its policy relating to deprivation of Liberty, and ensure there is flexibility within the policy when applying the 72-hour rule.
- The trust should look to provide an assessment for patients in critical care for any poor psychological outcomes or acute psychological symptoms, and provide support in line with National Institute for Care Excellence (NICE) guidance CG83.
- The trust should develop and implement approved strategies for patients admitted to critical care to keep them in touch with life around them. Improve the quality of communication aids for patients.
- The trust should improve the quality and quantity of information provided to patients and visitors to critical care on both printed and electronic format.
- The trust should look to analyse and determine how to reduce noise levels within the critical care unit.
- The trust should progress the business care to provide patients with a consultant-led follow-up clinic for critical care.
- The trust should ensure the critical care unit looks outside of itself to the wider hospital experienced specialist teams for input into patient care and meeting the needs of patients and their visitors.
- The trust should produce a meaningful vision and strategy for the unit with action plans designed to improve quality and performance of the service.
- The trust should provide effective use and management of the critical care risk register.
- The trust should find a solution to the continuing poor relationship with the bed management/site team and ensure all sides understand and empathise with the pressures and risks to each other's services.
- The trust should improve direct feedback to the critical care unit from visitors and patients to capture their views and deliver services to meet their needs.

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- The trust should ensure appropriate standards and auditing of cleanliness and infection control within the maternity and gynaecology services.
- The trust should ensure there is enough obstetric equipment to provide epidural pain relief and to monitor the foetal heart during labour.
- The trust should ensure there is evidence that all equipment on the delivery suite had been serviced and checked as required.
- The trust should ensure the safe storage of medical records on Charlotte ward.
- The trust should ensure clear, written evidence in records to identify if maternity care should be midwife or consultant led.
- The trust should ensure the obstetric consultant staffing complies with Royal College of Obstetricians and Gynaecologists (Towards Safer Childbirth, 2007) recommendations on staffing for a unit of this size.
- The trust should ensure effective systems are in place which evidence one to one care was provided to women in established labour 100% of the time.
- The trust should ensure gynaecology patients are supported by specialist trained nursing staff at all times.
- The trust should ensure systems are in place to effectively monitor and review patients for post-operative infection rates following a caesarean section.
- The trust should ensure there is regular audit and evaluation of the termination of pregnancy services to ensure and full compliance with national guidance and recommendations.
- The trust should make sure all confidential records are stored securely on the children's wards.
- The trust should ensure all areas used by children are child friendly and should particularly consider improving the environment for children in the theatre recovery rooms.
- The trust should make sure appraisal rates are closely monitored and actions taken to improve performance for the staff on the children's wards.
- The trust should ensure discharge summaries are completed in an appropriate time frame.
- Several outpatient areas were breaching their waiting time targets and had long follow-up appointment waiting lists. We acknowledge the work the trust had done to resolve these issues, but the trust should continue to work on this area and make sure patients are seen in a timely way.
- The trust should make sure that clinic letters are typed and sent to GPs within the trust target.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We rated this service as requires improvement overall because:

- The emergency department was overcrowded for a significant proportion of time and this was the department's biggest challenge. The trust was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department. The trust reported a year-to-date performance of 86.6% in January 2016. There had been a worsening trend since October 2015, and performance was at its worst for the month of January at 71.8%. Most breaches of the four hour target were attributed to issues of patient flow in the hospital and bed availability.
- The trust mostly performed worse than the England average against the standard that measures the time patients spend in the emergency department after the decision to admit them to an inpatient bed.
- Patients regularly queued in the corridor in the emergency department. We commended the steps which had been taken to mitigate the risks associated with queuing and the impact this had on patients' comfort and dignity. However, patients were nevertheless unwell, requiring ongoing monitoring and this was not a dignified experience for them.
- The emergency department was not consistently staffed to the planned level of nurses. Vacancies and short notice absences meant that shifts were rarely staffed by a full complement of nurses. Staff raised concerns with us about the relentless pressures placed upon them when planned staff to patient ratios were not maintained.
- Patients' records were not consistently completed to provide an accurate record of care and treatment provided. Record keeping was notably worse when the department was

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overcrowded. We were particularly concerned that patient observations were not always recorded or not recorded promptly enough and early warning scores were not consistently calculated. It was sometimes unclear whether this was a record keeping issue or an indication that assessment, care and treatment had not taken place or not taken place promptly enough.

- The trust did not monitor or report on the time that self-presenting patients waited for initial assessment in the emergency department. This meant we could not be assured patients were quickly assessed to identify or rule out life or limb threatening conditions to ensure patient safety. We saw examples of patients waiting over an hour for initial assessment.
- Pain scores and details of pre-hospital analgesia (self-administered medicines or medicines administered by ambulance personnel) were not consistently recorded at the time of patients' initial assessment. We also saw some examples where pain relief was not provided promptly. Delayed triage for some self-presenting patients meant that patients' pain was not assessed and treated promptly.
- Compliance with mandatory training was variable so we could not be assured that all staff were familiar with safe systems, processes and practices.
- Relationships with the wider hospital, and particularly acute medicine, were generally good but there was still more to be done to engage specialties in the urgent care improvement programme. Internal professional standards were being developed, which set out expected timeframes for the provision of support from specialties. These standards were not agreed for all specialities and were not being met at the time of our inspection.

However:

- Despite the fact that patients spent too long in the emergency department, the department consistently met other performance indicators,

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namely the time taken for ambulance crews to hand over patients to emergency department staff, the time to initial assessment by a clinician for ambulance-borne patients, the time patients waited for their treatment to begin, and the proportion of patients who left the department before being seen.

- Patients arriving in the emergency department by ambulance were quickly assessed to ensure they were streamed or directed to the appropriate part of the department. In the year-to-date as at January 2016, ninety-five percent of patients who arrived by ambulance received an initial assessment within eight minutes.
- The emergency department was taking steps to reduce the risks associated with overcrowding and to improve patient flow within the department. An escalation protocol had been developed to ensure that patients could be seen promptly in a treatment cubicle on arrival. This reduced ambulance delays and prevented patients being assessed in the corridor.
- There were few serious incidents reported in urgent and emergency care. There was openness and transparency about safety. Staff were encouraged to report incidents and received feedback when they did so. We saw good evidence that when incidents occurred, lessons were learned and improvements were made. Staff were familiar with their responsibilities under the Duty of Candour regulation.
- The emergency department was spacious and well laid out to support good lines of sight and patient flow within the department. The department was visibly clean and staff observed standard infection prevention and control procedures.
- There were effective processes in place for the identification and management of adults and children at risk of abuse, and staff were familiar with these.
- The emergency department had recognised that record keeping was an area which

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required improvement and a review of nursing documentation was underway. There was also a piece of work underway to raise awareness and improve compliance in relation to patient observations and identifying seriously unwell or deteriorating patients.

- People's care and treatment was planned and delivered in line with current evidence-based guidance and standards. We saw good levels of compliance with recognised care pathways, including those for sepsis and stroke care.
- Compliance with protocols and standards was monitored through participation in national audits. Performance in national audits was mostly in line with or better than other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services. Specialist teams such as the stroke team, the discharge assessment team, the medical nurse practitioner (older person's unit), the mental health liaison service and the alcohol liaison service worked closely and collaboratively with the emergency department.
- Staff demonstrated knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.
- A range of admissions avoidance and facilitated discharge schemes were in place to improve patient flow. There was a well-established and well integrated discharge assessment team which we saw to be effective. An older person's team was also working

Summary of findings

collaboratively with the emergency department to develop an acute frailty pathway at the front door, although this initiative was in its infancy.

- The emergency department was taking steps to be responsive to the needs of vulnerable patient groups. There was a well-integrated and responsive service provided to patients who attended the emergency department with mental health needs, and this service was to be extended into the evening.
- Complaints were listened to and acted upon. There was evidence that changes and improvements had been made in response to complaints.
- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. Comments included: “The staff are very attentive; I would give them ten out of ten”. This was consistent with the results of patient satisfaction surveys, which were overwhelmingly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- The emergency department had developed a mission statement and a set of strategic priorities. There was an improvement plan in place with clear milestones and accountability for actions.
- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of

Summary of findings

performance, which included safety, quality and patient experience. Risks were understood, regularly discussed and actions taken to mitigate them.

- The local leadership team was well respected, visible and accessible.
- Staff enjoyed working in the emergency department, although morale had been somewhat overshadowed by overcrowding and the pressures this placed on staff. Staff nevertheless felt valued and supported.
- Team work was cited by many staff as one of the best things about working in the emergency department. We saw excellent cooperative and collaborative working within and without the emergency department. There was a sense that collective responsibility for the four hour target was improving, although there was still some way to go.
- There was a strong focus on learning and improvement. Audit was used to drive improvement, mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient experience.

Medical care (including older people's care)

Requires improvement



Medical services were rated as requires improvement because:

- There were persistent shortages of registered nursing staff, particularly on the respiratory and cardiology wards.
- There were concerns following a fire safety review by an authorised engineer, that fire evacuation routes were not compliant with fire safety guidance on four medical wards. However action was being taken to rectify these issues.
- The trust faced significant challenges regarding the flow of patients through and out of the hospital. Many patients were not admitted to the most clinically appropriate ward because beds in specialty wards were not available
- The trust had taken steps to improve the patient outcomes in diabetes care as a result of poor performance in the National

Summary of findings

Diabetes Audit 2013. Improvement was evident in internal audits. However the trust performance in the National Diabetes Audit 2015 remained significantly below average.

- Performance in the Myocardial Ischaemia National Audit Programme was below national average. There were no effective plans in place to address these outcomes.
- Survey data showed that some carers did not feel involved in patients care.

However:

- Staff reported incidents and these were investigated.
- Medicines were managed safely.
- Apart from some omissions of recording of follow up venous thromboembolism assessments, we found that patient records were accurate and comprehensive.
- Staff were confident in the protocol for escalation of patients who were at risk of deterioration.
- The stroke service performance in the Sentinel Stroke National Audit programme had improved with an overall rating above the national average.
- Teams learned from complaints and made improvements to care following audits.
- Teams initiated conversations with patients and relatives who were making a transition to end of life care.
- We saw that staff were respectful and caring towards patients and their carers.
- Leaders were aware of risks and challenges to good quality care in the medical service.
- Several key projects such as the integrated discharge team, the ambulatory care improvement plan and the frailty flow project focussed on improving flow of patients through the hospital.

Surgery

Good



We rated surgery services as good because:

- The trust encouraged openness and transparency about incident reporting and incidents were viewed as a learning

Summary of findings

opportunity. Staff felt confident in raising concerns and reporting incidents. However, not all staff reported receiving feedback following the reporting of an incident.

- The trust encouraged an open culture. Staff were aware of the principles of Duty of Candour and apologised to patients when things went wrong.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies.
- Reporting on the Safety Thermometer between December 2014 and December 2015 indicated the number of reported harms to patients were low.
- The majority of feedback we received from patients and their relatives about their treatment by staff was positive. Patients gave us individual examples of where they felt staff 'went the extra mile' and exceeded expectations with the care they gave. Patients felt staff maintained their privacy and dignity at all times and provided them with compassionate care.
- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. However, we did find one incident where part of the care and treatment of a patient who lacked capacity to make a decision was not recorded on the consent form.
- Staff supported people living with a learning disability and those living with dementia to have a better experience of being in hospital. Staff were kind and patient with people living with dementia and a learning disability. We observed one-to-one care taking place and activities planned on their assessed needs. A specialist team of staff in the hospital provided support to patients living with a learning disability or dementia and for staff caring for them.

Summary of findings

- Patients care was coordinated when a number of different staff was involved in their care and treatment, for example physiotherapists and occupational therapists. All relevant staff were involved in the assessing, planning and delivery of patient care and treatment. Staff worked collaboratively to meet patients' needs.
- The hospital performed better than the England average in some national audits, for example, the national hip fracture audit 2015.
- The trust monitored the number of bed moves after 10pm on the surgical wards. The numbers had reduced in November 2015 compared to October 2015. However, two patients told us they had been moved very late at night and found it very disruptive.
- The service leadership was good and a cohesive clinical governance structure showed learning, change and improvement took place. Managers regularly reviewed the approach to risk management in the departments. A number of specialty meetings fed into the overall clinical governance and provided board assurance.

However:

- Patient records were not being stored securely on the admissions suite, so there was a potential risk of access by unauthorised people.
- The trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment 18 week standard) performance was worse than the England average for all but one of the six months to May 2015, when the target was abolished. By November 2015 performance had deteriorated to under 60%. Over the entire period, all specialties performed below 90%.
- The hospital performed worse than the England average in some national audits, including the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015, which is based on patients reporting to the hospital on their outcome following surgery for

Summary of findings

groin hernias, hip replacements, knee replacements, and varicose veins. In relation to groin hernias for both indicators and a mixed response in the varicose veins.

- There were periods of understaffing on the surgical wards where the trust's safer staffing numbers of qualified nurses were not met. Additional non-qualified staff were used at times to cover any gaps in the rota.

Critical care

Requires improvement



We rated this service as requires improvement because:

- Not all incidents were reported. Some had become 'everyday events' and staff were not discussing or formalising what incidents should always be reported. Staff were not receiving feedback or follow-up from reporting incidents. Not all staff were able to describe the duty of candour.
- The visible quality of cleaning on the unit in some areas did not meet acceptable standards for a high-risk area. There was a shortage of storage space, which did not help with effective cleaning.
- Servicing records for equipment did not provide assurance that everything was being regularly maintained. There was insufficient security of resuscitation trolleys, with no facility to show if they had been tampered with between checks. They had not been checked every day. The medicines refrigerator was not locked as it should be, and the temperature had not been checked every day. Some fluids and other consumables on the unit were not securely stored.
- There was a lack of security of some patient confidential information.
- Nurses were too often moved to other wards and this was often in contravention of the critical care unit's approved operating policy. The senior supernumerary nurse, shift coordinators, clinical nurse educators and nurses to take emergency admissions were too often being transferred from their duties to provide direct patient care.

Summary of findings

- There were insufficient physiotherapists to meet best practice in terms of the rehabilitation needs of patients, and not a full service from other allied health professionals.
- There was some support for patients who stayed on the unit for a long time in order to keep them in touch with life going on around them. The unit did not however, actively support a quality patient diary. There was no follow-up clinic provided to patients and limited psychological support for patients or those close to them.
- Services did not always meet patients' needs. There were bed pressures in the rest of the hospital and too many patients were delayed in their discharge from critical care to a ward, and too many were discharged at night. These delays were worse than the national average for critical care units.
- Although it was an older unit, the critical care unit facilities did not meet some of the recommendations for modern units, such as natural light, separate toilet facilities, separate entrances for patients and visitors, limited facilities for visitors including no toilets within the unit. There was a limited amount of printed or web-based information for patients and visitors. The unit had a higher level of noise at times.
- There had been no matron in post in the unit for 15 months. Although there was support, strength and guidance from the clinical lead, the senior sister, and the senior manager providing temporary oversight of the service, the unit was not performing as it should without the guidance of its most senior nursing post.
- There was sometimes a lack of sharing and inclusion both with, and sometimes by, the critical care unit and the wider hospital. The unit was not always benefitting from the wider expertise and skills of trust-wide teams and sometimes not inviting these skills onto the unit and into patient care.
- There were some areas of quality measurement and governance needing

Summary of findings

improvement. This included effective use and management of the risk register, a lack of direct general feedback requested and gathered from patients and visitors to use to improve practice, and a strong vision and long-term strategy for the unit.

However:

- There was a good record on safety and people were protected from abuse and avoidable harm. Rates for unit-acquired infection were relatively low. There was a good response to the deteriorating patient, although the risk scoring needed improvement. There were daily ward rounds and good handover between staff teams to identify deteriorating patients.
- There was a good level of mandatory training among the nursing staff, although the medical staff were not meeting trust targets. Almost all staff working on the unit had been assessed for their performance to meet trust targets. There was good support to new nursing/healthcare staff and junior and trainee doctors.
- There were safe levels of nursing staff delivering direct patient care, although supplemented by bank staff. There was however, a shortage of healthcare assistants and the level of supernumerary nurses on the unit did not meet recommended levels.
- There was wide-ranging experience and skills among the medical team and a strong commitment from the experienced consultant intensivists. The level of cover from the doctors mostly met the recommended levels, although there was not enough cover from the trainee doctors during part of their night cover.
- The provision for physiotherapist services did not wholly meet the recommendations of the Faculty of Intensive Care Medicine Core Standards in terms of cover, but the dedicated teams prioritised critical care patients and provided a safe service. A business case to increase this service was to be presented in 2016.
- Patients had good outcomes as they received effective care and treatment to meet their

Summary of findings

needs. There was delivery of medical treatment and care in accordance with best practice and recognised national guidelines. There was good management of patients' needs in relation to pain, nutrition and hydration. There had been a programme of audit and research leading to reduced infection rates and improved outcomes for patients. The mortality rates within the unit showed, over time, more people than would have been expected survived their illness due to effective care.

- There was a strong multidisciplinary approach within the unit in assessing and planning care and treatment for patients, although more skills and experience could be used. Services required to meet patient needs were available across all seven days of the week.
- There was a dedicated and successful contribution to the national organ donation programme.
- People were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients and visitors had been positive. Patients, their family or friends were involved with decision-making. We observed staff treating patients with kindness and warmth.
- There were fewer urgent operations cancelled due to the lack of a critical care bed than the national average. There was a much-reduced level of cancelled planned operations, specifically since the provision of two more beds on the unit.
- There was good evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC). Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance.
- There had been measureable and valuable innovation and change within the unit following audit, research and investigations into best practice.

Summary of findings

Maternity and gynaecology

Good



Overall, we rated the service as good because:

- There were effective safeguarding processes in place. Staff were knowledgeable about safeguarding, understood their responsibilities and had access to support.
- There were effective incident reporting processes, which staff understood and confirmed they received feedback for learning.
- Staff cared for pregnant women before, during and after birth with kindness, compassion, dignity and respect.
- Patients told us they felt involved with their care, had their wishes respected and understood.
- Systems were in place to support access and flow around the maternity services.
- There was evidence of personalised care provided to gynaecology and maternity patients and their relatives. This included gynaecology patients with memory loss conditions who had additional care and support needs.
- There were thorough risk management and governance structures and processes in place. These linked risk and governance meetings at both departmental and trust level. This produced an effective flow of information from ward to board and vice versa.
- The gynaecology and maternity services had an annual audit programme and evidence of learning and improving practice as a result of audits.
- Gynaecology cancer patients received appropriate care, which followed national standards and guidance.
- There was evidence of good clinical outcomes for maternity and gynaecology patients.
- There was evidence to show risk and quality measures were interrogated for service improvements and responsive actions were taken.
- There were systems to share information and learning.
- A positive and proactive culture was evident.

However, some improvements were needed:

Summary of findings

- There was no staff trained to provide specialist bereavement care for maternity and gynaecology patients experiencing loss, or to advise other staff who required specialist support in this sensitive area.
- The two designated areas identified to care for bereaved women and their families were inappropriate, lacking privacy, space and facilities.
- Improvements were required in records to demonstrate decisions relating to maternity care being midwifery or consultant led.
- Improvements were required in records to demonstrate that one to one care was provided to women in established labour 100% of the time.
- Additional equipment was required on the delivery suite and improvements were required to evidence all equipment had been safely maintained.
- Improvements were required on the standards of cleaning and improved evidence was required to show how this was audited.
- The obstetric consultant staffing levels did not meet national recommendations for the size of the maternity services provided on the Princess Anne wing at the Royal United Hospital.

Services for children and young people

Good



We rated the services for children and young people as good because:

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff. Staff adhered to infection prevention and control policies and protocols.
- The units were clean and well organised and suitable for children and young people.
- Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service and with other agencies.
- Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the high quality of care were encouraged and acknowledged. Children, young people and

Summary of findings

their families were respected and valued as individuals. Feedback from those who used the service had been exceptionally positive. Staff went above and beyond their usual duties to ensure children and young people received compassionate care.

- Care was delivered in a compassionate manner. Parents spoke highly of the approach and commitment of the staff who provided a service to their children.
- Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families.
- Staff understood the individual needs of children, young people and their families and designed and delivered services to meet them.
- There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to children, young people and their families and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the units as a place to work. They spoke highly of the culture and levels of engagement from managers.
- There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

However:

- As the outpatient area was not subject to the same environmental audit as other areas used for children, there were no checks in place to identify risks and to ensure the area was safe.
- There was a lack of security of some confidential information if left unattended on the children's ward.

Summary of findings

- Although safeguarding supervision was embedding across the division it remained a challenge and required continued improvement.
- Completion of appraisals was below trust target and required improvement.
- Some other areas used by children in the hospital were not child friendly, particularly theatre recovery rooms.
- There were ongoing concerns about the sustainability of safe provision of high dependency beds on the children's ward with the current workforce establishment.
- The performance for discharge summary completion required improvement.
- There were concerns about the impact of the ongoing tendering processes for inpatient therapy provision for children and young people.

End of life care

Outstanding



We have judged end of life care overall to be outstanding because:

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams.
- The staff in the palliative care team, bereavement and mortuary service were all up-to-date with their mandatory training.
- People's care and treatment was planned and delivered in line with the latest guidance, standards and legislation. The trust had undertaken a range of service developments over the 18 months prior to our inspection to support the improvement of effective care for patients with end of life care needs. New documentation had been introduced to record a personalised care plan for a dying patient.
- The trust had undertaken a project over the 12 months prior to our inspection called the Conversation Project, whose objective was to improve the identification of the dying patient and their subsequent care.
- Patients were respected and valued as individuals and were empowered as partners in their care. The evidence was universally

Summary of findings

positive about the way they were treated by staff. Several patients and relatives stated they could not think of how the care could have been improved.

- We found that people's individual needs and preferences were central to the planning and delivery of end of life care. The trust worked with services in the local community to provide continuity of care where possible and engaged with commissioners and community services to drive improvements. Staff were proactive in their approach to understanding individual patients' needs and wishes and in their approach to meeting the needs of vulnerable people.
- We found some aspects of leadership, particularly that of the palliative care team to be outstanding. We found that nursing, medical and healthcare staff across the hospital were being engaged and motivated to improve the service they provided in respect of end of life care. There were clear governance structures for end of life care with the objectives of the end of life working group being clearly laid out and monitored. There was positive leadership at board level for end of life care.
- All staff we spoke with were very positive about the trust as a place to work.

Outpatients and diagnostic imaging

Good



We rated this service as good overall because:

- There were good systems in place for incident reporting and learning from when things went wrong.
- Systems were in place for the safe administration of medicines and for the prevention of infection.
- The departments were clean and tidy and they scored well within cleaning and hand hygiene audits.
- Nursing staffing was good in terms of numbers and skills within outpatients and diagnostic imaging departments,
- Staff were competent in the roles they were being asked to perform. There was good multidisciplinary working both within the trust

Summary of findings

and with other external organisations such as other health care providers. A comprehensive audit programme was in place across outpatients and diagnostic services.

- Staff treated patients as individuals, and showed them respect and treated them with dignity. Patients told us how professional, kind and caring staff were towards them and how they provided emotional support for their patients. The family and friends test showed very positive results. This was reiterated in the positive comments of the 40 patients we spoke with during our inspection.
- Good governance systems were in place across outpatients and diagnostic imaging. Staff told us how their immediate line managers and divisional managers were always available and felt their view were listened to and respected. Managers also told us how proud they were of their teams and the care they provided to patients. Staff put patients at the centre of everything they did and the trust supported them to do that with an open and honest culture. Staff and patients had opportunities to give their feedback on services and they felt listened to.

However:

- Staffing was more problematic with the medical staffing numbers. This was mainly because of senior doctors retiring and subsequent problems in recruiting suitably experienced and qualified staff.
- Within some specialties patients were waiting long periods of time for their appointments. The trust was working to resolve the waiting times and acknowledged they still had improvements to make. We saw evidence that complaints were discussed at departmental meetings and changes were made where necessary to help prevent further complaints. We observed good practice for patients with dementia and learning difficulties.

Royal United Hospital Bath

Detailed findings

Services we looked at

<Delete services if not inspected> Urgent and emergency services; Maternity (community services); Maternity (inpatient services); Surgery (gynaecology); Spinal injuries centre; Medical care (including older people's care); Surgery; Specialist burns and plastic services; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging; Chemotherapy; Radiotherapy; Renal; Elective orthopaedic centre; Sexual health services

Detailed findings

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Background to Royal United Hospital Bath

The Royal United Hospital Bath NHS Foundation Trust is an acute trust, providing care and treatment to a population of around 500,000 across, Bath, North East Somerset and Wiltshire.

The trust became a foundation trust in November 2014 and in February 2015 it acquired the Royal National Hospital for Rheumatic Diseases, which was the smallest foundation trust in the country. In 2014 the trust also took over the provision of maternity services across Bath, North East Somerset and Wiltshire. This included maternity provision at the Royal United Hospital as well as a number of midwifery led birthing centres across the Wiltshire, Bath and North East Somerset and community midwifery services which were managed from Bath.

The trust has 772 beds across the main location, the Royal United Hospital in Bath, the smaller location of the Royal National Hospital for Rheumatic Diseases, and four midwifery led birthing centres in the community, at Chippenham, Frome, Trowbridge and Paulton. At the time of our inspection the Paulton Birthing Centre was temporarily closed.

According to the 2011 Census, the population of Bath and North East Somerset Unitary Authority was 94.5% white and 18.8% of the population were aged 65 and over. The population of Wiltshire Unitary Authority was 96.4% white and 19.5% were aged 65 or over.

Bath and North East Somerset Unitary Authority performed better than the England averages for 23 of the

32 indicators in the Area Health Profile 2015. There were three areas where the county performed significantly worse than average: incidence of malignant melanoma, hospital stays for self-harm and prevalence of opiate use. Wiltshire Unitary Authority performed better than the England averages for 17 of the 32 indicators in the Area Health Profile 2015. There were four areas where the county performed significantly worse than average: smoking status at time of delivery, incidence of malignant melanoma, hospital stays for self-harm and death and serious injury on roads.

In the 2015 Indices of Multiple Deprivation, Bath and North East Somerset Unitary Authority was in the best quintile for deprivation, while Wiltshire was in the second-to-best quintile.

We inspected the Royal United Hospital Bath, Royal National Hospital for Rheumatic Diseases, and the community midwifery service including Chippenham, Frome and Trowbridge birthing centres. We did not inspect Paulton birthing centre as it was closed at the time of our inspection.

We inspected eight core services at the Royal United Hospital:

- Urgent and Emergency Care
- Medicine (including older people's care)
- Surgery
- Critical Care
- Maternity and Gynaecology

Detailed findings

- Children and Young People's Services
- End of Life Care
- Outpatients and Diagnostic Imaging

We inspected three core services at the Royal National Hospital for Rheumatic Diseases:

- Medicine (including older people's care)
- Outpatients and Diagnostic Imaging
- Children and Young People's Services

We inspected the midwifery led birthing centres as a community midwifery core service.

Our inspection team

Our inspection team was led by:

Chair: Matthew Kershaw, Chief Executive, East Kent Hospital University Foundation Trust

Head of Hospital Inspections: Mary Cridge, Head of Hospitals Inspection, Care Quality Commission

The team included CQC inspection managers, inspectors and a variety of specialists including: A medical director, a board governance director, a director of nursing, a head of governance a divisional director of medicine, a specialist accident and emergency nurse, specialist

nurses in medicine, consultants in older people's care, a specialist occupational therapist in rheumatology, a specialist theatre nurse, a consultant surgeon, a consultant anaesthetist, a specialist critical care nurse, a junior doctor, a student nurse, a specialist critical care nurse, a consultant gynaecologist, a consultant midwife, a consultant in end of life care, a specialist nurse for end of life care, a doctor and nurse with experience in outpatients, a consultant in paediatrics, a specialist children's nurse and two experts by experience.

How we carried out this inspection

We carried out the announced part of our inspection between 15 and 18 March 2016 and returned to visit some wards and departments unannounced on 29 March 2016.

During the inspection we visited a range of wards and departments within the hospital and spoke with clinical and non-clinical staff, patients, and relatives. We held focus groups to meet with groups of staff and managers.

Prior to the inspection we obtained feedback and overviews of the trust performance from local Clinical Commissioning Groups and Monitor (now NHS Improvement).

We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

Facts and data about Royal United Hospital Bath

The Royal United Hospital Bath Foundation Trust has 772 beds across its sites. It provides care and treatment to a population of around 500,000 across, Bath, North East Somerset and Wiltshire. Between January 2015 and December 2015 there were 84,307 inpatient admissions, 803,566 outpatient attendances and 79,574 attendances at the emergency department.

In 2014/15 financial year, the trust had a revenue of £272.7m, of which the full cost was £270.5m which

resulted in a surplus of £2.2m. The trust had previously made significant improvements from a historic challenging financial position; a working capital loan of £38 million was taken in 2007 and repaid in full in 2012.

As of December 2015, the trust employed 5,539 staff (4,375 whole time equivalents), of whom 5% were bank, agency or locum.

The trust had a stable board, with the most recent executive appointments being the director of nursing and finance directors in 2013. The chief executive had been in

Detailed findings

post since 2007. The six non-executive directors had also been appointed for some time, most prior to 2012 with one new non-executive being appointed at the end of 2015. At the time of our inspection the chief executive had been appointed as the senior responsible officer for the B&NES, Swindon and Wiltshire Sustainability and Transformation Plan.

Inspection History:

This is the seventh inspection of the trust since it was registered with the commission in 2010. In February 2011 a responsive inspection of dementia care and learning disabilities was carried out the required outcomes were met but some areas for improvement were identified. In November 2011 a themed inspection regarding dignity and nutrition was carried out. Again the required outcomes were met and the improvements identified in the February inspection rectified.

In September 2012 a planned inspection was carried out and the required outcomes were met.

In February 2013 a responsive inspection was undertaken, following concerns being raised with the commission. The required standards were not met for care and welfare of people using the service; cooperating with other providers; and, the maintenance of records. We carried out an unannounced follow up inspection in June 2013. This review also included a review of governance systems and the Mental Capacity Act 2005. We found that the required standards were not met for: respecting and involving people who use the service; care and welfare; safeguarding; complaints; assessing and monitoring the quality of the service; and records. We served a warning notice on the trust for the significant non-compliance relating to assessing and monitoring the quality of the service; and records.

The trust was last inspected in December 2013 as part of our first wave comprehensive inspections as part of the new methodology. The trust was not rated during that inspection. However, we found that they had met the warning notice served following the inspection in June 2013.

Our ratings for this hospital







Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

Urgent and emergency care and treatment is provided at the Royal United Hospital, Bath (RUH) by the medical division. The emergency department (ED), otherwise known as the accident and emergency department, operates 24 hours a day, seven days a week. The ED saw 69,871 patients in 2014/15, of which around 15% were children. Thirty-nine percent of patient attendances in the ED arrived by ambulance. This was significantly higher than the national average of 23.9% and indicated that the department saw a higher proportion of acutely ill or injured patients.

The ED comprises seven areas:

- There is a minors' treatment area, equipped with trolleys and chairs, where patients are assessed and treated by senior nurses who specialise in the treatment of minor injury. There are procedure rooms, a plaster room and an eye injury assessment room.
- The majors' area has 18 cubicles, including a private examination room and an isolation cubicle, and accommodates patients with serious but not life-threatening illness or injury. The area is accessed directly by ambulance staff via a dedicated ambulance entrance.
- There is a separate high care area with six monitored beds for the care of more unwell patients or those who require continuous cardiac monitoring.
- The resuscitation area has four bays, including one which is equipped to treat children, and accommodates patients arriving by ambulance with life-threatening illness or injury.

- There is a paediatric assessment area with its own separate waiting area.
- The ED has a dedicated X-ray department providing 24 hour digital X-ray facilities.
- The observation unit has eight beds and accommodates patients who require a short period of observation.

There is a co-located urgent care centre (UCC). The service provides urgent care and treatment for patients whose illness or injury is not life-threatening. The UCC provides a walk-in service and can also be accessed by appointment via the NHS 111 telephone advice service. Patients are also referred there by the ED. This service is run by Bath and North East Somerset Doctors Urgent Care and as such, was not inspected as part of this inspection.

Although the ED is not the only point of urgent access to the hospital, most medical expected patients referred by their GP are admitted via ED because acute admission beds was not available.

The ED is designated a trauma unit and provides care for all but the most severely injured trauma patients. Severely injured trauma patients are usually taken by ambulance to a major trauma centre if their condition allows them to travel directly. They are otherwise stabilised at the RUH and either treated or transferred as their condition dictates.

We inspected urgent and emergency care between 15 and 18 March 2016. We returned, unannounced, on the evening of 29 March 2016. We spoke with approximately 15 patients and relatives. We spoke with staff, including nurses, doctors, managers, therapists, support staff and

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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. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

Summary of findings

We rated this service as requires improvement overall because:

- The emergency department was overcrowded for a significant proportion of the time and this was the department's biggest challenge. The trust was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department. The trust reported a year-to-date performance of 86.6% in January 2016. There had been a worsening trend since October 2015, and performance was at its worst for the month of January, at 71.8%. Most breaches of the four hour target were attributed to issues of patient flow in the hospital and bed availability.
- The trust mostly performed worse than the England average against the standard that measures the time patients spend in the emergency department after the decision to admit them to an inpatient bed.
- Patients regularly queued in the corridor in the emergency department. Although steps had been taken to mitigate the risks associated with queuing and the impact this had on patients' comfort and dignity, patients were nevertheless unwell, requiring ongoing monitoring and this was not a dignified experience for them.
- The emergency department was not consistently staffed to the planned level of nurses. Vacancies and short notice absences meant that shifts were rarely staffed by a full complement of nurses. Staff raised concerns with us about the relentless pressures placed upon them when planned staff to patient ratios were not maintained.
- Patients' records were not consistently completed to provide an accurate record of care and treatment provided. Record keeping was notably worse when the department was overcrowded. We were particularly concerned that patient observations were not always recorded or not recorded promptly enough and early warning scores were not consistently calculated. It was sometimes unclear whether this was a record keeping issue or an indication that assessment, care and treatment had not taken place or not taken place promptly enough.

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- The trust did not monitor or report on the time that self-presenting patients waited for initial assessment in the emergency department. This meant we could not be assured patients were quickly assessed to identify or rule out life or limb threatening conditions to ensure patient safety. We saw examples of patients waiting over an hour for initial assessment.
- Pain scores and details of pre-hospital analgesia (self-administered medicines or medicines administered by ambulance personnel) were not consistently recorded at the time of patients' initial assessment. We also saw some examples where pain relief was not provided promptly. Delayed triage for some self-presenting patients meant that patients' pain was not assessed and treated promptly.
- Compliance with mandatory training was variable so we could not be assured that all staff were familiar with safe systems, processes and practices.
- Relationships with the wider hospital, and particularly acute medicine, were generally good but there was still more to be done to engage specialties in the urgent care improvement programme. Internal professional standards were being developed which set out expected timeframes in relation to the provision of support from specialties. These standards had not been agreed by all specialties and were not being met at the time of our inspection.

However:

- Despite the fact that patients spent too long in the emergency department, the department consistently met other performance indicators, namely the time taken for ambulance crews to hand over patients to emergency department staff, the time to initial assessment by a clinician for ambulance-borne patients, the time patients waited for their treatment to begin, and the proportion of patients who left the department before being seen.
 - Patients arriving in the emergency department by ambulance were quickly assessed to ensure they were streamed or directed to the appropriate part of the department. In the year-to-date as at January 2016, ninety-five percent of patients who arrived by ambulance received an initial assessment within eight minutes.
- The emergency department was taking steps to reduce the risks associated with overcrowding and to improve patient flow within the department. An escalation protocol had been developed to ensure that patients could be seen promptly in a treatment cubicle on arrival. This reduced ambulance delays and prevented patients being assessed in the corridor.
 - There were few serious incidents reported in urgent and emergency care. There was openness and transparency about safety. Staff were encouraged to report incidents and received feedback when they did so. We saw good evidence that when incidents occurred, lessons were learned and improvements were made. Staff were familiar with their responsibilities under the Duty of Candour regulation.
 - The emergency department was spacious and well laid out to support good lines of sight and patient flow within the department. The department was visibly clean and staff observed standard infection prevention and control procedures.
 - There were effective processes in place for the identification and management of adults and children at risk of abuse, and staff were familiar with these
 - The emergency department had recognised that record keeping was an area which required improvement and a review of nursing documentation was underway. There was also a piece of work underway to raise awareness and improve compliance in relation to patient observations and identifying seriously unwell or deteriorating patients.
 - People's care and treatment was planned and delivered in line with current evidence-based guidance and standards. We saw good levels of compliance with recognised care pathways, including those for sepsis and stroke care.
 - Compliance with protocols and standards was monitored through participation in national audits. Performance in national audits was mostly in line with or better than other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.

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- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services. Specialist teams such as the stroke team, the discharge assessment team, the older person's unit medical nurse practitioner, the mental health liaison service and the alcohol liaison service worked closely and collaboratively with the emergency department.
- Staff demonstrated knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.
- A range of admissions avoidance and facilitated discharge schemes were in place to improve patient flow. There was a well-established and well integrated discharge assessment team which we saw to be effective. An older person's team was also working collaboratively with the emergency department to develop an acute frailty pathway at the front door, although this initiative was in its infancy.
- The emergency department was taking steps to be responsive to the needs of vulnerable patient groups. There was a well-integrated and responsive service provided to patients who attended the emergency department with mental health needs, and this service was to be extended into the evening.
- Complaints were listened to and acted upon. There was evidence that changes and improvements had been made in response to complaints.
- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. Comments included: "The staff are very attentive; I would give them ten out of ten". This was consistent with the results of patient satisfaction surveys, which were overwhelmingly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- The emergency department had developed a mission statement and a set of strategic priorities. There was an improvement plan in place with clear milestones and accountability for actions.
- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, which included safety, quality and patient experience. Risks were understood, regularly discussed and actions taken to mitigate them.
- The local leadership team was well respected, visible and accessible.
- Staff enjoyed working in the emergency department, although morale had been somewhat overshadowed by overcrowding and the pressures this placed on staff. Staff nevertheless felt valued and supported.
- Pressures faced by staff in the emergency department in relation to overcrowding were well understood and articulated by the management team. Risks relating to staff wellbeing, resilience and sustainability were also recognised and a range of staff support systems were in place, including an employee assistance programme and the appointment of staff as designated "stress observers."
- Team work was cited by many staff as one of the best things about working in the emergency department. We saw excellent cooperative and collaborative working within and without the emergency department. There was a sense that collective responsibility for the four hour target was improving, although there was still some way to go.
- There was a strong focus on learning and improvement. Audit was used to drive improvement, mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient experience.

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Are urgent and emergency services safe?

Requires improvement



We rated this service as requires improvement because:

- The emergency department was not consistently staffed to planned levels of nursing staff due to nurse staff vacancies and short notice absences. This situation was further compounded when the department was busy and nursing staff were deployed to care for patients in the corridor. During our inspection many nurses raised concerns about staffing levels, the impact this had on the level of care they were able to provide and the impact it had on their wellbeing. Managers acknowledged the pressures placed upon staff, associated with overcrowding, could not be sustained.
- Record keeping was not consistently maintained so that we could be assured that patients received prompt and appropriate care and treatment. This was notably worse when the department was over crowded. In particular, we were concerned about the recording of observations and the calculation of early warning scores. Records indicated that patient observations were not always carried out consistently or early enough and early warning scores, which may alert clinical staff that a patient's condition is deteriorating, were not consistently calculated.
- The emergency department did not measure or report on the time that self-presenting patients waited for initial assessment (triage). This meant we could not be assured patients were quickly assessed to identify or rule out life or limb threatening conditions to ensure patient safety. We saw examples of patients waiting over an hour for initial assessment.
- Compliance with mandatory training was variable so we could not be assured that all staff were familiar with safe systems, processes and practices.

However:

- Patients arriving in the emergency department by ambulance were quickly assessed to ensure that they were streamed or directed to the appropriate part of the department. In the year-to-date as at January 2016, ninety-five percent of patients who arrived by ambulance received an initial assessment within eight minutes.

- There were few serious incidents reported in urgent and emergency care. There was openness and transparency about safety. Staff were encouraged to report incidents and received feedback when they did so. We saw good evidence that when incidents occurred, lessons were learned and improvements were made. Staff were familiar with their responsibilities under the Duty of Candour regulation. We saw evidence that patients and their relatives received an apology when things went wrong and were informed of any actions taken as a result of mistakes made.
- The emergency department was spacious and well laid out to support good lines of sight and patient flow within the department. The department was visibly clean and staff observed standard infection prevention and control procedures.
- There were effective structured nurse and medical staff handovers/safety briefings when shifts changed. This ensured that incoming staff were well briefed concerning factors affecting safety.
- There were effective processes in place for the identification and management of adults and children at risk of abuse and staff were familiar with these.

Incidents

- There were three serious incidents reported in the emergency department (ED) between February 2015 and January 2016. One incident related to delayed treatment and two incidents were categorised as slips/trips/falls.
- Staff told us that they were encouraged to report incidents and that they received feedback when they did so.
- Learning from incidents was disseminated at handover meetings, team briefs and via email. At the team brief meeting held on 3 March 2016 there was a discussion about an incident involving a confused patient who had fallen from an emergency department trolley while in the X-ray department and had sustained an injury. A number of possible measures to reduce the risk of this type of accident happening again were discussed. These included improving the way in which patients who were confused were identified. A number of options were to be taken forward. It was agreed that in the meantime all unobserved patients on trolleys should have the safety rails in the 'up' position.

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- Incidents and learning from them were discussed at governance meetings. In February 2016 there was discussion arising from an incident where there was failure to quickly identify neutropenic sepsis.
- There were quarterly mortality and morbidity meetings where the care of patients who had complications or unexpected outcomes was reviewed so that learning could be identified and shared. We attended a meeting during our visit. The meeting was well attended by consultants and registrars. Three cases were discussed openly and there was discussion and reflection about the management of these cases and how they could have been managed better. Key learning messages were disseminated more widely through clinical governance meetings and handover meetings.

Duty of Candour

- Staff were familiar with their responsibilities under the duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Senior nurses had received a presentation about the duty of candour and were issued with a quick reference guide which outlined the steps which should be taken. There was a prompt within the incident report form to consider duty of candour.
- We were shown an example of a duty of candour disclosure. A patient had fallen in the observation unit and sustained an injury. A discussion had taken place with the patient and a verbal and written apology had been given. The patient had been informed in writing that the incident was under investigation and that the outcome of the incident would be shared with them on completion of this investigation.

Safety Thermometer

- Safety thermometer data (data collected on a single day in each month and used to record patient harms) for the period September 2014 and September 2015 showed:
 - There were no pressure ulcers reported,
 - There was one fall reported,
 - There were no catheter acquired urinary tract infections reported.

Cleanliness, infection control and hygiene

- In CQC's 2014 A&E survey the trust scored 8.7 out of 10 in response to the question which asked patients whether the emergency department was clean.
- We observed that the department was visibly clean, tidy and free of any offensive odours. Patients told us they were happy with the level of cleanliness.
- Staff reported that the emergency department was well supported by cleaning staff.
- There were monthly environmental audits of cleanliness. The department consistently performed well in these audits (94% in October 2015).
- The sluices were clean and well organised. Clinical waste was disposed of appropriately.
- There were monthly regular hand hygiene audits undertaken in the emergency department. Results for the period January to March 2016 were between 93% and 99%.
- We observed that staff regularly washed their hands and observed the bare below the elbow policy. Training records showed that 85.9% of nursing staff and 78.1% of medical staff had received mandatory training in infection prevention and control, including hand hygiene.
- We saw that staff used appropriate protective clothing such as gloves and aprons.
- There was a designated cubicle used for infectious patients in addition to a private examination room where patients could be isolated. There were also side rooms on the observation unit.

Environment and equipment

- The emergency department was spacious and laid out to support good lines of sight and patient flow within the department. The nurses' and doctors' workstations were located in the centre of the department to allow easy observation of patients.
- There was a dedicated ambulance entrance which allowed easy access to the resuscitation and majors areas.
- The adjacent X-ray department was easily accessible for the emergency department. The resuscitation room was equipped with overhead X-ray machines.
- There were numerous areas within the emergency department where plaster and paint work on walls were damaged. Cracks to flooring were temporarily covered with tape in anticipation of longer term repair. Poor

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maintenance meant that these areas were difficult to keep clean to prevent the spread of infection. The trust confirmed to us in July 2016 that the floor had been repaired.

- The trust underwent a patient-led assessment of the care environment in 2015. This included an inspection of the emergency department. A number of minor environmental issues were highlighted and remedial actions had been taken. A more significant issue, which related to the condition of the floor in the corridor linking the emergency department to the rest of the hospital, remained outstanding.
- There was a separate waiting room for children. Access to this area from the main waiting room was controlled by reception staff so it could not be entered or overlooked by adults in the main waiting area. There were separate children's cubicles; however, because the children's area formed part of the minors area, neither the children's waiting room or the treatment area was completely secure and could be entered from the adults' treatment area.
- The department was well equipped. Equipment was accessible, well maintained and clean.
- We found that weekly checks of resuscitation equipment took place consistently.

Medicines (includes medical gases and contrast media)

- Medicines were appropriately stored in secure areas. In the minors area medicines were stored in a locked cupboard and the key was held by the nurse in charge. In majors, medicines (apart from controlled drugs) were stored in unlocked cupboards in the pharmacy room. The pharmacy room was locked and could be accessed only by swipe card. Swipe cards were issued by the matron to authorised staff and this was regularly reviewed. The lack of lockable storage was identified as a minor risk on the emergency department's risk register; however, the matron told us the risk was managed and was outweighed by the fact that medicines, including intravenous antibiotics used in the treatment of sepsis, could be accessed quickly. We were satisfied this had been risk assessed and the risk was being managed to ensure that only authorised staff had access to medicines.
- Medicines stored in fridges were stored at the correct temperature at the time of our visits. Records were maintained to show fridge temperatures were regularly

checked. These had not been consistently recorded in the resuscitation area (one of five fridges in the emergency department). We could not be assured therefore that medicines stored there were safe to use.

- Controlled drugs were appropriately stored in each area of the emergency department and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- In CQC's 2014 A&E survey the trust scored 9.4 out of 10 in response to the question which asked patients whether the purpose of new medicines was explained before they left A&E. The trust scored 4.2 out of 10 in response to the question that asked patients whether they were told about possible side effects of medicines for those prescribed new medicines while in A&E. This was about the same as other English trusts. The trust was in the process of recruiting a dedicated pharmacist position in emergency department. This position had been created in response to the 2014 survey results in relation to medicines.
- Patient Group Directions (PGDs) were in place and were up-to-date. PGDs are agreements which allow some registered and appropriately trained nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor.

Records

- Patients' records were appropriately stored to enable easy access for staff, whilst not being easily accessible for people who were not authorised to view them.
- Patients' records in the emergency department were in paper format and were scanned on to the hospital's electronic system on discharge or transfer. We looked at a sample of records. We found that they were not consistently completed. For example, on 16 March 2016 seven out of 17 records checked did not record whether patients had known allergies. We could not be assured therefore that patients were protected from the risk of adverse drug reactions. Observations and early warning scores were not completed consistently (see assessing and responding to patient risk below). We saw that a patient who was admitted to the observation unit overnight on 16 March did not have an admission passport documented. The admission passport documents the reason for admission and the investigations and interventions required. It also documents comorbidities, including the need for

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assistance with, for example, mobility or personal care. This was completed retrospectively at the consultants' morning ward round. When we asked the nurse on duty about this they told us that it had been a busy night and patients had arrived in quick succession, so the paperwork had not been completed.

- There were monthly audits of records relating to the recording of observations of vital signs and National Early Warning Scores (NEWS). NEWS is a recognised early warning score tool to assess patients' risk and their need for physical observations. There were weekly audits of pressure ulcer risk assessment and management.

Safeguarding

- Staff understood their responsibilities in respect of safeguarding vulnerable adults and children. They were aware of safeguarding policies and procedures. All emergency department staff were required to complete level two safeguarding training as a minimum. This is one of the safeguarding children's standards set by the Royal College of Emergency Medicine (RCEM). Training records showed that approximately 90% of medical and nursing staff had received level two and three training.
- There were processes in place for the identification and management of children at risk of abuse:
- There was a children's safeguarding nurse employed in the emergency department. They worked three days a week and checked all records relating to child attendances to ensure that safeguarding issues had been considered and, where identified, acted on appropriately. Any omissions or concerns were followed up.
- The emergency department patient record for children included a child protection screening tool which prompted staff to consider safeguarding in their assessment of each patient. We saw that these assessments were completed consistently.
- The patient record system identified previous child attendances so staff would be alerted to possible safeguarding issues.
- There was access to a senior paediatric opinion 24 hours a day for child welfare issues.
- All child attendances were notified to GPs and to health visitors and school nurses.
- Staff understood their responsibilities to safeguard women or children with, or at risk of, female genital mutilation. Responsibilities were outlined in a policy

and formed part of mandatory safeguarding training. We saw from minutes that the subject was discussed at the emergency department team brief meeting held on 3 March 2016.

Mandatory training

- Compliance with mandatory training was variable so we could not be assured that all staff were up-to-date in their knowledge of safe systems, processes and practices. Particular areas of concern were:
 - Conflict resolution: Only 62% of administrative staff and 70% of nursing staff had received recent training.
 - Fire safety: Only 67% of administrative staff, 76% of nursing staff * and 59% of medical staff had received recent training
 - Medical gas safety: Only 34% of medical staff had received recent training
 - Mental Capacity Act: Only 70% of nursing staff* had received recent training
 - Moving and handling patients: Only 74% of nursing staff* had received recent training
 - *Data for nursing staff includes health care assistants and emergency department assistants.
- There was a system in place to report on training compliance which could be reported at personal, managerial and subject level.

Assessing and responding to patient risk

- The trust used a recognised triage tool (Manchester triage system). Patients arriving in the emergency department by ambulance were quickly assessed to ensure that they were streamed or directed to the appropriate part of the department. In the year-to-date, as at January 2016, 95% of patients who arrived by ambulance received an initial assessment within eight minutes, against a national standard of 15 minutes.
- A computerised patient administration system provided a live view of how many patients were waiting for assessment and how long they had been waiting. However, the trust was unable to provide us with information to assure us that self-presenting patients were quickly assessed to identify or rule out life or limb threatening conditions to ensure patient safety. They told us "in minors we operate a see and treat system where decision making clinicians assess the patients and triage is not required. The trust does not report on

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this standard for self-presenting patients. Accurate performance data is not available as recording of the initial assessment time is not mandatory and it is subsequently not routinely or consistently recorded.” The Royal College of Emergency Medicine’s (RCEM) Triage Position Statement (April 2011) states that a face-to-face rapid assessment should occur within 15 minutes of arrival or registration and assessment should be carried out by a trained clinician.

- Patients who self-presented were streamed by nursing staff and prioritised based on information recorded by reception staff. Streaming is advocated by RCEM because it allows patients’ needs to be matched to the appropriate part of the department or practitioner. Patients were streamed either to be assessed (triaged) by an assessment nurse or seen and treated directly by an emergency nurse practitioner. Some patients with minor illness were streamed by the nurses to be seen by the staff in the co-located urgent care centre.
- Nursing staff told us that they aimed to assess all patients within 15 to 20 minutes but acknowledged that this was not always achieved. On the evening of our unannounced visit some patients were waiting over an hour to be assessed.
- On the night of 15 March 2016, which was a very busy night, five patients who attended the minors’ area left the department before being assessed. They had waited between 65 minutes and 123 minutes. The senior consultant on duty had advised waiting patients that the department was extremely busy and that long waits were anticipated. Patients were advised to consider alternative sources of help such as primary care or pharmacists or to consider returning in the morning. The records of these five patients were reviewed the following day by the matron. They were satisfied that no harm had resulted from these delays and found that two of the patients had been telephoned at home to check on their wellbeing. We were nevertheless concerned that when the department was busy there were undifferentiated unwell patients waiting too long in the waiting room, where they were not observed by healthcare practitioners. The trust assured us that there were many clinical staff who entered the waiting room and had oversight of waiting patients, and told us they were satisfied with the clinical model to manage self-presenting patients.
- Nurses told us they were confident that reception staff would alert them to any patient who required

immediate or urgent treatment. Reception staff confirmed that they had received training and guidance about conditions which required immediate assistance. They felt confident to use their judgement to request assistance from nursing staff if they were concerned about a patient’s condition. They described conditions which would trigger an alert, such as chest pain, symptoms of a possible stroke and allergic reactions. They told us they used a speaker phone to seek assistance or spoke with nursing staff directly. They told us that patients who reported severe pain or deterioration in their condition would also be alerted to nursing staff. There was a ‘red star’ cubicle in the minors’ area which was designated for ‘priority’ patients. Receptionists told us these might be patients with burns, open wounds or a child with asthma.

- The RCEM guidance states: “Some elements of the triage process, such as initial recognition of urgency, may be undertaken by an unregistered health worker, e.g. reception staff using clearly defined “red flags” which identify urgency. For this reason non-registered health care workers in emergency settings should have basic training in red flag presentations and how to call for immediate assistance... Well defined red flag presentations, e.g. crushing chest pain or profuse bleeding, may be recognised by non-registered health care workers such as Emergency Department (ED) or Urgent Care Centre (UCC) reception staff who should seek the immediate assistance of a registered clinician... Assessing urgency in other presentations is a more complex process, and requires the skills of a trained health care professional.”
- There was an alert system which allowed the ambulance service to notify emergency department staff of the impending arrival by ambulance of seriously ill or injured patients.
- Patients presenting in ED with mental health issues were assessed using a recognised mental health risk assessment. We were told patients who were assessed as medium or high risk of causing harm to themselves or others would be kept under close supervision. This may be in the majors’ area, in one of the mental health assessment rooms or in the observation unit. Staff told us if they were concerned about safety, they could request support. This may be a healthcare assistant to provide one to one observation or a registered mental health nurse.

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- There was an enhanced nursing risk assessment tool used to assess the need for additional nursing support for patients, including those who had some form of cognitive impairment, learning difficulties or mental health concerns. We saw that requests for additional staff to support these patients were consistently met.
- The emergency department, in common with the rest of the hospital, used NEWS. NEWS scores are calculated by measuring vital signs such as blood pressure, respiratory rate and temperature. A high score may indicate the need for more frequent observations or immediate intervention. Monthly audits were undertaken to measure compliance with this system. Results showed room for improvement. Between December 2015 and February 2016 the emergency department scored between 78% and 95% against the standard which measured the percentage of patients with a NEWS score recorded. Compliance was worse for the standard which measured the percentage of observations performed where an accurate NEWS score was recorded. Scores ranged from 71% to 79%. In the ED observation unit scores were similarly variable but improving, with scores ranging from 70% to 100%. For the second standard, scores ranged between 76% and 100%.
- The emergency department had recognised that this was an area which required improvement. There were two identified leads within the department who were tasked with increasing awareness and teaching. Nurse education sessions were planned for May 2016 and NEWS was to be the topic of the month, to be discussed at various staff forums. The nursing handover process had been changed to include a review of nurse documentation.
- We looked at a sample of observations and NEWS charts during our inspection and found a similar variable picture, with accuracy of recording being notably worse when the emergency department was busy. We checked eight patient records for patients who attended the emergency department on 13 March 2016. Three records did not have NEWS scores recorded. We looked at nine patient records for patients who attended on 15 March 2016. We had concerns about four of these records.
 - One patient waited 40 minutes before the first set of observations was completed and a NEWS score calculated.
 - One patient had no nursing documentation completed at all during the two and half hours they were in the department. The patient left the department without being seen.
 - A third patient waited over two hours before observations were completed and a NEWS score was not calculated.
 - A fourth patient waited an hour for observations to be completed. No NEWS score was recorded.
- During our unannounced visit on 29 March 2016, two of the four patient records we looked at did not have a NEWS score calculated. One patient had observations recorded but a NEWS score had not been calculated.
- The second patient record had no nursing documentation completed at all. The patient had arrived in the department at 5.42pm. At 7.15pm there was no evidence that an assessment had taken place, there were no observations or a NEWS score recorded. We drew this to the attention of the nurse coordinator. They told us the nurse allocated to this patient was taking their break. We checked the record again at 8pm and the nurse documentation remained blank.
- The emergency department was not consistently meeting all national quality indicators, however some were consistently met:
 - Time to treatment - this measures how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. In January 2016 the trust's year-to-date performance was 52 minutes. A downward trend (improvement) was seen since October 2015, with performance consistently below 50 minutes.
 - Ambulance handovers - this measures the time that patients wait to be handed over by ambulance personnel to emergency department staff. The trust performed well, compared with other trusts. We spoke with ambulance crews during our inspection. They told us patient handovers were managed well, with minimal delays. There were seven black breaches in the period January 2015 to September 2015. A black breach is where an ambulance handover is delayed by over an hour.

Nursing staffing

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- The emergency department was not consistently staffed to planned levels. At the time of our visit the department had 6.4 whole time equivalent registered nurse vacancies (approximately 6% vacancy rate). Vacancy levels, combined with long term and short term absences, resulted in staffing shortfalls in most 24 hour periods during the month of February 2016. Recruitment was ongoing and there were interviews scheduled to take place for both band five and band six nurses shortly after our inspection. The matron was confident that all vacancies would be filled at this time.
- Staffing levels and skill mix in the emergency department were reviewed twice annually. The department took into account the draft 'Safe Levels of Nurse Staffing in the Emergency Department' published in January 2015 by the National Institute for Health and Care Excellence (NICE). Nurse to patient ratios had been defined for each area of the emergency department, although staff were used flexibly according to the numbers of patients in the department and their level of dependency and acuity. Nursing rotas were planned six to eight weeks in advance and reviewed weekly by a senior nurse to identify shortfalls and proactively seek cover. The matron and senior nurses oversaw daily nursing allocation to ensure that appropriate skill mix was in place and that temporary staff were sought for planned or short notice shortfalls in the rota. This included utilising staff on non-clinical duties to fill vacant shifts.
- There was a senior nurse (band seven) deployed to manage each shift. The planned nurse to patient ratio in majors was one to four. On a late shift an additional nurse was employed to care for patients in the corridor, allowing for the one to four ratio to be maintained. However, the full nursing complement was rarely achieved and this frequently meant that nurses were required to care for six patients. Nurses told us that a ratio of one to six was the norm. We were told that nurses in the minors' area were deployed to assist in majors when needed. This impacted on waiting times for minors' patients. There were three nurses allocated to the resuscitation and high care areas. Staff expressed concerns that this was frequently insufficient and nursing staff from minors were deployed to assist. The trust told us that other senior staff, such as a clinical practice facilitator, a research nurse and two sepsis sisters were all utilised to support the department at busy times. There were also five diploma qualified health care assistants who could perform an extended range of duties to support registered nurses. We were told that assistance from staff working in other parts of the hospital could be requested via the site management team but staff told us that assistance was rarely requested or provided. Some staff expressed frustration that when the emergency department was fully staffed, staff were taken from the emergency department to assist in other parts of the hospital. The trust assured us this was a rare occurrence and that staff would be recalled to the emergency department before any queuing in the corridor commenced.
- We spoke with nine nurses. Whilst we acknowledged the steps taken to ensure staffing could be flexed to meet demand, most of the nurses we spoke with raised concerns about staffing levels when the department was busy. Staff expressed frustration that they were not able to provide the level of care that patients required. One nurse told us "paperwork suffers when we are busy". Another nurse told us that they were frequently asked to look after six patients in the majors' area and this was "too much". They told us "Patients don't get everything they need because we are so stretched".
- Bank staff were regularly used to cover shortfalls in the rota, although usage was relatively low (less than 5%) compared with other areas of the trust. The emergency department had established a dedicated bank, using existing members of staff or previously employed staff who had completed supervised shifts and had a copy of the department's orientation pack. The department rarely employed temporary staff from the trust's bank but when they did so, these staff were required to complete the same level of supervision and induction as the dedicated bank staff. The emergency department did not employ agency staff, except registered mental health nurses required to support patients with mental health issues who required close observation.
- There was a structured safety handover undertaken when shifts changed. This ensured incoming staff were well informed of all factors which may affect operational performance and safety. Areas discussed included each of the areas of the department, bed state, staffing levels, and any known risks such as safeguarding concerns. Nurse to nurse handovers then took place for each individual patient.
- Although there was not a dedicated paediatric trained workforce in the emergency department, the department had taken steps to ensure that there was

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always a suitably skilled or qualified nurse on duty.

There were seven registered children's nurses employed (4.2 whole time equivalent). The management team told us that the department aimed to have a registered children's nurse on duty on every shift but this was not always possible. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identifies that there should always be registered children's nurses in the emergency department or trusts should be working towards this. The guidance further states that "all clinical staff working in emergency settings have a minimum level of knowledge, skills and competence in caring for children and young people, e.g. recognition of serious illness, basic life support, pain assessment, and identification of vulnerable patients".

- Training records showed that 88% of nursing staff had completed basic and enhanced paediatric life support training. Senior nurses had completed advanced paediatric life support training. All nursing staff had completed safeguarding children training at level two and all except one nurse had completed level three training. The department also had dedicated child protection leads who provided supervision and training. In addition, some staff had achieved paediatric competencies. In addition, eleven emergency nurse practitioners had undertaken a minor illness and minor illness in children course and most nurses and healthcare practitioners had received training in children's pain scoring. A number of training sessions had been provided in the department in the daily lunchtime training slot. These had included respiratory problems in paediatrics, bronchitis and croup and paediatric cardiac conditions.
- We were told that the assistance of a paediatric trained nurse would be provided by the children's ward when requested. The senior nurse on the children's ward could be contacted by bleep. The department continued to try to recruit registered children's nurses, although, given the small numbers of children attending the department, this remained challenging. A number of adjustments had been made in order to retain paediatric nurses, such as allowing nurses to work only nights or certain hours.

- The observation unit was staffed by one registered nurse, supported by a healthcare assistant. Staff told us that this was reduced to one staff member when breaks were taken but they could request assistance from the emergency department staff if required.

Medical staffing

- There was consultant cover in the emergency department for 14.5 hours a day (8am to 10.30pm), seven days a week. This was slightly less than the recommended 16 hours recommended by the RCEM. Outside of these hours consultants were available on-call.
- There was middle grade (ST4 or above) and junior doctor cover 24 hours a day, seven-days-a week.
- Most junior medical staff told us they were happy with the level of consultant and senior medical staff cover in the emergency department. They told us that consultants often stayed in the department until midnight if the department was busy. One doctor told us they felt that more medical staff were needed on late shifts at the weekend and on night shifts. They told us these shifts were very busy and stressful for staff.
- Locum doctors were employed infrequently (on average 2.5% of total staff spend from January to October 2015) and shortfalls in the medical rota were mostly covered by doctors who had previously been employed in the emergency department and who had completed both the trust and departmental induction. On rare occasions, external locums were employed who worked under the supervision of a consultant or registrar.
- There was a consultant with a special interest in the care of children. All medical staff had received appropriate levels of life support training for children.
- Junior medical staff told us they were happy with the level of consultant and senior medical staff cover in the emergency department.
- There were structured medical staff handovers using proformas to ensure that important information, including all known risks, were shared and discussed.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. All staff received training as part of their departmental orientation on appointment and thereafter annual updates were provided. There were action cards kept in the doctors' work area, which outlined responsibilities for each staff

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role in the event of a major incident. The emergency department took part in a trust-wide major incident exercise facilitated by Public Health England in March 2014. This was to test the trust's major incident plan. The emergency department's teamwork and leadership during this exercise were praised by Public Health England.

- There were arrangements to deal with casualties in the event of a chemical, biological, radiological or nuclear (CBRN) incident. There were identified leads within the emergency department for CBRN and they attended external training events. CBRN equipment and processes were audited annually by the local ambulance service. CBRN response was last practised in the emergency department in December 2015.
- There were appropriate security arrangements to keep staff, patients and visitors safe. The department had close-circuit television with a monitor in reception. There were panic alarms at reception and on the observation unit, which, when activated, alerted security staff. Staff told us security staff responded quickly. Some staff also carried personal alarms.
- In CQC's 2014 A&E survey the trust scored 9.8 out of 10 in response to the question which asked patients if they felt safe in the emergency department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated this service as good because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance and standards. We saw good levels of compliance with recognised care pathways, including those for sepsis and stroke care.
- Compliance with protocols and standards was monitored through participation in national audits. Performance in national audits was mostly in line with, or better than, other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.

- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services. Specialist teams such as the stroke team, the discharge assessment team, the specialist nurse for older people, the mental health liaison service and the alcohol liaison service worked closely and collaboratively with the emergency department.
- Staff demonstrated knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.

However:

- Pain scores and details of pre-hospital analgesia (self-administered medicines or administered by ambulance personnel) were not consistently recorded at the time of patients' initial assessment. We also saw some examples where pain relief was not provided promptly. Delayed triage for some self-presenting patients meant that patients' pain was not assessed and treated promptly.

Evidence-based care and treatment

- Care and treatment was delivered using recognised clinical guidelines, for example, National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) Clinical Standards for Emergency Departments. There were clear pathways supported by proformas for the management of conditions such as stroke and sepsis and we saw evidence in patients' records that staff were familiar with these pathways and that they were followed. Junior doctors had access to guidance on the intranet.
- There were three sepsis nurses employed in the emergency department covering seven days a week. They provided education and support to the emergency department and had contributed to the significantly improved awareness of, and engagement with, the sepsis pathway.

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- We saw several examples of the stroke thrombolysis pathway being used and effective joint working with the hospital's stroke team.
- There was a protocol in place for direct transfer of eligible patients to the cardiac catheterisation laboratory where urgent diagnostic tests to the heart were carried out. Out of hours, patients were transferred to the Bristol Royal Infirmary.

Pain relief

- In the CQC 2014 A&E survey the trust scored 7.9 out of 10 in response to the question which asked patients if staff did everything they could to control their pain. However, the score was only 6.6 out of 10 in response to the question in relation to waiting too long to receive pain relief if requested.
- Pain was assessed using a numerical system (one to 10). A pictorial pain scoring system was used for patients with communication difficulties who could not verbalise pain.
- We found in our examination of patient records that pain scores and details of pre-hospital analgesia (self-administered medicines or administered by ambulance personnel) were not consistently recorded at the time of initial assessment. We also saw a few examples where pain relief was not provided promptly. Delayed triage for some self-presenting patients meant that patients' pain was not assessed and treated promptly.
- It was reported in the minutes of the governance committee meeting held in January 2016 that the emergency department had performed poorly in audits in relation to administration of analgesia and recording pain scores. It was noted that performance had deteriorated compared with the previous three years. Possible reasons for performance were discussed and were thought to include nurses having multiple tasks to perform, the emergency department being busy and that practice was not being accurately documented. This was consistent with our findings.

Nutrition and hydration

- Patients in the emergency department had access to food and drink. There were no set drinks rounds undertaken in the emergency department, although we observed staff serving drinks from time to time. Patients told us they had been offered and/or provided with drinks and sandwiches.

- In the CQC 2014 A&E survey the trust scored 7.3 out of 10 in response to the question which asked patients whether they were able to get suitable food or drinks when they were in the A&E department. This was about the same as other English trusts.

Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The emergency department employed a data analyst who produced and reported weekly audits on sepsis and Trauma Audit and Research Network (TARN) data. The trust participated in local and national audits so they could monitor compliance with national guidelines and best practice and benchmark their practice and performance against other emergency departments. Action plans had been developed to improve performance where shortfalls were identified.
- The emergency department conducted an audit of the management of acute ischaemic stroke, which was published in January 2016. This assessed how quickly eligible patients received thrombolysis treatment (door to needle), received a CT scan (door to CT) and were admitted directly to a stroke unit. Results for the period October to December 2015 showed a median door to needle time of less than 50 minutes and a door to CT time of 10 minutes. During the same time period 96% of patients diagnosed with a stroke were admitted directly to the stroke unit.
- In the RCEM 2013-14 audit of severe sepsis and septic shock, although most scores were similar to the national average, the trust did not meet any of the national standards, including two "key performance indicators". These require that:
 - 75% of patients receive first intravenous crystalloid fluid bolus in the ED. The trust scored 42%.
 - 50% of patients receive antibiotics within one hour. The trust scored 36%.
- The emergency department undertook its own audit of sepsis management which looked at the care of sepsis patients over a two year period (December 2013 to December 2015). This showed significant improvement over time in the identification and prompt treatment of sepsis and the two key indicators were now being met consistently. This improvement was attributed to a change in culture brought about by education. There were three dedicated sepsis nurses employed in ED who supported and educated staff in the identification and

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treatment of sepsis. All patients who attended the majors or resuscitation/high care areas in ED were routinely screened for sepsis. There was a highlighted section on the patient assessment record completed by nurses. This prompted staff to consider and record signs of infection and to initiate the 'sepsis six pathway' where this was indicated. The 'sepsis six pathway' is a recognised series of diagnostic and treatment interventions which should be delivered within one hour.

- In the 2014/15 RCEM audit of initial management of the fitting child the trust's performance was mostly in line with other trusts nationally. The trust achieved two national standards, including the 'fundamental standard' which requires that blood glucose is recorded in all children actively fitting on arrival. A checklist to be used for the management of seizures in children had been developed in response to the audit findings.
- In the 2013/14 RCEM asthma in children audit the trust's performance was mixed when compared with other trusts. Scores were in the upper England quartile for two standards and in the lower quartile for three standards. Since the audit, the emergency department had introduced a paediatric early warning score chart in collaboration with paediatric colleagues at the RUH and the regional centre for children in the south west. A more recent local audit had shown compliance with the standards.
- In the 2014/15 mental health in the ED audit the trust performed relatively well compared with other trusts and met both of the standards classified by the RCEM as 'fundamental', which all providers should meet. These standards relate to the completion of a risk assessment and the provision of a dedicated assessment room for mental health patients.
- In the 2013/14 RCEM paracetamol overdose audit the trust performed reasonably well compared with other trusts. Only 2% of staggered overdoses received N-acetylcysteine within one hour of arrival but this performance was better than most trusts.
- In the 2014/15 RCEM audit: assessing for cognitive impairment in older people, the trust did not meet the fundamental standard which requires all patients to have an early warning score documented. Two of the five remaining standards were met and the trust's performance was mostly good compared with other trusts.

- The unplanned emergency department re-attendance rate was consistently lower (better) than the national average and fluctuated at around the national standard of 5%.
- The emergency department conducted an audit of the trust's performance in relation to the RCEM standard which requires that certain patient groups should be reviewed by a consultant in emergency medicine (or a senior trainee or appropriately experienced staff grade doctor) prior to discharge. In a recent local audit (February 2016) the trust reported that 76% of adults with non-traumatic chest pain and 86% of febrile children less than 12 months old were reviewed by a consultant or ST4 or above. Performance, although not 100% was better than the national picture in 2013 when this was last audited.

Competent staff

- Nursing staff had appropriate qualifications, skills, knowledge and experience to do their job. There was an identified education lead who maintained a department-wide overview and oversight of nurse staff competencies.
- Nurses were supported to keep themselves up-to-date professionally. Nurse training sessions were provided four weekdays per week. These took place for one hour in the overlap between the early and the late shift. On the fifth day a department-wide team brief took place. Training sessions covered a range of topics. On one of the days of our inspection a clinical nurse specialist in oncology had provided teaching. Other topics recently covered included domestic violence and National Early Warning Scores (NEWS). Regular study days were provided. Nurses told us these provided opportunities to further their education to support revalidation and progress in their careers. They told us they were also encouraged and supported to research and develop areas of interest and act as a source of advice and training for the team. For example, there were link nurses in dementia care, bereavement, infection control, and gynaecology. Link nurses were given protected time to pursue their area of interest.
- There was a system in place to provide supervision of nursing staff. A band seven nurse was the designated Clinical Practice Facilitator and undertook three to four shifts per week of clinical supervision.

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- Ninety percent of emergency department staff had received a performance appraisal in the last 12 months as at December 2015.
- There was regular teaching provided to junior and middle grade medical staff. Junior medical staff told us they felt well supported by senior clinicians in the emergency department. Like their nurse colleagues, medical staff were encouraged to research and develop special areas of interest.

Multidisciplinary working

- Care was delivered in a coordinated way with support from specialist teams and services. Specialist teams, such as the stroke team, the discharge assessment team, the older person's unit medical nurse practitioner supporting the geriatrician of the day, the mental health liaison service and the alcohol liaison service worked closely and collaboratively with the emergency department.
- Staff told us there were good working relationships with the medical admissions unit and we saw that the acute physicians were often in the department.
- Medical staff reported good collaborative working arrangements with radiology.

Seven-day services

- There was senior medical staff presence in the emergency department seven days a week. Other services, including radiology, mental health liaison and therapy services were also available across the whole week

Access to information

- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.
- Patients admitted to inpatient wards from the emergency department had their records scanned onto the hospital's electronic system before they were transferred to the ward. For those patients who were discharged from the emergency department, an electronic discharge summary was generated and sent to the patient's GP. We saw an example where a doctor in the ED had contacted the GP of a patient with mental

health needs who had attended the department but who had left before being seen. The doctor was concerned about this patient's welfare and wanted to ensure that the patient was followed up by the GP.

- There was a white board in majors which allowed staff to view activity in the department as a whole. This was an effective tool which helped staff to manage patient flow in the department. A separate white board showed the patients who were being cared for in the corridor. A range of icons was used to alert staff to particular needs of patients, for example patients who were confused, patients who were deaf or blind, patients who were at risk of falling and patients, such as those with Parkinson's disease, who needed to take medicines on time.
- A 'real time' ambulance screen allowed staff to see anticipated ambulance arrivals so they could plan patient and staff movement in the department to accommodate incoming patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- We observed doctors and nurses asking patients' permission before they undertook examinations or provided care or treatment. Patients who had undergone tests told us the reasons for these tests had been explained to them.

Are urgent and emergency services caring?

Good



We rated this service as good because:

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. Comments included: "The staff are very attentive; I would give them ten out of ten." A patient who was being cared for in the corridor in the emergency department told us "Whilst this is not the

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most dignified experience, the staff have done their very best to make it bearable. They are angels". This was consistent with the results of patient satisfaction surveys, which were overwhelmingly positive.

- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.

Compassionate care

- In a patient experience survey conducted between July and December 2015, 98% of patients admitted to the emergency department observation unit rated their care overall as excellent or very good.
- The trust used the friends and family test to capture patient feedback. Results were consistently good, with over 90% of respondents indicating that they would recommend the service (December 2014 to November 2015).
- We spoke with approximately 20 patients and relatives and feedback was overwhelmingly positive. One patient in the emergency department told us "The staff are very attentive; I would give them ten out of ten". A patient on the observation unit told us staff were friendly. They said "They (nursing staff) take time to chat to you." Another patient on this unit told us "the staff are marvellous." A patient who was being cared for in the corridor in the emergency department told us "Whilst this is not the most dignified experience, the staff have done their very best to make it bearable. They are angels."
- We observed positive interactions between staff and patients. We saw a healthcare assistant regularly checking on the comfort and wellbeing of a patient who was being cared for in the corridor. They offered words of reassurance to one patient and held their hand. A healthcare assistant on the observation unit frequently reassured an elderly patient who was a little muddled and disorientated.
- Staff took care to maintain people's privacy and dignity. Cubicle curtains were drawn when private conversations, examination or treatment took place. In

CQC's 2014 A&E survey, the trust scored 9.2 out of 10 in response to the question which asked patients whether they thought that overall, they were treated with dignity and respect while they were in the ED. This was better than most other trusts.

- Patients were treated with respect and consideration. In CQC's A&E survey the trust scored 9.1 out of 10 in response to the question which asked patients if staff did not talk in front of them as if they weren't there. We observed that staff were friendly, polite and courteous. We heard them introduce themselves to patients by name and by role.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. In CQC's 2014 A&E survey the trust scored:
 - 8.1 out of 10 in response to the question which asked patients whether they were as involved as much as they wanted to be in decisions about their care and treatment.
 - 8.3 out of 10 in response to the question which asked patients whether they felt the doctor or nurse explained their condition and treatment in a way they could understand.
 - 8.9 out of 10 in response to the question which asked patients if they felt the doctor or nurse listened to what they had to say.
 - 7.8 out of 10 in response to the question which asked patients whether their family or someone else had enough opportunity to talk to a doctor if they wanted to.
- Patients told us they were kept well informed about what was happening and what would happen next, although timescales were not always known. We heard a doctor taking a medical history from a patient and explaining the tests they were going to carry out. The consultation was undertaken in an unhurried and sensitive manner and everything was explained to the patient in a way that they could understand.
- We saw staff engaging well with children, as well as their parents.

Emotional support

- In CQC's 2014 A&E survey the trust scored 7.7 out of 10 in response to the question which asked patients if they felt reassured by staff if they were distressed while in

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A&E. This was better than most other trusts. The trust scored 7.5 out of 10 in response to the question which asked if they had any anxieties and fears about their condition or treatment, a doctor or nurse discussed these with them.

- During our unannounced visit we saw that a nurse spent a significant amount of time with relatives of an anxious patient who was awaiting a mental health assessment. They stayed on duty long after their shift should have ended because they had built up a rapport with the patient and their family.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement



We rated this service as requires improvement because:

- The trust was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department. The trust reported a year-to-date performance of 86.6% in January 2016. There had been a worsening trend since October 2015, and performance was at its worst in the month of January 2016, at 71.8%. Most breaches of the four hour target were attributed to issues with patient flow in the hospital and bed availability.
- The trust mostly performed worse than the England average against the standard that measures the time patients spend in the emergency department after the decision to admit them to an inpatient bed.
- The emergency department was overcrowded for a significant proportion of the time and this was the department's biggest challenge. Patients regularly queued in the emergency department corridor. Although these were mostly patients who had been assessed as being stable and who were awaiting admission to hospital beds, they were nevertheless unwell and required ongoing monitoring. Despite commendable steps taken by staff to ensure that patients were as comfortable as possible, this was not a dignified experience for patients. This was highlighted by the fact that when we attempted to speak with some

patients in the corridor, they felt too unwell to engage in conversation. We witnessed queuing only during our unannounced visit, which took place following an extended Bank Holiday period.

However:

- Despite the fact that patients spent too long in the emergency department, the department consistently met other performance indicators, namely the time taken for ambulance crews to hand over patients to emergency department staff, the time to initial assessment by a clinician for ambulance-borne patients, the time patients waited for their treatment to begin, and the proportion of patients who left the department before being seen.
- The emergency department was taking steps to reduce the risks associated with overcrowding and to improve patient flow within the department. An escalation protocol had been developed to ensure that patients could be seen promptly in a treatment cubicle on arrival. This reduced ambulance delays and prevented patients being assessed in the corridor. Patients awaiting admission still queued in the corridor. The department had recognised the impact that queuing had on the comfort, privacy and dignity of patients. They had introduced comfort rounds to ensure that these needs were met.
- A range of admissions avoidance and facilitated discharge schemes were in place to improve patient flow. There was a well-established and well-integrated discharge assessment team which we saw to be effective. An older person's team was also working collaboratively with the emergency department to develop an acute frailty pathway at the front door, although this initiative was in its infancy.
- The emergency department was taking steps to be responsive to the needs of vulnerable patient groups. There was a well-integrated and responsive service provided to patients who attended the emergency department with mental health needs, and this service was to be extended into the evening.
- Complaints were listened to and acted upon. There was evidence that changes and improvements had been made in response to complaints.

Service planning and delivery to meet the needs of local people

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- The trust was working closely with commissioners to identify system-wide strategies to improve patient flow. The trust participated in a whole-system review of urgent care undertaken by the Emergency Care Intensive Support Team (ECIST) at the request of the host (one of four) clinical commissioning group. There was a system-wide four hour recovery programme led by the CCG and the emergency department participated in a number of the work streams.
- Premises and facilities were mostly adequate for the services provided, although with some limitations.
- The emergency department was well sign-posted within the hospital grounds. There was a drop-off zone and short-term parking (limited to 20 minutes) available close to the department. Further parking was available within a five minute walk. One patient told us they had spent 15 minutes trying to find a parking space. We experienced some difficulty parking on our unannounced visit.
- Patients entered the emergency department via two entrances, one for patients brought by ambulance, the other for self-presenting patients.
- Self-presenting patients checked in at the main reception desk. Here, steps had been taken to protect patients' privacy and dignity. Patients were invited to sit in private booths so that confidential information could not be overheard by other queuing patients and visitors. In CQC's 2014 A&E survey the trust scored 7.7 out of 10 in response to the question which asked patients if they had enough privacy when discussing their health problem with the receptionist. During our unannounced visit patients sometimes queued at the reception desk and there were no reception staff visible because they were booking in patients in the private booths. This was not explained to patients and caused some confusion and frustration.
- There was a large waiting room which provided adequate seating during our visits, although staff told us that on occasions visitors had to stand. A patient told us that on the evening of 15 March 2016 there were no seats available in the waiting room. We thought the waiting room, although functional, was stark and unwelcoming.
- There were vending machines where visitors could purchase drinks and snacks. Toilets were available which were suitable for adults and children. There were nappy changing facilities and breast feeding mothers could be accommodated in side rooms.
- Patients brought in by ambulance were usually taken directly to a cubicle in the majors or high care areas or a bay within the resuscitation area. Patient's privacy was maintained by use of curtains. In the resuscitation area, mobile screens were used to preserve people's dignity. There was one side room in majors which could be used for private examinations.
- The majors' area, although spacious, frequently became overcrowded. This was usually because inpatient beds were not available for patients who had been assessed and required admission. In order to maintain flow within the department and allow incoming patients to be assessed in privacy, patients who had been assessed and seen by a doctor were moved into the corridor. In extreme circumstances, when there were no available cubicles, incoming patients also queued on the corridor. The staff in the emergency department had recognised that this practice impacted on patients' comfort, privacy and dignity and had taken steps to improve the experience for patients. A nurse in the department had developed an escalation care proforma, which prompted staff to consider whether patients were warm enough, whether they wanted anything to eat or drink, whether they needed pain relief, whether they needed to use the toilet, or if there was anything else they needed. Staff told us that queuing patients would be moved into identified cubicle spaces or the relatives' room if required for private conversations, examination, toileting or treatment. Nevertheless, this remained an undignified experience for patients, highlighted to us, not only by the shame that staff described, but the fact that some patients, who we attempted to speak with in the corridor, told us they felt too unwell to engage in conversation.
- In CQC's 2014 A&E survey the trust scored 9.3 out of 10 in response to the question which asked patients whether they were given enough privacy during examinations and treatment. These scores were about the same as other trusts.
- There was not a dedicated children's department because the number of children attending the emergency department did not make it viable to staff a dedicated unit. There was a separate waiting area and treatment area for children with minor injuries, which was suitably decorated, furnished and equipped. Seriously ill or injured children were cared for in the adults' majors or resuscitation area.

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- There were two dedicated mental health assessment rooms in the emergency department and another on the observation unit. These were appropriately furnished to ensure that furniture and fittings could not be used to cause self-harm or harm to others. Occupants of the room could be viewed through viewing panes and there were two doors as recommended made by the psychiatric liaison accreditation network.
- The observation unit accommodated male and female patients in an eight-bedded ward, including two side rooms. The emergency department risk register identified that single-sex accommodation could not be consistently provided in the observation unit. There were separate male and female toilets but only one shower room. Staff told us that they did their best to maintain patients' privacy and dignity by cohorting male and female patients and using the side rooms effectively. They told us they had received no complaints about privacy and dignity. There had been no single sex breaches reported in the last 12 months.

Meeting people's individual needs

- The emergency department was mostly responsive to patients' needs, including those with complex needs.
- Patients living with dementia were identified on the patient information board using a forget me not symbol. This is a universally recognised symbol used to alert health and social care professionals that a patient has some form of cognitive impairment and may need additional support. We saw this being used. There was an identified dementia lead in the emergency department but they were not on duty during our visit. Staff we spoke with had received training in dementia care and were alert to the particular needs of this patient group but acknowledged that the department had taken limited steps to become "dementia friendly". Staff told us that patients living with dementia would not be cared for in the corridor. Staff on the observation unit told us they would try to accommodate patients with any form of cognitive impairment in the bays directly opposite the nurses' station so that they could be closely observed. A project group had recently been established to develop a comprehensive older person's assessment and they had been tasked with making recommendations to make the emergency department more 'dementia friendly'.
- The emergency department used 'This is me' profiles for patients living with dementia and 'passports' for patients with learning difficulties. These profiles, often completed by family members or carers, set out patients' needs and preferences, which they may not be able to communicate themselves.
- There was a resource folder which provided advice to staff providing care to people with learning difficulties. This included an easy read booklet entitled 'Going to the Emergency Department', which had been produced with input from a patient. This included a guide for assessing pain in patients who were not able to communicate this verbally. There was advice and support available to staff and patients and their carers from specialist nurses who worked from Monday to Friday.
- The emergency department was accessible for people with limited mobility and people who used a wheelchair. Although the reception desk was too high for patients who used a wheelchair, there were individual cubicles where the desks were at an appropriate height.
- There were interpreter and translation services available for patients and visitors whose first language was not English.
- The trust used an on-line interpreter service for deaf people which allowed them access to a trained interpreter who interpreted the consultation between a deaf person and their clinician to explain treatments, procedures and diagnoses. The system also converted over 500 medical questions into British sign language video clips. These questions were also available in 12 foreign languages.
- The trust provided a bereavement service. Booklets were available, which provided information for bereaved families and friends. This included an invitation to contact the department where their family member or friend died and speak with staff involved in their care. There was a dedicated viewing room for deceased patients and a relatives' room leading from it.
- There were arrangements in place for patients who presented to the emergency department with mental health issues, including those who had self-harmed. There was a mental health liaison service provided by the local mental health trust. This operated from 8am to 8pm, seven days a week. The service was well-integrated with the emergency department and was described by staff as being responsive. The service

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aimed to respond to referrals within timescales advocated by the Royal College of Psychiatrists (emergency 60 minutes, urgent five hours, same working day, and routine within two working days). Although the service was not specifically monitored against these standards, four hour emergency department breaches attributed to mental health assessment delays were jointly monitored at the monthly joint operational group. Breaches coded under this category were currently reported as being insignificant (1.9%). Out of hours, mental health assessment was provided by the mental health trust's community intensive service. This was reported to be less responsive than the day time service. The emergency department risk register dated 10 March 2016 identified a moderate risk in relation to out of hours provision. It stated "As a result of the lack of out of hours mental health care in the emergency department there is a risk that patients with mental health issues will remain in the department awaiting mental health assessment which may result in the need to provide a high level of nursing and security supervision, a prolonged stay in ED resulting in a breach of the four hour target and failure to comply with NICE clinical guidance no. 25". Staff told us that patients who required a mental health inpatient bed also experienced delays. The department was working with the mental health trust to mitigate the identified risks:

- There were monthly joint meetings with the local mental health trust.
- The mental health trust had increased staffing in the intensive service to provide a "twilight" shift. The trust was also currently recruiting staff to enable the mental health liaison service to be extended from 8pm to midnight.
- The emergency department and mental health liaison service had jointly developed management plans for frequent attenders to the emergency department. These were held in a file in the doctors' work area.
- There was a database maintained of patients who had self-harmed. Information packs had been developed to be given out by staff to people who had self-harmed, providing sources of advice and support. The mental health liaison service had developed a project whereby postcards were sent to patients who had self-harmed

with a supportive message, reminding them where they could seek help. This allowed regular contact with this patient group with the aim of preventing re-attendance in the emergency department.

- There was a Child and Adolescent Mental Health Service (CAMHS) provided by another trust. The service was provided from 9am to 5pm Monday to Friday. There was emergency telephone advice available out of hours. We were told the CAMHS team telephoned the emergency department each morning and arranged to see appropriate patients that morning. The trust (RUH) was unable to provide any data to show how responsive this service was but told us that responsiveness would be monitored by a newly established sub-group of the joint trust mental health group. The lead consultant for mental health in the emergency department told us that sometimes patients who required an assessment by the CAMHS team had to wait until the following day, which meant that they had to be admitted.
- There was an alcohol liaison service provided by the local mental health trust from 8.30am to 5pm Monday to Friday. The service provided assessment and support to patients at the time of their emergency department or observation unit attendance. Patients who attended out of hours may have been seen by the mental health liaison service and/or referred to the alcohol liaison service at a later date. Emergency department staff told us this was a valuable and responsive service.
- There was no service provided for patients who misuse substances; however, we were told by the trust that patients would be 'signposted' to other services.

Access and flow

- The emergency department was not consistently meeting all national quality indicators, however some were consistently met:
- 4 hour performance - this standard requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. The department was consistently failing to meet this target and reported a year-to-date performance of 86.6% in January 2016. There had been a worsening trend since October 2015, and performance was at its worst in the month of January, at 71.8%. Reasons for breaching the four hour

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standard were monitored and reported each month. In November 2015 there were 823 breaches of the four hour target, of which 625 were attributed to issues with patient flow in the hospital and bed availability.

- Time to admit - this measures the time that patients, who require admission to a hospital ward wait from the time of decision to admit (percentage of patients waiting four to twelve hours). The trust mostly performed worse than the England average between November 2014 and November 2015.
- Left without being seen - this measures the percentage of patients who leave the ED before they have been seen by a clinician and is indicative of patient dissatisfaction with waiting times. The national standard is that this should be below 5%. The trust's performance was consistently less than 2%.
- Trolley waits - this measures the number of patients who wait more than twelve hours on a trolley in the emergency department. There were no such delays reported from October to December 2015. Patients sometimes stayed in the emergency department overnight because there were no beds available in the hospital. They were provided with hospital beds if this occurred.
- A diagnostic review of the urgent and emergency care system in Bath and North east Somerset was undertaken by the Emergency Care Intensive Support Team (ECIST) in September 2015. This was a whole system review requested by the Clinical Commissioning Group for Bath and North East Somerset. ECIST noted "the significant pressures on the emergency department, with crowding aggravated by difficulties in patient flow. On the day of their visit they noted the emergency department having to manage a situation which was "compromising patient safety" and which was "unsatisfactory for staff and patients". They reported that the ED was operating at 100% occupancy levels for long periods, and as a consequence, "patients and staff experienced an area which was severely crowded and not resilient." They concluded the pressures placed on the ED and staff due to the constant heightened pressure was neither a sustainable nor safe way of working. ECIST acknowledged the major problem faced by the emergency department was 'outflow', in other words, patients who required admission were not able to be transferred promptly to a hospital bed and the whole system approach to admission avoidance, particularly out of hours, was not effective.
- Overcrowding was a regular challenge in the emergency department. The department had developed a protocol to manage circumstances where the number of patients in the department outstripped capacity. The protocol entitled 'Managing Escalation in the Emergency Department' described a system known as "queuing out", which was implemented during times of escalation and crowding. This entailed moving stable patients who had had been assessed and who had completed their investigations and treatment, and were awaiting admission, into the corridor. This freed up cubicles to enable incoming patients to be assessed and treated. The protocol set out the staff to patient ratios and a range of staff responsibilities to ensure the safety, comfort, privacy and dignity of affected patients. We saw the shift coordinator utilising this protocol effectively. There was an ambulance screen which displayed anticipated ambulance arrivals. They used this information and started to implement patient moves in anticipation of arrivals. The coordinators were assisted by a receptionist and, during the late shift (the busiest shift), they were supported by a flow assistant. In extreme circumstances, patients were required to "queue in". This occurred when cubicles could not be freed up for incoming patients. In these circumstances staff were required to identify a side room or cubicle which could be used for private conversations, examinations or toileting of these patients.
- There was a trust-wide escalation policy which outlined a series of actions to be taken according to the escalation status of the hospital and the emergency department. Status was designated from 'green' (optimum working), through 'amber' and 'red' to 'black' (the trust is in a critical position and the emergency department or other departments are clinically unsafe). There were a range of trigger factors in the emergency department, including staffing levels, number of patients in the department or expected, waiting times and actual or anticipated four hour breaches.
- There was a four hour improvement plan which had been developed following the ECIST visit. The improvement plan had three work streams: front door, specialities and back door, each led by an executive director. The front door work stream focussed on

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emergency department internal working, ambulatory care services, medical and surgical admissions units and admissions avoidance. We noted the following progress since September 2015:

- The emergency department had a well-established 'see and treat' service provided by emergency nurse practitioners. In October 2015 the service was extended to operate 24 hours a day, seven days a week. The department's performance against the national time to treatment standard had improved over this time.
- Admissions avoidance and facilitated discharge schemes were in place and their effectiveness was being monitored. The discharge assessment team supported the emergency department and the observation unit to facilitate early discharge and avoid inappropriate hospital admission. Physiotherapists and occupational therapists provided this service seven days a week. A service review published in July 2015 reported that between January and June 2015 the service received a total of 798 referrals, of which 78% of patients were discharged and 22% were admitted to hospital. The service had increased and adjusted its hours of operation, using this data, to improve its efficiency. Emergency department staff were very complimentary about this service and its contribution to patient flow. The British Red Cross also provided an assisted discharge service (introduced in November 2015). A nurse practitioner had been appointed to work with the emergency department and the medical admissions unit (MAU) staff to facilitate early discharge of frail elderly patients. An older persons' front door service had been established to identify patients in the emergency department or MAU who could be transferred to the assessment unit for older people for short term assessment/care, or who could be discharged. Data was being collected to evaluate the effectiveness of this initiative.
- In response to a recommendation from ECIST the model of care provided by the co-located urgent care centre had been reviewed to create an integrated front door with a single streaming process to avoid duplication.
- The emergency department had developed internal professional standards to agree expectations of, and

between, the emergency department and supporting services. At the time of the ECIST visit, the emergency department was the default for the majority of expected medical admissions, which contributed to crowding and delays. This was also the position at the time of our inspection. ECIST recommended that expected patients should be admitted directly to an assessment area or speciality ward. When this could not be achieved, the patient should be assessed by a senior speciality doctor within 30 minutes of arrival. The emergency department had produced referral guidelines which required that GP referred medical patients should be reviewed by the acute physicians within one hour of arrival in the emergency department. This was longer than the timeframe recommended by ECIST but it was felt to be a more realistic target. The guidelines for other specialties were awaiting approval by the Urgent Care Collaborative Board at the time of our visit. Assessment times by specialties were not routinely monitored. However, the emergency department clinical lead had analysed the time to treatment times for all patients admitted to the emergency department in February 2016. This showed the median time to treatment times for non-expected patients was 39 minutes for self-presenting patients and 55 minutes for ambulance-borne patients. This compared with a median time to treatment time of 95 minutes for GP-referred medical and surgical/urology patients.

- There were eight beds in the ED observation unit, which accommodated patients who required a short stay for monitoring. During our visit we saw this unit used appropriately to avoid admission to the main hospital bed-base and improve patient flow within the emergency department. There were admission criteria in place to ensure that the unit was used appropriately. An admission passport had to be completed and signed by a senior doctor to verify that the admission was clinically appropriate.
- We noted that waiting for transport was a criterion for admission to the observation unit. Staff told us that the patient transport service was not always responsive. The contract with the ambulance provider stipulated that transport would be provided within a four hour window from the time of request. This inevitably meant that some patients remained in the emergency department or the observation unit for longer than necessary.

Learning from complaints and concerns

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- Complaints leaflets were available in the emergency department and staff were informed about how to support people who wanted to raise concerns. Complainants were offered face-to-face meetings with senior staff to discuss their concerns and received written accounts of the department's investigation and findings.
- Complaints and learning from them were discussed at departmental team briefing meetings and staff handover meetings. We saw a number of complaints were discussed at a team brief meeting held in March 2016. A theme relating to poor communication and staff attitude was identified and there was discussion about how this could be improved. Complaints were also discussed at clinical governance meetings. There was a review underway, following a complaint, of advice given to women experiencing bleeding in early pregnancy. This included the production of a revised leaflet to be given to relevant patients.
- Following a complaint from a relative that they had not been contacted when their family member attended ED and was admitted, it was agreed to amend nursing process documentation. We observed in a number of patients' records that nurses had documented that relatives had been informed.
- We noted that a complaint was discussed at a recent meeting of reception staff. All staff were given clear guidance to ensure that the circumstances which led to the complaint were not repeated.
- It was noted at a recent governance committee that a complaint had been received from a patient who felt their injury had been trivialised. There was discussion and reflection recorded on the importance of communication and empathy.
- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, which included safety, quality and patient experience. Risks were understood, regularly discussed and actions taken to mitigate them.
- The local leadership team was well respected, visible and accessible.
- Staff enjoyed working in the emergency department, although morale had been somewhat overshadowed by overcrowding and the pressures this placed on staff. Staff nevertheless felt valued and supported.
- Teamwork was cited by many staff as one of the best things about working in the emergency department. We saw excellent cooperative and collaborative working within and without the emergency department. There was a sense that collective responsibility for the four hour target was improving, although there was still some way to go.
- There was a strong focus on learning and improvement. Audit was used to drive improvement, mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient experience.
- Pressures faced by staff in the emergency department in relation to overcrowding were well understood and articulated by the management team. Risks relating to staff wellbeing, resilience and sustainability were also recognised and a range of staff support systems were in place, including an employee assistance programme and the appointment of staff as designated "stress observers".

However:

- Relationships with the wider hospital, and particularly acute medicine, were generally good but there was still more to be done to engage specialties in the urgent care improvement programme. Internal professional standards were being developed, which set out expected timeframes for the provision of support form specialties. These standards had not been agreed by all specialties and were not being met at the time of our inspection.

Are urgent and emergency services well-led?

Good



We have rated this service as good because:

- The emergency department had developed a mission statement and a set of strategic priorities. There was an improvement plan in place with clear milestones and accountability for actions.

Vision and strategy for this service

Urgent and emergency services

- The emergency medicine speciality had developed a vision: “To provide high quality, safe and effective assessment, care and treatment to emergency patients 24 hours a day, seven-days-a week by senior decision makers who are fully integrated with community services”. There was a series of strategic priorities which underpinned this vision. Staff were not all familiar with the strategic priorities, but they all passionately articulated shared values; safety, quality, care and compassion, which underpinned their work.

Governance, risk management and quality measurement

- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, which included safety, quality and patient experience. There was a monthly clinical governance meeting attended by senior nursing and medical staff. A standard agenda included incidents and risk management, patient experience, including complaints, safety alerts, clinical guidelines and audit. Key messages were communicated by distribution of minutes, email, team briefs, teaching sessions and handovers. The emergency department clinical governance meeting reported to the divisional governance meeting which reported ultimately to the board. Divisional operational performance reports monitored and reported on key safety and quality standards. There were regular role-specific meetings for consultants and senior nurses.
- A risk register was maintained for the emergency department. Risks were discussed at monthly governance meetings. Risks were appropriately mitigated and escalated. The risk register largely mirrored the concerns voiced to us, with a few notable omissions. These related to staffing levels and staff resilience, and concerns about the responsiveness of the patient transport service.
- There were good, cooperative relationships with third party providers and partners, including the ambulance services, the urgent care centre and the local mental health trust. Regular joint meetings were held to promote partnership working.

Leadership of service

- The local leadership team comprised the lead consultant, matron and deputy divisional manager. They were well respected and were considered by staff

to be visible, accessible and approachable. The matron regularly worked as shift coordinator so they were familiar with the challenges and pressures faced by staff. The nursing staff we spoke with regarded this senior presence as supportive. The trust’s chief operating officer was a regular visitor and was regarded as supportive, particularly when the department was under pressure.

- We observed nurse coordinators very ably managing shifts in the emergency department, coordinating the flow of patients and staffing requirements. We received many positive comments from staff in the department and ambulance personnel about the calm and efficient way in which they managed competing pressures.

Culture within the service

- Staff told us they enjoyed working in the emergency department. They felt respected and valued. Team work was cited by many staff as one of the best things about working in the department. Morale was generally good, although somewhat overshadowed by concerns about overcrowding and the pressure this placed on staff. A number of staff felt that work pressures had resulted in staff sickness, although sickness absence rates were about the same or lower than others parts of the trust. Staff felt that leaders recognised the pressures they faced and placed emphasis on their wellbeing.
- There was a culture of openness and honesty. Staff told us they felt able to raise concerns and they would be listened to.

Public engagement







- The ED used the friends and family test (FFT) to capture views about the service. However, response rates were consistently poor. It was noted in the performance report to the trust board in January 2016 that the emergency department was working to identify FFT champions to support increased response rates. Feedback from surveys was shared with staff.
- Patient stories were presented to each meeting of the ‘front door group’ to highlight both positive and negative patient experiences.
- The emergency department had engaged with a person with a learning disability to develop an easy read guide ‘Going to the Emergency Department’.

Staff engagement

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- There were weekly team briefing meetings held in the emergency department and minutes were circulated so that all staff were kept informed. We observed a meeting during our inspection. It was a well-attended, inclusive meeting which generated discussion. Staff told us that they felt well informed and their views and contributions were encouraged and welcomed. Regular role-specific staff meetings were held and minutes were circulated so that staff were kept informed of news and developments.
 - A nurse in the emergency department had developed a 'care proforma' which was used to document care provided to patients who were queuing in the corridor. This formed part of a protocol which was developed to reduce the risks created by having undifferentiated patients queuing on arrival in the emergency department. The 'care proforma' prompted nurses to undertake safety checks but also to consider comfort, privacy and dignity. The nurse had researched arrangements in other emergency departments and considered CQC judgements and requirements in this area.
 - A project was undertaken by a medical student entitled 'What am I waiting for?' This examined whether patients waiting in the emergency department at various stages of the patient journey, knew what they were waiting for and whether they had been told how long they may have to wait. An audit of patients concluded that most patients knew what they were waiting for but most were uncertain about timescales. This was discussed at clinical governance meetings and it was agreed that "honest uncertainty" was the best response. This was to be taken forward at nurse teaching sessions.
 - An emergency department doctor was working on some information for patients answering the question "why has that patient been seen before me?" Posters were to be produced to provide advice to patients regarding this.
 - The emergency department was developing an advanced nurse practitioner programme.
- Innovation, improvement and sustainability**
- There was a strong sense of drive to improve the service. There was an urgent care improvement plan which had been developed in response to ECIST recommendations. The plan had three work streams, 'front door', 'specialities' and 'back door' and each work stream was monitored via a performance dashboard, overseen by an executive-led urgent care collaborative board. Members of the executive management team had recently attended an A&E workshop facilitated by Monitor and attended by 29 other NHS trusts.
 - The 'front door group', which met weekly, was attended by representatives from a range of 'front door' functions and disciplines. These included the emergency department ambulatory care, medical and surgical admissions units, older people's unit, pharmacists and therapists. It was described by staff as "energised and focussed" and there was optimism expressed that it would deliver improvements. There was an action tracker used to record and monitor progress on agreed actions.

Medical care (including older people's care)

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

Information about the service

Medical care encompasses a broad range of specialties that use non-surgical interventions to assess, diagnose and treat patients. There were twelve medical wards at Royal United Hospital Bath. These included wards that specialised in neurology, respiratory, acute oncology, endocrinology, medical short stay, plus an ambulatory care unit, a medical therapies unit, a coronary care unit, a medical assessment unit and the four wards that made up the older persons unit (OPU). The OPU included the assessment and comprehensive evaluation unit (ACE).

During 2014 – 2015, there were 39,106 admissions to the medical service. Of these admissions, 61% were emergency admissions, 2% were elective and 47% were day case patients. There were approximately 600 inpatient beds within the medical division at the hospital.

The age profile for the non-elective admissions to the hospital showed that 31.5% of patients were aged over 75 compared to a national average of 25%. The percentage of patients over 90 was 5.5% compared to a national average of 3.6%.

Summary of findings

We rated medical services as requires improvement. This was because

- There were persistent shortages of registered nursing staff, particularly on the respiratory and cardiology wards. These shortages were addressed proactively on a shift by shift basis. However, the last staffing review dated August 2015 had not included the data from these wards. The data from these wards was included in a subsequent staffing review dated February 2016.
- There were concerns following a fire safety review by an authorised engineer, that fire evacuation routes were not compliant with fire safety guidance on four medical wards, but action was being taken to rectify these issues.
- The trust faced significant challenges regarding the flow of patients through and out of the hospital. Many patients were not admitted to the most clinically appropriate ward because beds in specialty wards were not available
- Performance in the National Diabetes Inpatient Audit 2013 was significantly below national average. The trust had implemented several actions to address the shortfalls identified in this audit, but performance in the 2015 audit remained poor.
- Performance in the Myocardial Ischaemia National Audit Programme was below national average. The trust identified inaccuracies in the data submitted for

Medical care (including older people's care)

the MINAP audit but did not rectify this prior to publication of this audit. The trust provided further unpublished data that indicated improvement in the patient outcomes for this specialty.

- Survey data showed that some carers did not feel involved in patients care.

However:

- Staff reported incidents and these were investigated.
- Medicines were managed safely.
- Apart from some omissions of recording of follow up venous thromboembolism assessments, we found that patient records were accurate and comprehensive.
- Staff were confident in the protocol for escalation of patients who were at risk of deterioration.
- The stroke service performance in the Sentinel Stroke National Audit programme had improved with an overall rating above the national average.
- Teams learned from complaints and made improvements to care following audits.
- Teams initiated conversations with patients and relatives who were making a transition to end of life care.
- We saw that staff were respectful and caring towards patients and their carers.
- Leaders were aware of risks and challenges to good quality care in the medical service.
- Several key projects such as the integrated discharge team, the ambulatory care improvement plan and the frailty flow project focussed on improving flow of patients through the hospital.

Are medical care services safe?

Good



We rated the medical care service as good for safe because:

- Staff understood their responsibilities to report incidents and learning was shared as a result of these incidents.
- Staff we spoke with demonstrated understanding of the duty of candour.
- The medical service monitored the incidence of falls, pressure ulcers, venous thromboembolism, and clostridium difficile on the wards. Leaders took action to reduce and prevent the incidence of these events.
- Staff consistently used good hand hygiene and followed infection control procedures.
- Staff stored and managed medicines safely.
- Apart from some omissions of recording of follow up venous thromboembolism assessments, we found that patient records were accurate and comprehensive.
- There were clear protocols for staff to manage deteriorating patients.

However:

- The actual number of registered nurses was below the planned number of registered nurses across medical wards. The staffing review dated August 2015 did not include two wards (respiratory and cardiac). These two wards had a greater level of staffing shortage than others. However, the staffing review dated February 2016 did include the data from these wards and matrons were mitigating the staffing risk on a day to day basis.
- There were concerns following a fire safety review by an authorised engineer, that fire evacuation routes were not compliant with fire safety guidance on four medical wards, but action was being taken to rectify these issues.
- Not all staff had completed all mandatory training. The trust had introduced a trajectory of targets for achieving full compliance and at the time of our inspection the trust was on track to achieve these

Incidents

Medical care (including older people's care)

- Staff understood their responsibilities to raise concerns and to report safety incidents, concerns and near misses. The majority of staff told us they always reported incidents and managers confirmed that their teams did so.
- There were 37 serious incidents reported in medicine over the 12 month period February 2015 to January 2016. Twenty five of these serious incidents were slips, trips or falls and three related to infection control.
- When things went wrong in medicine, senior managers carried out thorough and robust investigations. Investigators identified and shared learning from these incidents and took action to improve safety when needed. On the cardiac ward, there were incidents of confused patients leaving the ward unsupervised. Following the investigation, a change of protocol determined staff screened all patients for mental capacity and considered the need for deprivation of liberty safeguards at the time of admission.
- Staff described varied feedback from incidents. One nurse told us she did not receive feedback or support from senior staff when she had reported incidents of violence and aggression. Another nurse said that after she had reported an incident of verbal aggression, her manager had contacted her the next day to offer support and had reassigned the patient to a different nurse.
- Following incidents, teams shared learning across directorates to improve safety beyond the affected team or service. An incident had occurred because staff on a non-medical ward had not made reasonable adjustments for a patient with learning disability, such as flexible visiting arrangements. Leaders shared learning from this incident in the clinical governance meetings.
- Mortality and morbidity review meetings were effective at identifying trends or issues of concern that led to learning and subsequent action to improve care. For example, on the OPU, analysis of a case study had identified that teams should ensure results of myeloma screening tests were checked with patients after hospital discharge. On the cardiac ward, learning from mortality and morbidity meetings was shared via a newsletter attached to staff payslips and in a ward communication book.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation required the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff we spoke with were aware of this legislation.
- Staff were not always aware of the trust guidance regarding duty of candour and how to access this. However staff at all levels were able to describe what the duty of candour involved and the actions required. Since February 2016, training for duty of candour was incorporated into staff induction. Duty of candour training had been delivered at various staff meetings such as the clinical reference group, the professional nursing and midwifery forum, the RUH leaders forum, hospital thrombosis committee, medical division senior sisters meeting plus various clinical specialty governance meetings
- Staff told patients when an incident had impacted upon their care. Staff told us that patients were always given an apology and they were informed of any actions taken as a result of investigations.
- Staff volunteered information about how they complied with the duty of candour requirements. For example, a ward sister described an incident when a medication was administered by injection after it had been discontinued. The sister supported the nurse to apologise to the patient and inform the doctor. Serious incident reports showed consideration of duty of candour.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for monitoring patient harm and harm free care. Rates of new pressure ulcers, falls and catheter acquired urinary tract infections reported to the Patient Safety Thermometer between December 2014 and December 2015 were variable with no discernible trends. The prevalence rate for pressure ulcers and for falls ranged between zero and 1, and for catheter acquired urinary tract infections the prevalence rate ranged from zero to 1.7.

Duty of Candour

Medical care (including older people's care)

- The wards used a cross-box chart to display incidence of falls, venous thromboembolism, commode cleanliness and clostridium difficile infection. This meant that staff and visitors to the ward could access information about safety performance.
- The medical service monitored the incidence of pressure ulcers. Whenever a patient's skin was damaged as a result of pressure, teams investigated the reasons why this occurred. Trends from these analyses identified that staff did not always complete skin checks accurately. The medical service took appropriate action to reduce the incidence of pressure ulcers, for example, a recent change of protocol identified that registered nurses were required to complete all skin checks. Evaluation of this change was not completed at the time of our inspection.
- The mortality risk at weekends was similar to the mortality risk during weekdays and was within the expected range for a trust of this size. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospital admission and the number that would be expected to die on the basis of average England figures. The hospital standardised mortality ratio is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than would be expected. On both these measures, the trust performed within the expected range.
- The medical service monitored the rates of infection occurring on the wards. Of particular concern were the four cases of clostridium-difficile blood stream infections reported in November, and two in December 2015. This type of bacterial infection could affect the digestive system.
- In 2015, the trust made some improvements against standards for clostridium difficile management but there were still significant areas of concern. At the time of our inspection, there was a vacancy for one whole time equivalent consultant microbiologist which equated to 25% of the team. In December 2015, the trust had invited a peer review of their processes. This team consisted of advisors from the clinical commissioning group, NHS England and Public Health England. This review highlighted the limited staffing in microbiology and made several recommendations. The trust had devised a comprehensive action plan in response to this review which included further training regarding optimum use of antibiotic medicines, more effective use of risk assessments to prioritise isolation facilities, and more extensive environmental cleaning. However in February 2016 it was noted at the trust wide infection prevention and control committee meeting that there were some areas of the action plan that had not been started.
- Staff audited the procedures that were in place to prevent patients contracting Clostridium difficile. For example, wards completed a collection of preventative and protective measures on wards where a patient had a clostridium difficile infection. Compliance with these measures was 100% over the six months prior to our inspection.
- Patients were not always screened for carriage of methicillin resistant staphylococcus aureus (MRSA). In June 2015, MRSA screening was low on some wards ranging from 73% to 89% compliance. The trust screening processes were reviewed in 2015 and this led to the introduction of a tool to identify patients who were at high risk of developing an infection. In December 2015/January 2016 the infection control team completed an audit of compliance with MRSA screening of high risk patients in line with trust policy. This audit identified that although staff were taking swabs of patients, the dates and times of these swabs were not recorded, skin washes had not commenced and patients were not given information leaflets about MRSA. In January 2016, the infection control team

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from healthcare associated infections. Staff confidently explained hospital protocol for protecting patients and carers from a healthcare associated infection.
- We saw that isolation room doors were usually closed, except when patients requested that the door be left open. There was appropriate signage on these doors. Staff wore appropriate personal protective equipment such as gloves and aprons and utilised effective hand-washing techniques.
- Patients that needed to be hoisted were allocated a sling for the duration of their hospital stay. This was then disposed of after their discharge.
- Cleaning audits for October, November and December 2015 indicated above 92% compliance for most wards. On the wards we visited, commodes were visibly clean and labelled as clean.

Medical care (including older people's care)

completed an audit to identify whether patients who were MRSA positive received their treatment. This audit showed that 57% of MRSA positive patients had commenced decolonisation and 77% of MRSA positive patients had a care plan in place. Action plans to improve compliance with decolonisation were not in place at the time of our inspection. A follow up audit had commenced in April 2016.

- Staff took precautions in the medical inpatient settings when seeing people with suspected communicable diseases such as tuberculosis or influenza. Specialist infection control nurses were available 24 hours a day, seven days a week. When a patient was suspected of having influenza on the medical assessment unit, the infection control nurse attended promptly and put in place an action plan to isolate the patient immediately.
- The Patient Led Assessments of the Care Environment for 2015 indicated that the trust scored similarly to the national average for cleanliness.
- We observed that healthcare workers decontaminated their hands immediately before and after every patient contact. Hand hygiene audits completed during October 2015 to December 2015 indicated that all medical wards achieved 96% or above for hand hygiene compliance. On the neurology ward, one patient commented that patients were encouraged to wash their hands regularly.
- Staff followed safe protocol for the insertion and removal of vascular access devices. In December 2015, most medical wards showed 100% compliance with the trust policy regarding removal of cannulae, except for the acute stroke unit, the Coronary Care Unit at 80% and William Budd ward at 90%.

Environment and equipment

- There was a system for monitoring the maintenance of medical equipment including a central asset equipment register. Engineers visited all departments twice a year to service medical equipment. Engineers highlighted to ward sisters the equipment that could not be serviced because it was in use or not available, and wards were responsible for sending these items to the depot for servicing or decommissioning. However some items of equipment were considered to be lost because they were not sent to the depot or because frequent attempts to service them had been unsuccessful. This resulted in a risk that some equipment might be in use and not adequately serviced. However, staff were trained to check equipment servicing dates prior to use.
- Items of equipment that had not been seen by engineers or at the depot were manually removed from the database. As this process was not undertaken frequently, there was a risk that the dataset did not convey an accurate and up to date understanding of performance. However, with inaccuracies of the dataset accounted for, 90% of equipment was up to date with routine servicing.
- On four wards we saw that cleaning materials such as bleach, sanitizer, and antichlor were stored on an easily accessible shelf in an unlocked room.
- Staff could always access pressure relieving mattresses and cushions for patients 24 hours per day from a central equipment library. Staff told us they felt confident to use equipment safely. All of the equipment competencies for staff were completed on the trust intranet which enabled staff to access refresher information with ease.
- There were safe systems for managing waste and clinical specimens. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.
- Resuscitation equipment was readily available. This equipment was stored securely, in tamper evident packs and was checked daily in accordance with the trust policy.
- The trust had commissioned a review of fire safety by an authorised engineer which reported in November 2015. This raised concerns that there were four medical wards (the ACE OPU, Helena ward, Midford ward and medical short stay unit) which had challenges with fire evacuation routes in line with current fire code legislation. Some of these items were noted on the corporate risk register as an ongoing risk.
- Action was being taken to rectify these issues related to fire safety, some of which were as a result of older architecture and some to do with work to install new IT cabling. There was also planned work to install a new internal fire-escape from one of the wards and the possibility of installing misting sprinkler systems. We were told that actions would be completed by November 2016/17. The trust told us about the mitigating actions that were being undertaken and provided a fire safety action plan. However this plan did

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not include details of actions resulting from the review of fire safety in November 2015, nor any interim mitigating actions or progress made with actions to date.

Medicines

- Medicines were safely and securely stored and managed on the medical wards. Staff kept medicines and intravenous fluids in locked cupboards or rooms with restricted access, and stored medicines at suitable temperatures to maintain their quality and ensure they were fit for use. Temperatures of storage areas were checked daily. There was a pharmacy top-up service provided by the on-site pharmacy to maintain appropriate levels of stock medicines on the wards, and medicines storage audits were regularly completed to check compliance with the trust's medicines code policy.
- However, medicines storage on the Ambulatory Care unit was not always appropriate; for example, we saw individual patients medicines (including one dispensed in the community) were kept in the ward's stock medicines cupboard. Intravenous fluids were stored in a publicly accessible area and not locked securely.
- Controlled drugs are medicines that require additional security. We saw that controlled drugs were stored in locked cupboards and appropriate staff held the keys. Staff maintained accurate records of controlled drugs. Nursing staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council Standards for medicine management.
- We observed good practice on wards during preparation of medicines. The trust reviewed medication errors. A recent incident involved a missed dose of medication that had been documented in the patient's notes but not escalated to the doctor. Following this incident, the ward leader educated the team regarding the correct protocol. An omitted dose audit was completed on one medical ward, results were not yet available.
- We looked at the prescription and medicine administration records for 12 patients on six wards. Prescription charts had been fully and legibly completed, and all allergies were documented. Administration records showed that people received their medicines as prescribed, and monitoring was recorded as necessary for certain medicines.
- When doctors prescribed medicines for patients, patients were involved in these decisions as recommended in NICE clinical guideline 76. We observed that during medication rounds staff took time to explain the medication to the patient. In the trust inpatient survey July 2015 to December 2015, 77.5% of patients and 100% of carers said that staff explained the possible side effects of medications to them. On the neurology ward, staff adhered to a patient's existing routine for Parkinson's medication. This involved administering medicines nine times per day.
- On some wards, staff supported patients to administer their medicines themselves during their stay in hospital. Their medicines were locked in their bedside cabinets and nurses supported patients to access their medicines when they needed them. However, at the time of our inspection, very few patients were managing their own medicines. Risk assessment and consent forms were available for staff to complete in line with the Royal Pharmaceutical Society's guidance on self-administration but these were not consistently completed.
- Medicines were usually available to facilitate timely discharge of patients who were going home. Patient's own medicines were kept in lockers by their bed, and discharge planning helped to avoid delays in the supply of medicines at discharge. We saw evidence that, on average, 95% of medicines to take home were available within two hours from the pharmacy; however, this was reported to still occasionally cause delays in discharge on some wards.
- The medical service ensured that medicines were used safely and effectively for the best possible outcomes. A well-established clinical pharmacy service was provided to most medical wards. Pharmacy staff reviewed the prescriptions for people on first admission to hospital to reduce the risk from discrepancies in medicines being prescribed, and recorded their advice on the prescription charts to help guide staff in safe medicines administration.
- However, this process did not always occur promptly. The pharmacy team visited wards each weekday, but a reduced service was available at weekends. During 2015, the Trust had frequently been unable to achieve the national target of 90% of patients' medicines being reconciled within 24 hours.
- The trust audited the percentage of patients who were prescribed antibiotics within trust antibiotic guidelines. This included documentation of the indication for antibiotics, review or stop date on medicine charts and

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intravenous antibiotic prescriptions reviewed within 48 hours. Results for 2015/2016 showed improvement in compliance with all four parameters. We looked at seven prescription cards and saw that antibiotic prescribing was within guidelines. However, on five of these records staff had not recorded a stop date or review date.

Records

- Patients individual care records were not always stored securely to protect their privacy. We saw several sets of patient records stored on a shelf behind a nurse's station that was not attended. Fifteen sets of patient notes were stored on the open shelf beneath secure trolleys and patient records and hydration charts were stored on open clipboards outside of side rooms in full view of visitors.
- On every ward we saw that patients' full names were displayed on the white board, visible to staff, patients and visitors.
- We checked 19 individual care records and these were accurate, legible and up to date. Admission notes were legibly documented. Nursing assessments conformed to nursing standards. For example all patients who were assessed as having a pressure ulcer had a documented positioning and repositioning regime. Patient records showed evidence that fluid charts and intentional-rounding records were consistently completed.
- Patient records showed evidence that individualised care plans were consistently reviewed. For example, patient care plans were discussed during white board rounds on the acute stroke unit. The multidisciplinary team provided input to this discussion including therapists, nurses and consultants. After the white board round, a record of the multidisciplinary team discussion was stuck into the patient's medical record.

Safeguarding

- Safeguarding systems, processes and practices were in place to protect people from abuse. Staff were able to explain these procedures.
- The trust had completed the Nursing and Midwifery Council self-assessment framework for safeguarding. There were several recommendations from this audit including the need to increase compliance with training and to implement domestic violence training.

- Not all staff had completed safeguarding training. However, in March 2016 compliance with safeguarding level two for adults training had increased to 87%, for safeguarding children level two this figure was 77.8% and for safeguarding children level three compliance was 95.5%.

Mandatory training

- Not all staff had completed mandatory training updates in safety systems, processes and practices. Data received from the trust indicated that in December 2015, the rate of compliance with mandatory training across medicine was 86.2%. The trust was achieving their target of 90% compliance for the following subjects: corporate induction, health and safety, infection control and hand hygiene, information governance, moving and handling level one, and safeguarding children level one. However, there were 15 other courses that were not reaching the 90% threshold for compliance. These included equality and diversity training at 77% and conflict resolution at 79%.
- Not all staff were invited to complete dementia awareness training. This category included security staff. The trust launched a dementia awareness programme in February 2016 in order to address this.

Assessing and responding to patient risk

- Staff in medicine completed comprehensive risk assessments for patients. At daily safety briefings, staff discussed those patients who had been identified as 'at risk'. This included identification of patients at risk of aggressive behaviour, absconding, pressure damage, falls, deterioration, plus those patients carrying an infection, patients requiring assisted nutrition, diabetic patients and patients who were for cardiopulmonary resuscitation.
- Magnetic symbols were used were used to identify on the ward whiteboards those patients who were at risk of pressure ulcers, falls, had nutritional needs, had communication needs, or were living with dementia.
- There was a hospital wide standardised approach to the detection of the deteriorating patient. There was a comprehensive policy detailing the implementation of the National Early Warning Score (NEWS) for all patients using the medical service. There were allocated leaders who were responsible for implementing the action plan to embed the use of NEWS. This group reported to the Patient Safety Steering Group. These leaders were

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responsible for ensuring that staff consistently and accurately used the NEWS system to monitor patients' vital signs, that nurses reliably escalated concerns when required and correct actions were taken to ensure optimal care for that patient.

- On the wards we visited, all staff were familiar with the method of calculating and interpreting the National Early Warning System (NEWS). The use of this system was audited on a monthly basis using a sample of ten sets of notes looking at the last five observations. The audits for December 2015 indicated an overall compliance of 96% with recording of NEWS on medical wards apart from William Budd at 80%. Accuracy of recordings was less compliant with an overall score of 87%.
- Staff felt able to escalate concerns even when a patient was not scoring as at risk on the NEWS. One nurse explained that she had raised her concerns regarding a medical patient located on a surgical ward who she felt was deteriorating despite a low NEWS score. The doctor from the medical team reviewed that patient promptly. When we visited a ward at night, we saw that medical staff responded promptly to a nurse's request to attend the ward to write up an urgent prescription.
- The hospital had on-site access to levels two and three critical care (intensive care units with full ventilator support). There was a critical care outreach service that was available seven days a week from 7.30am until 8pm. This was a nurse led team who were able to offer education and support for ward staff plus interim specialist care whilst wards awaited allocation of correct skill mix to meet acuity needs of a deteriorating patient.
- Several staff told us that the critical care outreach team was an invaluable resource out of hours for nurses who were managing deteriorating patients. The night nurse practitioner was available for staff to contact during the night shift if they had any concerns regarding patients at risk of deterioration. This nurse was aware of any patients identified by medical teams during the preceding day who might be at risk of deterioration and where possible she visited these patients to check on their status during the night.
- Urgent or unplanned medical admissions were seen by, and assessed by a relevant consultant within 12 hours of admission or within 14 hours of the time of the arrival at the hospital. When patients were triaged as high risk of deterioration, consultants attended within one hour to assess. Consultants regularly reviewed patients on the

medical assessment unit.. However, renal patients received their specialist renal treatment at a neighbouring hospital and were reviewed approximately twice per week by the renal consultant from that hospital.

- Protocols for managing challenging behaviour in the medical inpatient wards relied on the use of security personnel. Staff on medical wards reported that they felt comfortable calling security for assistance when needed and that the response times were effective.
- Staff completed a mental health risk assessment for patients requiring special observation and sought advice from the mental health coordinator or the mental health liaison team.
- Comprehensive risk assessments regarding falls were in place for patients. On the cardiac ward, we saw that all patients had a falls risk assessment and a subsequent falls care plan if patients were identified as at risk of falling.
- Following every patient fall, a falls risk analysis was completed and learning was shared. For example, patient had broken their hip following a fall on the ACE ward. Following the investigation of that incident, the staff meetings room was locked when not in use because bulky equipment such as patient hoists were stored in that room.
- There was a trust-wide multi-professional falls group that was leading the implementation of a group of measures designed to reduce the incidence of falls within the hospital such as colour coding of walking frames, nursing pods within bays, non-slip slippers. At every safety briefing, staff discussed patients who were at risk of falls. On the inpatient wards, beds were available that could be adjusted to both high and very low settings to minimise harm for patients falling out of bed. Teams told us they were able to access one to one agency nursing cover for patients who were at risk of falls.
- Staff documented patient risk of falls using a standardised assessment tool, and recorded any fall as a 'harm event' to prompt an investigation of the incident.
- In the OPU, the team were working in collaboration with the Older Peoples Fellowship at Kings Hospital in London to trial a new soft version of hip protectors for patients at risk of falls
- All patients admitted to the wards had a pressure risk assessment completed within six hours of admission.

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We saw in patients records that updates to these assessments were completed. Staff told us they were able to obtain air mattresses for patients assessed as at risk of pressure damage to skin. Patients assessed as having a grade one or two pressure ulcer were placed on a high specification foam mattress or cushion with pressure reducing properties. Patients who were assessed as having a grade three or four pressure ulcer were placed on an alternating pressure mattress or continuous low pressure system. Senior nurses completed spot checks to ensure that patients had the appropriate assessments completed and correct equipment issued to them.

- All clinical staff in the healthcare teams on the medical wards completed training in pressure ulcer management. Staff we spoke with demonstrated understanding of the requirements of prevention, identification and management of pressure ulcers.
- The trust had developed a sepsis management plan. The trust had achieved both commissioning for quality and innovation targets for sepsis management in 2015/2016. Risk assessments regarding patients risk from septicaemia were in place for patients. Staff we spoke with were aware of the actions to take when patients were showing signs and symptoms of septicaemia. The trust had piloted a sepsis education tool with patients and GP's.
- The medical service monitored and took appropriate action to reduce the incidence of venous thromboembolisms. Teams assessed all patients on admission for risk of venous thromboembolism and bleeding. Trust policy was to re-assess patients within 24 hours of admission however when we specifically checked for evidence of reassessment of venous thromboembolism 24 hours after admission, we found that this had been recorded in only 45% of the 11 records checked.

Nursing and therapy staffing

- Staffing levels were reviewed every six months using the safer nursing care tool. The last staffing review had taken place August 2015. However, there were limitations to this review. It did not include the cardiac ward or the respiratory ward because these wards did not submit sufficient data. Also, the accuracy of the acuity and dependency levels was not validated by the matrons due to operational pressures at the time of the review. For the six months between August 2015 and

February 2016, managerial oversight of the challenges around staffing on the respiratory and cardiac wards was therefore not fully informed. However, in February 2016 the trust completed a subsequent staffing review which included full data collection and validation for these wards.

- The staffing review in August 2015 had identified several wards where the funded establishment for staffing required adjustment. For example, the establishment of registered nurses for the night shift on the oncology ward increased following the staffing review.
- In February 2016, the average actual staffing for registered nurses for daytime shifts on the medical wards was 85.5% of the planned numbers and for night-time shifts 86.2% of the planned numbers. On some wards, the actual rate was considerably lower than the average. For example, on the respiratory ward the actual staffing of registered nurses was 73.5% of the planned rate for daytime shifts and 76.3% for night shifts. On one of the older person's wards, the average actual staffing for registered nurses was 75% of the planned numbers for daytime shifts and 66.8% for night shifts. On the cardiac ward, the average actual staffing for registered nurses was 82.9% of the planned numbers during the day and 74.7% at night. Supervisory ward sisters told us they were frequently required to work in a clinical capacity to cover the shortage of registered nurses, and this impacted upon their availability for managerial tasks.
- On some wards, although registered nurse staffing was low, unqualified care staff were above planned levels to compensate for this shortage. The average actual rate of staffing for healthcare assistants was 100.6% for daytime shifts and 123.52% for night time shifts. This resolved the dependency needs but did not necessarily meet the patients' acuity needs for care. However, on some wards such as ACE OPU and Waterhouse (an older persons ward), both the registered nursing staff and the unqualified care staff actual staffing levels were significantly below the planned levels during February 2016.
- Staffing for the respiratory ward had been consistently below the planned rate for the three months preceding our inspection. During February 2016, there were only four shifts when the registered nurse quota equalled the planned levels. There were only four shifts when the health care assistant quota equalled the planned levels. On seventeen occasions during February 2016, the

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registered nurse quota was two nurses short of the planned levels. Staff told us that it was not uncommon for one member of staff to care for twelve patients during daytime shifts on this ward.

- There were two incident reports related to staffing on the respiratory ward during the twelve months prior to our inspection. One of these highlighted an occasion when there were no high-care trained nurses working on the ward and there were four patients requiring non-invasive ventilation. Another incident report highlighted that staff had been unable to complete positioning turns for patients due to lack of staff and during this shift one patient had been noted to exhibit damage to the skin on their sacrum.
- On most wards we visited, the actual establishment of nurses was less than the planned for at least one of the shifts throughout the 24 hour period. On the night we visited the hospital, there was only one night nurse practitioner on duty when the planned capacity was two night nurse practitioners.
- In December 2015, there was a vacancy rate across medicine of 4.7% and a turnover rate of 11.6%. There was a high turnover rate of nursing staff at 15% across medicine, compared to a trust target of less than or equal to 10%. In some departments there was overstaffing of nursing, for example the senior nurse team within medicine 13.2%. However, on some wards the vacancy rate was high, for example 15.9% on the stroke unit, 10.4% in care of the elderly and 10.3% in oncology. In the medical assessment unit, there were 12 whole time equivalent nursing vacancies at band 5. The trust informed us that all vacancies had been recruited against with start dates after our inspection.
- The sickness absence rate for nursing staff in medicine was high in some specialties, such as rheumatology at 9.3%, respiratory at 7.4%, cardiology at 5.3% and acute medicine at 4.7%. compared to a national average of 4.3%.
- On a day to day basis, matrons reviewed and monitored the staffing levels on all of the wards. Matrons mitigated staffing risks by moving staff between wards. Nursing staff on all wards told us that when they started the shift with full staffing, it was likely that matrons would move them to another ward to cover shortages.
- The shortfalls were being supported by healthcare assistant staff and supervisory sisters and matrons working in a clinical capacity. The trust had recruited 15

trainee assistant practitioners at band 4 as an alternative resource to registered nurses. There was an ongoing recruitment campaign that had looked to Italy and Spain for recruitment of registered nurses.

- During November and December 2015, the adult therapies team at the hospital was above planned staffing levels at -7.3% vacancy rate. The turnover rate for allied health professionals working in medicine was low at 3.3% compared to a trust target of less than or equal to 10%
- The percentage of the total spend of staff pay that was attributable to agency staff was 1.5%. We were told that agency staff received a comprehensive induction to the medical inpatient setting.
- There were adequate processes in place to keep patients safe at times of handover and shift changes. Healthcare assistant staff from the previous shift stayed on the ward to ensure there were sufficient staff to meet the needs of patients whilst the next shift received handover.

Medical staffing

- The proportion of consultants employed by the trust was similar to the national average. The proportion of junior doctors was slightly lower than the national average.
- Vacancy rates for medical staff varied across disciplines and specialties. During October 2015, the trust target of less than or equal to 5% vacancy rate was met in four out of 21 teams. Medical staff were overstaffed on the respiratory team at -18.8% vacancy rate. However, there was a 16.7% vacancy rate in rheumatology, 11.3% in gastroenterology and 10% in neurology.
- The use of agency staff in medical teams was high in the following specialties: cardiology 26.9%, the medical therapy unit 41.5%, cardiology 24.3%, coronary care unit 12.8%, medical assessment unit 17%, and acute stroke unit 14.7%.
- There was a separate rota for the geriatrician and the consultant in general medicine who were on call 24 hours a day, seven days a week. There was a seven day consultant presence on all wards except 'Parry' which was an endocrine/general medicine ward and 'Helena' which was a neurology ward.
- There was not always sufficient medical staff available for patients during 'out of hours'. Staff requiring medical assistance for patients contacted the junior doctor using a pager system. Junior doctors told us that the night

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rota was unsustainable as there was only one doctor to cover both the wards and the new patients arriving at the medical assessment unit. The non-availability of the on-call medical divisional registrar at night and weekends was recorded on the medical risk register. Previous trials of a second on-call rota had not been successful.

- There was a 24 hour rota of cover to respond to gastrointestinal bleeding. Teams referred patients with uncontrolled acute upper gastrointestinal bleeding from varices to alternative trusts for treatment.
- A system was in place informing staff of the arrangements for medical cover for medical patients on surgical wards. The trust operated a 'buddy ward' system for the review of medical patients who were located on surgical wards. For example, medical staff from the gastroenterology ward reviewed all medical patients who were located on the surgical short stay unit regardless of their presenting clinical condition. This review occurred every day during the week. At weekends, the review was dependent upon the weekend management plan written by the patient's consultant. Staff told us that this system worked because there was consistency and clarity of medical cover arrangements.

Major incident awareness and training

- The trust had participated in a major incident exercise carried out by NHS England in 2014. Following this exercise, the trust had undergone extensive review of its incident response capabilities and procedures. A draft incident response plan had amalgamated previous policies. This plan could be scaled up or down according to the nature and severity of the incident.
- At the time of our inspection, the trust planned to incorporate major incident training into new staff induction. Ward staff, including ward sisters, we spoke with were not familiar with their role in the major incident plan.

Are medical care services effective?

Requires improvement



We rated the effectiveness of the medical service as requires improvement because:

- The outcome data for care of patients with diabetes was poor. Performance in the National Diabetes Inpatient Audit 2013 was significantly below national average. The trust had implemented several actions to address the shortfalls identified in this audit, and reported improvement in internal audits, but performance in the subsequent external audit remained poor. The trust scored worse than the England median average for eleven out of seventeen indicators in the National Diabetes Inpatient Audit in 2015.
- The trust scored lower than the national average in the Myocardial Ischaemia National Audit Programme in 2013-2014. The trust provided unpublished outcome data for 2015 that indicated improvement in the percentage of patients seen by the cardiologist and minor improvement in the percentage of patients admitted to the cardiac ward.
- Seven day working was not available across all services. The trust had completed a self assessment exercise and this indicated that 80% of patients in general medicine and older persons care and 60% of patients in cardiology and respiratory services were seen by a doctor within six hours.
- The acute intervention service within radiology was available for only 40% of the recommended cover. This meant that a small number of patients were required to transfer to a neighbouring acute NHS trust for this treatment.
- Therapists on the acute stroke unit told us they were struggling to meet the requirements of NICE guidelines for 45 minutes of daily therapy input.
- For some patients there was adequate therapy provision but this was not universal.

However:

- In the Sentinel Stroke National Audit Programme, the trust was rated C, which placed it within the top 44% of trusts offering acute stroke care. Trust performance in the Heart Failure Audit 2013/14 was better than national average.
- The service was compliant with NICE Quality Standard QS68 Acute coronary syndromes.
- Staff had a comprehensive induction and were offered training. Staff felt comfortable asking more experienced staff for help.

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- Multidisciplinary teams worked effectively for the benefit of patient care. Patients were regularly reviewed by a consultant and nurse practitioners were integral to the coordination of nursing and medical care.
- The discharge access team offered a discharge focussed therapy input to patients in the medical assessment unit. Discharge coordinators offered valuable skills in facilitating safe discharges on the wards.
- The alcohol liaison team provided a useful resource for the multidisciplinary teams planning care.
- There was good access to information for healthcare professionals and patients.
- The trust held accreditation with the Joint Advisory Group for endoscopy.
- Nutrition, hydration and pain were assessed and managed effectively.

Evidence-based care and treatment

- Teams strived to ensure that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- The medical service incorporated relevant and current evidence-based best practice guidance and standards, to develop how services, care and treatment were delivered. For example, the dermatology clinical governance meeting in December 2015 considered the impact of NICE guidance with reference to the prescription of a treatment for moderate to severe chronic plaque psoriasis. Actions were agreed to incorporate this guidance into practice.
- The medical service used NICE Quality Standard QS9 Chronic Heart Failure to identify and implement best practice. At the time of our inspection, the trust had been unable to recruit skilled specialist cardiac physiologists, contributed to by a national shortage. Instead, the trust recruited three newly qualified cardiac physiologists. These staff were training to offer the specialist services recommended in this standard. In addition, the trust had used agency staff to mitigate the risk from the gap in staffing provision.
- The trust had reviewed the guidelines in NICE Quality Standard QS68 Acute coronary syndromes and deemed the service fully compliant.
- On the medical assessment unit we saw that the treatment pathway of a patient with acute kidney injury followed NICE guidelines Quality Standard QS76 Acute kidney injury. However, the trust had identified there were two areas of non-compliance with these guidelines. These were: aspects of the information and support given to patients, and the monitoring and prevention of deterioration of patients at risk of acute kidney injury.
- To address this, the service had introduced a system that included an alert for acute kidney injury on the pathology system. In November 2015, the trust had introduced a standard set of measures to prevent acute kidney injury. Part of this was an awareness programme for staff and patients.
- The medical service had identified non-compliance with one recommendation from NICE Quality Standard QS38 Acute upper gastrointestinal bleeding. The guidelines require that interventional radiology treatment is available for certain patients. At the time of our inspection, there was cover for 40% of the required service. This non-compliance was recorded on the medical divisional risk register. The trust was negotiating with a neighbouring trust to provide the remaining cover.
- Endoscopic procedures such as diagnostic upper gastrointestinal endoscopy were carried out in line with professional guidance. At the time of our inspection, the trust had current accreditation with the Joint Advisory Group for endoscopy and in October 2016 all aspects of care were scored as either excellent or acceptable. Between August 2015 and November 2015, 93 patients who had used the irritable bowel disease service completed satisfaction questionnaires. The majority of indicators scored highly, giving an overall satisfaction score of 93%.
- Consultants reviewed all patients on the medical assessment unit twice daily. Consultants worked several days in a row in order to maximise continuity of care. Once patients had left the acute area of the hospital, they were reviewed at least once every 24 hours, seven days per week unless it had been determined that this would not affect the patients care pathway.
- In March 2016, 82.7% of patients who had a stroke were located on the stroke ward for more than 90% of their stay. The trust achieved compliance with this national standard for the three months preceding our inspection.
- Therapists on the acute stroke unit told us they were struggling to meet the requirements of NICE guidelines for 45 minutes of daily therapy input. Data showed that compliance for 45 minutes of therapy input was 62% for OT and 79% for Physiotherapy and 70% for speech and

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language therapy. There were 2.9 whole time equivalent physiotherapists as compared to the recommended 4.2. Specialist therapists on the stroke unit identified that they had no capacity to outreach to stroke patients accommodated in areas other than the acute stroke unit. Instead, these patients were seen by the non-specialist therapy team covering the wards under the guidance of the therapists from the acute stroke unit.

Pain relief

- Staff assessed the level and location of pain in adults using a number and picture chart and then scored this on the NEWS charts. We saw that nursing staff offered patients pain relief. Physiotherapists on the stroke unit were involved in the assessment of patient's pain on movement.
- Staff demonstrated a good understanding of methods available to them for management of patient's pain. Teams had access to a specialist pain service during weekday's normal working hours.

Nutrition and hydration

- Nurses used a standardised nutritional needs screening tool to assess nutrition needs. Nurses completed a nutritional assessment on admission when the screening score indicated that patients were at risk.
- Staff demonstrated a good understanding of the importance of assessing nutrition and hydration needs. Healthcare assistant staff told us that they were responsible for recording patients' intake of food and drink and explained how they would escalate reduced intake to the nurse in charge. On the wards we visited, all patients had drinking water within reach.
- Staff ensured that patients were not disturbed during mealtimes. We observed staff providing specialised cutlery and cups for patients who needed them. Speech and language therapists had provided training to volunteers whose role involved assisting with patient feeding. However, during the trust inpatient survey July 2015 to December 2015, only 68.8% of patients who required help with feeding said they received the assistance they needed.
- Patient led assessments of the care environment for 2015 the trust scored 94.4% for food and hydration, which is higher than the national average of 88.5%. In the trust inpatient survey July 2015 to December 2015, 74.5% of patients rated the food as good.

Patient outcomes

- The outcome data for patients with diabetes was poor. In 2015, the National Diabetes Inpatient Audit identified that the trust was scoring worse than the England median average for eleven out of seventeen indicators.
- Since 2013, diabetes service performance had worsened in relation to medication errors at 60.3%, and management errors 27.9%. Prescription errors had improved at 48.5%, but were still more than twice the national median average. Insulin errors had also improved but were still worse than the England median average at 25%. The number of patients seen by a multidisciplinary foot team within 24 hours had deteriorated significantly at 25%, half the median average for England.
- The trust had taken steps to address the shortfalls identified in the diabetes national audit. These included a specialist acute diabetes team for the MAU that provided daily review of patients, development of diabetes care plans, medication reviews, direct support for ward staff and bespoke education for medical and nursing staff. The trust had also increased the number of diabetic foot clinics to three times a week and a business case had been presented for more specialist nurses and podiatry cover within this service. This model of care was then expanded and piloted for six months on five diabetes 'high density' wards. The six month project involved 446 patients and spanned 5518 bed days. This was one of the Trusts 5 Quality improvement priorities for 2015-16.
- The trust lead for diabetes care recognised that although some improvements had been made, the service was not meeting standards in three key areas, namely, review of diabetic inpatients, education of inpatient nursing staff and provision of inpatient foot care.
- The trust scored lower than the national average on several indicators in the Myocardial Ischaemia National Audit Programme in 2013/14. These included the percentage of non-ST segment elevation myocardial infarction (nSTEMI) patients seen by a cardiologist was 69.1% compared to a national average of 94.3%, the percentage of nSTEMI patients admitted to a cardiology ward was 25.4% less than half the national average, and the percentage of nSTEMI patients referred for angiography was 67.9% compared to a national average of 77.9%.

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- The trust identified inaccuracies in the data submitted for the 2013/2014 MINAP but had not sought to rectify this prior to publication of this national audit.
- Leaders of the cardiology specialty identified a need for more consultant cover to provide a 24 hour service. Performance in this specialty was reviewed and validated and discussed at cardiology clinical governance meetings and any adverse outcomes were reviewed at mortality and morbidity meetings to inform future practice. Steps had been taken to improve the quality of care in this specialty. In April 2016, the trust implemented an 'interventionist of the day' to work alongside the cardiac catheter laboratory nurse coordinator to ensure timely access to the laboratory for primary percutaneous coronary intervention patients and those admitted with acute coronary syndrome.
- The trust provided unpublished outcome data for 2015 that indicated improvement in the percentage of patients seen by the cardiologist and minor improvement in the percentage of patients admitted to the cardiac ward.
- The trust scored better than the England and Wales average in the Heart Failure Audit 2013/14 for all the in-hospital care indicators. It scored better than average for two of the discharge indicators, but worse than average for the remaining five. Steps had been taken to improve the quality of care in this specialty as a result of this audit. Heart failure multidisciplinary meetings were being introduced with the aim of improving links with primary care and to support earlier access to specialist opinion.
- Leadership teams monitored information about the outcomes of care and treatment. For example, senior staff on the endocrinology ward carried out monthly audits of compliance against several measures of quality and safety. Staff received monthly newsletters attached to their payslips, which communicated these audit results, plus any feedback and business affecting the ward.
- The risk of patients being readmitted for non-elective care was lower than the England average.
- The medical service did not participate in the Improving Quality in Physiological Services (IQIPS) programme. However, the trust had introduced an in-house quality accreditation scheme for the inpatient services. All medical wards except for one had passed the initial foundation stage of this programme. The ward that had not passed, had since made improvements and leaders expected this team to reach the accreditation level when re-assessed. There was a plan for all medical wards to complete the next stage of assessments for the bronze level of the scheme.
- The neurology ward nursed patients with a tracheostomy. This allowed patients to transfer from the intensive care unit and for neuro-rehabilitation to commence as early as possible, enabling patients to work toward specific goals. This service monitored patient outcomes using a standardised measure. This data indicated that the outcomes for patients in the neurology specialty were better than the national averages.
- The trust had demonstrated improvement in the Sentinel Stroke National Audit Programme (SSNAP). Overall, the trust was rated C, which places it within the top 44% of trusts offering acute stroke care. The trust scored within the top 30% of trusts for quality improvement, training and research and in the top 48% of sites for the neurovascular service offered. However, therapy services were not meeting the standard of assessment within 24 hours.

Competent staff

- There were reliable arrangements in place for supporting and managing new staff including a comprehensive induction and a supernumerary period during which senior staff assessed their clinical competencies. Staff from other countries participated in a four-week induction.
- Clinical practice facilitators based on the medical assessment unit facilitated these inductions and on-going learning for staff based in the unit. However, on other medical wards, senior sisters told us they were sometimes required to work clinically as opposed to supervisory during periods of short staffing and this may have impacted upon oversight of staff competencies. This risk was highlighted on the medical divisional risk register
- The trust ran a nurse preceptorship programme that included five study days over five months, and they were in the process of developing a preceptorship policy.
- There was a system for identifying the learning needs of staff using appraisals. However, appraisals were not always completed in a timely way. The trust target for appraisal completion during April – June 2016 was 80%, with an end goal of 90% completion. In December 2015, 82.9% of staff in the medicine division had participated

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in an appraisal within the last twelve months.

Underperforming specialties included respiratory at 69.7%, cardiology at 70%, dermatology at 73.1%, gastroenterology at 77.4% and acute medicine at 77.5%.

In January 2016, only 18.2% of allied health professionals working in care of the elderly, 58.4% of nursing staff working in dermatology and 60.7% of doctors in acute medicine had participated in an appraisal within the preceding twelve months.

- We saw that staff asked for help from senior staff when they did not have the skills to complete patient care. This included band five nurses working on the night shift who escalated any concerns to the band six night nurse practitioner.
- In some instances, staff received appropriate training to meet their specific learning needs and were encouraged and given opportunities to develop. For example, one band 3 staff member was planning to attend a British sign language course. On the respiratory ward, there were weekly journal clubs and team teaching sessions. All nursing staff working on the medical assessment unit were trained to administer non-invasive ventilation and high flow oxygen.
- Junior doctors told us they were supported to learn, with access to effective teaching. The night nurse practitioner supported junior doctors to practice their skills. The 2015 National Training Survey monitors junior doctor experiences of education. In 2015, the trust scored above the national average for several indicators in this survey including handover in acute internal medicine and emergency medicine, induction in general psychiatry, otolaryngology and respiratory medicine, and adequate experience in haematology and otolaryngology. The trust scored below the national average for workload in acute internal medicine, overall satisfaction in clinical radiology, induction in general internal medicine and clinical supervision in ophthalmology.
- Physiotherapists participated in an in-house training course lasting three weeks. It provided specialist competencies in respiratory physiotherapy and was undertaken prior to physiotherapists being part of the on-call respiratory roster.
- Physiotherapy staff told us that they met regularly with other band 5 staff for peer support and education.

However, formalised peer support was not evident for higher grades of therapy staff and therapy staff did not participate in regular one to one meetings with supervisors outside of appraisals.

- There was a policy for clinical supervision for registered nurses and the trust offered various options to staff for support such as one to one and group meetings. However nursing staff we spoke with told us they did not participate in regular one to one meetings with supervisors outside of appraisals.
- Nursing revalidation is the new process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The trust education centre had given all nurses a 'revalidation information pack.' Nurses we spoke with felt supported with the revalidation process.
- The general medical council had revalidated 274 of the doctors working for the trust since December 2012, and 14% of these decisions had been deferred due to insufficient evidence or ongoing process.

Multi-disciplinary working and coordinated care pathways

- All relevant professionals were involved in the assessment, planning and delivery of patient care. The discharge access team were a team of physiotherapists and occupational therapists working in the emergency department, the medical assessment unit, and with some input to the inpatient medical wards. The discharge access team were piloting a streamlined version of a comprehensive geriatric assessment to plan for treatment and follow-up of frail elderly patients.
- Input from this team ensured that where possible, patients could return home without the need for admission onto the wards and packages of care could continue without interruption.
- Since October 2015, an experienced registered mental health nurse reviewed all patients with mental health issues to determine their mental health needs and to support their timely and safe discharge.
- There were good examples of working with community partners. For example, hospital and community teams jointly planned discharge for patients with complex needs and community therapists visited the patients the day after discharge if necessary. Matrons from the community setting frequently telephoned or visited the respiratory ward to handover details about their patients.

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- There were examples of care being well coordinated. An enhanced therapy project on Midford, Waterhouse and Combe was resulting in more comprehensive treatment plans that enabled continuity of care and reduced length of stay. The acute oncology team operated a 'consultant of the week' system and this was seen as positive for continuity of care for patients.
- Nurse practitioners facilitated continuity of care through their specialist understanding of both the medical and nursing roles. These members of staff were highly praised by their teams. On the stroke unit, the specialist nurse practitioner provided an outreach service to the emergency department and the medical assessment unit. This ensured that the patients received prompt assessment and diagnosis and transfer to the acute stroke unit.
- There were non-clinical discharge coordinators in several ward teams. The discharge coordinator arranged transport, liaised with social workers, pharmacy, families and several different providers of equipment and care.
- The alcohol liaison team were able to respond promptly to referrals to facilitate discharge from the inpatient wards. We observed this team visiting the medical assessment unit to identify patients that might benefit from their intervention.
- We saw that on the neurology ward, teams planned complex discharges carefully to ensure that necessary support mechanisms were in place. Patients sometimes participated in a phased discharge allowing them to return to their discharge destination overnight to build confidence and to test the suitability of the discharge arrangements.
- On some wards, the multi-professional team including occupational therapy, physiotherapy, nursing, pharmacy and medical staff completed prompt screening assessments for patients with complex needs. The therapy team on the acute stroke unit assessed all neurology patients based on the ward within 24 hours if they were medically fit for rehabilitation. During working hours, 88% of acutely unwell patients with chest conditions saw the physiotherapist within 24 hours. Out of hours, this figure improved to 100%.
- During October to December 2015, the discharge access team saw 70% of patients on the medical assessment unit on weekdays within one hour. This dropped to 58% of patients at weekends. Once assessment had started, 82% of patients had a discharge plan in place within two hours. In the OPU, an enhanced therapy project enabled all patients to be seen for physiotherapy assessment within 24 hours. However, only 54% of patients on medical wards requiring physiotherapy for discharge planning were seen within 24 hours.
- However, staff were not always able to plan ongoing care in a timely way. On the medical assessment unit, there had previously been multidisciplinary ward rounds but these had stopped. Although teams reported there was adequate social work input during the week, no social workers were available at weekends. This meant the discharge access team tended to discharge patients to the community hospitals rather than straight home because they were unable to access social care out of hours. Staff on several different wards told us delays to patient discharge were frequently due to a lack of available social and nursing care in the community setting.
- The unreliability of the patient transport service meant that patient discharges were sometimes delayed overnight when transport had not arrived. When we visited a ward at night, one patient was still waiting for her transport home at 9.30pm. Staff experienced difficulties restarting care packages because they were unable to be specific about the timing of patients discharge.
- Hospital teams were not always prompt to provide necessary information to the wider health and social care team outside of the hospital when patients were discharged. In December 2015, several wards were not consistently completing discharge summaries within 24 hours including the medical assessment unit, William Budd ward, respiratory ward, medical short stay unit and the coronary care unit.

Seven-day services

- The trust had completed a self-assessment exercise using the NHS IQ levels of service to benchmark their provision of various aspects of seven day working.
- The trust had identified that some areas of medical service provision were not fully delivering a seven days a week service. In particular, doctors managed to assess 80% of patients in general medicine and older peoples care within six hours. Doctors assessed 60% of patients in respiratory and cardiology within six hours. Consultants did not see all patients twice a day. At weekends, consultants reviewed only patients identified as requiring review in their weekend plan

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- Not all patients received a multi professional assessment out of hours, not all handovers involved multi professional participation and an integrated care record was not used. Mental health services did not offer extended hours during weekdays. The tissue viability service was not available at weekends. However, twelve of the 14 diagnostic services were available seven days a week. Patients had 24 hour, seven days a week access to emergency diagnostics such as computer tomography, magnetic resonance imaging and lumbar puncture.
- The discharge access team was available 8am until 7pm Monday to Friday and until 4pm on Saturday and Sunday.
- There was medical matron cover available on the weekends from 8am until 4pm. Where patients were receiving chemotherapy that required discontinuation over the weekend, staff on the acute oncology ward made time to accommodate this around their inpatient duties.
- There was a percutaneous coronary intervention service for patients at risk of cardiac dysrhythmia available from 7pm until 10pm. Outside of these hours patients were transferred to Bristol for treatment.
- Some teams offered a partial seven-day service. The alcohol liaison service was partially available at weekends. At the time of our inspection there was a six day therapy service funded for the ACE OPU. On the acute stroke unit, speech and language therapy was available for two out of every three weekends.

Access to information

- The information needed to deliver effective care and treatment was available to staff in a timely and accessible way. For example, on some wards, staff completed their assessment documentation at the patients' bedside using mobile computer stations. Medical staff of all specialties used an application on their mobile phones that enabled them to access a hospital directory of information and all hospital guidelines. A junior doctor based at the hospital designed this application. Doctors used weekend plans to provide guidance and information to out of hours staff
- Diagnostic imaging and endoscopy results were available in a timely manner. For example, in the endoscopy department, procedures were reported on the same day, and a copy of the results were given to the patient before they left, and also sent to the GP.

- When patients were admitted to the medical wards, information from the previous health care professional was available. There was an electronic record system that contained all the discharge letters, including blood test results, pathology results and radiology reports.
- When patients moved between teams and services, accurate information needed for their ongoing care was shared appropriately and in a timely way. The trust was piloting a 'discharge passport'. Teams gave this document to patients when they were discharged. It provided personalised information about patients' medication, ongoing care planning, future appointments, and contact information.
- Patients had access to relevant information. In endoscopy, patients were sent a booklet in the post prior to their procedure with pre-assessment questions and information. Patients were given leaflets detailing aftercare for the 24 hours following their procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated understanding of the consent and decision making requirements of current legislation. Staff were supported by the learning disabilities team when considering the mental capacity of patients with learning disability.
- We heard staff seeking consent prior to invasive procedures. On the ambulatory care unit there was an ongoing consent audit. This audit was part of a quality improvement plan that aimed to standardise the consent procedure, using a 'consent pack' and checklist.

Are medical care services caring?

Good



We rated the medical services as good for caring because:

- Staff were respectful and kind towards patients.
- On some wards patients were encouraged to wear their own clothes.
- Patients were involved in decisions about their care.
- We saw good examples of carer involvement in patient care.
- There was a hospital-wide approach to initiating conversations with patients and relatives who were making a transition to end of life care.

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However:

- Survey data showed that some carers did not feel involved in patients care.
- Patient led assessments of the Care Environment indicated a lower than average score for patient privacy.

Compassionate care

- Staff understood and respected patients' personal, cultural, social and religious needs. On the older persons ward, the ward sister permitted a relative to bring a patients dog onto the ward to promote his well-being.
- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner. We saw that staff introduced themselves by name and role and checked how patients preferred to be addressed.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. In the trust inpatient survey conducted during July 2015 – December 2015, 96.3% of inpatients said staff were 'kind and friendly'. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate way.
- Staff took account of patients' psychosocial needs. Patients we spoke with said that staff treated them as a person rather than a 'set of symptoms'.
- Staff respected patients' privacy and dignity. For example, we saw that on some wards, patients were wearing their own clothes. This had formed part of the enhanced therapies programme on certain wards to promote well-being and enhance daily routine. In November 2015, the results of the friends and families test indicated the percentage of patients who said they would recommend the service ranged from 93% on the ACE OPU to 100% on five wards including the cardiac ward, Combe ward, the coronary care unit, Midford ward and William Budd ward.

Understanding and involvement of patients and those close to them

- In the trust inpatient survey conducted during July 2015 – December 2015, 78.7% of patients felt they were involved in decisions about their care, to some extent. During our inspection, we observed staff taking time to explain care and treatment. We observed a consultant talking to a patient, positioning himself to take account

of the patients hearing impairment. On the neurology ward, all the patients we spoke to said they felt involved in decisions about their treatment, however none of them were aware of discharge plans.

- The trust had commissioned a report from the Emergency Care Intensive Support Team (ECIST) in September 2015. This report had identified that staff did not give patients timely and clear information regarding the expectations of discharge. Staff themselves were not aware of the trust policy regarding choice of discharge destination, which was under review at the time of our inspection.
- The trust Inpatient Carers Survey conducted during July 2015 – December 2015, showed mixed results; 64.6% of carers said staff actively tried to communicate with them; 70.6% said doctors allowed time for carers to ask questions; 55.7% were involved in discharge planning, and 78.9% were involved in the patients stay on the ward and 89.8% said they felt welcomed on the ward
- However, during our inspection we saw several examples of carers being directly involved in patient care. Staff we spoke with valued the role of carers. On the respiratory ward, staff gave carers of patients with learning disability a badge to show they were permitted to provide direct care for their relative. On some wards such as Combe, there were no fixed visiting hours. This meant that carers could visit at times that were most beneficial to the patient and to the carer.
- On some wards, information regarding safeguarding from abuse was displayed where patients would see it but this was not consistent across all medical wards.

Emotional support

- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. For example, patients had access to a telephone if they needed to contact relatives.
- Teams regularly assessed patients' psychological needs. During the initial assessment, nurses used a checklist to identify patients at risk of or experiencing anxiety and depression and then discussed these patients with the multidisciplinary team.
- Patients and their carers were given support and information to cope emotionally with their, treatment or condition. This included a hospital wide approach to

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initiating conversations with patients and relatives who were making a transition to end of life care. One patient told us "They (the staff) give you confidence. They take away the worry".

- Clinical nurse specialists were available to provide emotional support to patients and carers in some services such as acute oncology.
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. For example, on the respiratory ward, patients could talk to a smoking cessation link nurse.
- Chaplaincy services for patients requiring spiritual support were available. There was a multi-faith chapel on-site for worship.

Are medical care services responsive?

Requires improvement



We rated the medical service as requires improvement for responsive because:

- There were high numbers of medical patients located on wards that did not specialise in their condition. Cardiac patients were delayed in accessing angiograms for this reason.
- The flow of patients from admission through to discharge was not efficient.
- Patients were not always transferred to the most clinically appropriate ward because beds in specialty wards were not available.
- Patients sometimes stayed longer in hospital because ward teams were not able to arrange transfer to community hospitals or were not able to access social care at home or care home beds. The ambulatory care unit was not large enough to allow ease of access for wheelchair users.
- At the time of our inspection, call bell response time audits were not completed.
- Sometimes patients waited more than 18 weeks for specialist treatment in gastroenterology, cardiology and dermatology.

However:

- On two wards, there were very good facilities and for patients living with dementia. Dementia coordinators were available six days a week.

- Support was available for patients with learning disabilities and their carers.
- Facilities were available for bariatric patients.
- The alcohol liaison service helped patients with alcohol dependency to access appropriate community services.
- Telephone advice lines were available for GP's and patients.
- There was a ward flow pilot project that was streamlining the processing of transfer of patients from the medical assessment unit to specialty wards.
- Teams learned from complaints.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of the needs of patients. For example, there was a pleural clinic where respiratory patients were seen for ambulatory pleural taps and this had avoided the need for patients to be admitted to hospital. In the ambulatory care service, patients were seen for ascetic drains and this meant that they did not require to be admitted as an inpatient. The inpatient team in respiratory service worked closely with a chronic obstructive pulmonary disorder outreach team and community bronchiectasis team to prevent hospital admissions.
- Most wards could be located using the information provided on maps throughout the hospital. Staff on one ward gave patients a card detailing directions to the ward to enable visitors to find them.
- Some of the facilities and premises were appropriate for the services planned and delivered. There were two wards within the older persons unit specifically designed to meet the needs of patients living with dementia. Contrasting colours drew attention to obstacles such as chairs and highlighted doorways to toilets. Exit doors painted in non-contrasting colours eliminated the need for a locked door. Bays were colour coded to aid orientation. Within bays, there were mini nursing stations and day/date/time/location clocks with analogue and digital display.
- On Combe ward, patients were encouraged to move freely through the ward and the outside garden area following a circular walkway. Programmable lighting that simulated real daylight was available in one of the isolation rooms. Visual posters were kept to a minimum to avoid disorientating visual cues.

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- However, not all facilities reflected the needs of the population served. The ambulatory care service was not large enough to accommodate patients who required the use of a wheelchair. Conversations in curtained consultation areas could be overheard. The acute stroke unit did not have reality orientation clocks. Due to pressures on bed availability, older patients were often not located on the wards designed to meet the needs of patients living with dementia.

Meeting people's individual needs

- The medical inpatient service ensured that support was available for patients with complex needs. The discharge liaison team included a representative from a charity for older people. This charity was available to help patients with complex needs to settle into home after discharge, such as transporting medications to home.
- Translation services were always readily available if required. Staff on the medical assessment unit had used this service for a patient whose first language was polish.
- Appropriate facilities were available for bariatric patients. The trust had two bariatric beds and mattresses on site. Nurses created bed spaces for bariatric patients by closing the adjoining bed space where necessary.
- Two dementia co-ordinators were available six days per week to support patients who were living with dementia and their carers.
- Patients living with dementia were encouraged to maintain their individual preferences. 'This is me' booklets were on several medical wards. On Combe ward, a patient with dementia was permitted to sleep on the sofa in the activity room because this was his usual routine at home.
- Activities were available to promote well-being on some wards. Musicians performed live music for patients on one of the wards for older patients. On the acute stroke unit, there was a box available for dementia patients containing items such as twiddle muffs, reminiscence cards, paper and paint.
- Support for people with learning disabilities was available. Staff worked collaboratively with the carers of learning disabilities patients to meet their individual needs. Staff made reasonable adjustments for patients with learning disabilities such as open visiting and allowing carers to stay overnight.
- One carer of a patient with learning disabilities on the neurology ward confirmed that the learning disabilities nurse had visited daily to ensure that she had everything she needed. On one ward, staff had prepared 'comfort boxes' containing items that relatives might need if they were required to stay overnight. This included items such as toiletries, tea bags and crockery, blanket, children's colouring books.
- However, we noticed on one ward that only one camp bed was available and a relative was required to sleep on a mattress on the floor.
- The medical service took action to remove barriers when people in vulnerable circumstances found it hard to access services. For example, the alcohol liaison team visited the emergency department and the medical assessment unit to offer brief intervention and advice for patients with alcohol dependency. Data for 2013 – 2014 indicated that this service had reduced the average length of stay and number of admissions and had promoted access to treatment services for this patient group.
- Consultants held clinics at some community hospitals. In the acute oncology service, there was an out of hour's advice telephone line for patients. The ward staff answered these calls and triaged calls using a standardised rapid assessment and access toolkit. Nurses could access specialist advice from the oncology and haematology registrars who were on call 24 hours a day. GPs had direct access to a consultant by telephoning the geriatrician rostered on each day. In the ambulatory care unit, GP's had access to a link GP with whom they could discuss and refer patients for treatment; this was available weekdays and was covered by a junior doctor on Saturdays.
- At the time of our inspection, call bell audits were not completed on the medical wards. However, monitoring of call bells was included as part of the bronze level in house accreditation scheme which was due to commence April 2016. On Combe and Waterhouse ward, the use of call bells had decreased because there were small nursing desks situated in every bay. On the wards we visited, we noted that call bells were within reach of patients and patients told us that nurses responded promptly
- Patients were offered a choice of hot and cold menu items that included vegetarian, low sugar, low fat, weight reducing and high calorie options

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- However, the timing of meal serving was not always well organised. On one ward, we saw that menu cards were not always completed and so mealtime was delayed whilst staff checked what food had been ordered and requested extra meals from the kitchen.

Access and flow

- The bed management team coordinated patient flow within the hospital. The matrons reviewed all patients who had stayed more than seven days and reassessed those patients when they had stayed more than 14 days. Patients whose discharge was delayed were discussed at a multi-agency meeting once a week. This included community health providers and social services.
- There were bed management meetings three times per day. A 'matron of the week' for medicine and for surgery represented the wards at this meeting. These matrons prioritised which patients should urgently transfer to specialty wards. Overnight plans confirmed availability of male and female beds plus patient admissions and discharges. On medical wards, discharge planning commenced on the first day of admission. On the medical assessment unit, consultant ward rounds commenced at 7 a.m. with identification of patients who were ready for discharge. Staff were required to identify potential discharges that day or for the following day by 4pm.
- The process of admission for patients to the medical services was not always efficient. The trust had access to a 'live' ambulance tracker system that could identify planned ambulance arrivals. However, the medical assessment unit was often full and this meant that patients referred via their GP were sometimes admitted via the emergency department
- During December 2015, the median number of outlying medical patients was 35, rising to 53 and dipping to 11 on 25 and 26 December as the result of a 'home for Christmas' initiative.
- Patients were not always able to be located on the specialist ward appropriate for their condition. The bed management team admitted medical patients to surgical wards when no beds were available on medical wards. On the week of our inspection, there were 60 medical patients located on wards not designated for the specialty they required. Three days later, this figure had dropped to 32 patients
- During the period January 2015 to November 2015, 13% of bed moves occurred between 10pm and 6am. Some wards recorded a high number of patients moved at night. For example, during October 2015, this affected 40 patients on the cardiac ward; 38 patients on the respiratory ward; 22 patients on the medical short stay unit; 19 patients on Parry ward; and 26 patients on the ACE OPU
- The percentage of patients admitted to medical services that moved wards three or more times had increased during the period December 2014 to November 2015 to 2.9% when compared to 2.5% during the same period one year earlier.
- The requirement to isolate patients with infections resulted in further demand for the side rooms within the hospital. There were 72 side rooms on medical wards and 30 side rooms on surgical wards. Snapshot data for 7 April 2016 indicated that 80 medical patients required side rooms.
- The bed management team were working with community colleagues to identify which patients were vaccinated against influenza so that these patients could be co-located with influenza patients in bays.
- The bed management team followed an escalation protocol to communicate the status of bed availability within the hospital and to sanction the use of escalation wards when required. At times, the medical therapy unit became an escalation area for cardiac patients. This affected gastroenterology patients who would then be required to wait for their medical infusions. This also limited the responsiveness of the ambulatory care unit who tried to cover those patients requiring the planned interventions that would have taken place in the medical therapy unit.
- The ambulatory care unit was sometimes unable to function effectively because it was limited in space and it was frequently understaffed. On the day we visited, instead of the establishment of a nurse practitioner, a registered nurse and a healthcare assistant, there was one nurse plus a supernumerary nurse on the first day of induction.
- The medical assessment unit was sometimes unable to function effectively because it was not able to move patients promptly onto the wards due to lack of bed availability. Staff on the medical assessment unit could not discharge patients promptly because the transport was often delayed and community hospital beds were not available.

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- Some wards were struggling to function effectively as a specialist treatment area because significant numbers of their beds were used by other specialties. Staff on medical specialty wards such as cardiology were limited in their capacity to 'pull' from the medical assessment unit because often their beds were taken by patients with complex needs who should have been on an older persons ward.
- Patients benefitted when they were located on the correct specialty ward. For example, frail patients admitted to the ACE OPU accessed the frailty pathway. This pathway of care prompted clinicians to complete comprehensive assessments and thorough discharge planning. Patients on the acute stroke unit had access to daily specialist therapy input.
- Patients accommodated on wards that were not specialised to their needs experienced some disadvantages. Some cardiac patients required an angiogram and this was delayed because they were temporarily located on a different ward.
- There were rapid access clinics available for assessment and treatment of transient ischaemic attack or chest pain. There were delays to discharges. On the day we visited the medical assessment unit, some patients had been there for significantly longer than the expected length of stay. Nine patients out of 21 patients had been on the unit longer than 12 hours. On another visit, 17 out of 32 patients had been on the unit for more than 12 hours. The longest staying patient had been on the medical assessment unit for 142 hours. This patient was waiting for a bed on the neurology ward. The second longest length of stay was 52 hours for a patient waiting for a bed in the gastroenterology ward.
- The reasons for delayed discharge were audited. This audit indicated that from April 2014 to April 2015, the primary cause of delays to discharges was waiting for placement in either nursing home or residential care home. Patients requiring heart bypass surgery waited up to two weeks for a bed in a Bristol hospital. This increased the length of stay of these patients at the Royal United Hospital.
- The performance of the patient transport service was reviewed monthly by a joint working group that included the clinical commissioning group and representatives from the non-emergency transport providers. Data indicated a gradual improvement in performance. In January 2016, 85.7% on inpatients arrived on time, 46.9% of inpatients departed the hospital within an hour of the planned time and 82.6% of inpatients booked on the day of departure were collected within a four-hour window.
- The trust used alternative transport for example, private ambulance when discharge was urgent. With sufficient notice, a voluntary provider transported patients home and ensured they were settled back to their home environment.
- Patients requiring admission to a specialty bed on the MAU were allocated by the senior decision maker to the most appropriate clinical specialty. Information regarding patients pending transfer from the MAU was available to all specialty wards electronically and via a daily email.
- A ward-flow pilot project had commenced on the respiratory ward. The ward sister identified patients ready for discharge from the respiratory ward the following morning and identified patients in the medical assessment unit and on the wards that required non-invasive ventilation or pleural intervention. Together with the medical staff, the sister then prioritised these patients and arranged their transfer to the available beds on the respiratory ward. Progress with this initial pilot was interrupted in March 2016 by the ward closure due to influenza.
- Teams planned to extend the ward flow project to gastroenterology in April 2016. Further potential cohorts included oncology patients presenting with neutropenic sepsis and cardiac patients requiring cardiac catheterisation that could be 'pulled' onto the relevant ward for specialist intervention.
- Sometimes patients waited more than 18 weeks for routine specialist treatment. There had been a trend of improvement in the length of time patients waited, except for cardiology, which had performed below standard from November 2014 to December 2015. In January 2016, there were three specialties not meeting the 18-week standard for referral to treatment, cardiology at 87.6%, gastroenterology at 87.7%, and dermatology at 91%. In December 2015, there were 66 patients who had waited more than 30 weeks for routine treatment, 39 of these were in gastroenterology, 21 were in cardiology.
- At trust level, patients in elective rheumatology, clinical haematology, non-elective general medicine and

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cardiology had longer than average lengths of stay. However, when only location-specific data for Royal United Hospital was considered, average length of stay was lower than average for elective care.

Learning from complaints and concerns

- Teams took action to improve care following complaints. For example, on one ward, a carer had struggled to cope once their relative went home, even though they had been successfully managing care tasks for the patient in the ward setting. The team reflected on this complaint and subsequently felt they were more aware of the need to test their assumptions about a carers understanding or capabilities.
- On one ward, the band seven nurse had initiated teaching sessions with all ward staff using patient stories from complaints as a focus of discussion. She felt that this method had enhanced the way that staff listened to patients concerns. Patients told us that they felt comfortable to raise concerns.

Are medical care services well-led?

Good



We rated the medical service as good for well-led because:

- The medical service leadership team were aware of the challenges to patient care. In particular, the trust had identified a clear and comprehensive plan to address problems of patient flow.
- There was a plan to improve the efficiency of the ambulatory care unit.
- There were plans to improve the flow of patients from the medical assessment unit.
- There was a comprehensive frailty flow project that aimed to improve the flow of older people through the hospital and into the community.
- An integrated discharge service was about to be launched. The purpose of this team was to facilitate safe and efficient flow of patients out of the hospital.
- There were plans to reconfigure beds to resolve non-compliance with fire evacuation guidelines on one of the three wards that were non-compliant

- There was an effective governance framework. Risks were assessed and mitigations were identified for some of these risks. However we saw that the measures in place to mitigate the risks around fire evacuation on medical wards were not robust.
- Leaders were participating in learning to increase their understanding of patient flow and advice had been sought from peers to resolve the flow challenges.
- An innovation panel encouraged staff to present ideas for improvements to patient care.
- Combe ward had achieved the quality mark for elder friendly hospital wards.

However:

- There was a lack of pace in the trusts response to the fire risks identified on four wards
- The medical service had not responded effectively to the results of the Myocardial Ischaemia National Audit Programme 2013-2014. Data quality issues in this audit had not been rectified.
- Clinical governance meetings were infrequent in some specialties.
- Oversight of the challenges around staffing was compromised by a reliance on incomplete and invalidated data used within the latest staffing review.
- Staff engagement forums had not been well attended.
- Ward leaders were not always able to lead effectively due to pressures to work in a clinical capacity.

Vision and strategy for this service

- The trust had adopted a set of values developed in collaboration with the staff. All staff we spoke with were aware of these values.
- The trust had a clear vision for the medical service. The 'front door' group was a task force focussing on service delivery in the medical assessment unit, the ACE OPU, the medical short stay unit and the emergency department.
- Since September 2014, this group had been driving a strategy to improve performance against the four-hour target in the emergency department. The strategy combined the recommendations of the ECIST report in 2015 and national Commissioning for Quality and Innovation targets around reducing avoidable

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emergency department admissions and improving diagnosis and re-attendance rates of patients with mental health conditions. Progress against delivering the strategy was regularly monitored and reviewed.

- Part of this strategy was the two-year plan to improve the ambulatory care service. The initial planning phase was completed during 2015/2016 and implementation was scheduled for 2016/2017. The aims of the ambulatory care improvement plan were comprehensive. Thirty-one high level programme outcomes were identified. These included a review of the current service offered in ambulatory care, workforce review, and a review of the footprint of the premises. The review of the footprint was completed but capital funding had not been secured for development of the physical space. A joint clinical commissioning ambulatory care working group had reviewed ambulatory care sensitive pathways and a cardiac hot clinic was to be introduced early 2017.
- In April 2016, the acute medical service planned to introduce changes to the way that teams assessed and reviewed patients in the medical assessment unit. These changes were designed to improve patient flow onto the correct medical specialty wards. Specialty doctors would be responsible for conducting the reviews of patients assigned to their specialty. Doctors who referred patients from outpatient clinics were required to use the assessment process of the specialty into which the patient was being referred. This would enable the patient to be admitted to the ward with an identifiable management plan.
- The frailty flow project was a long-term transformational project that aimed to improve the flow of frail older patients through the hospital and into the community. This project included four elements of improved service delivery: implementation of a 'geriatrician of the day' in the medical assessment unit, frailty clinics to enable patients to be seen urgently as an outpatient to avoid hospital admission, redesign of the medical clerking process to include frailty scoring for patients over 75 which prompted completion of a comprehensive geriatrician assessment, and a refocus of the ACE on short stay admissions for patients aged over 75 years
- A business case was submitted for the respiratory service to increase consultant staffing and to provide endobronchial ultrasound. This service was working closely with GPs to manage patients with asthma, bronchiectasis and chronic obstructive pulmonary disease with a view to reducing demand for inpatient beds.
- There was an integrated discharge service piloted during December 2015. The aim of this service was to work with the multidisciplinary teams on the wards to identify patients suitable for discharge onto one of three pathways: to home with support, to community step-down facility with rehabilitation or re-ablement, to nursing or care home facility. There was an aspiration to use a discharge to assess model but this was not yet operational.
- At the time of our inspection, the integrated discharge service was not fully operational because informational technology systems and single assessment processes were not in place. A standard operating procedure was under development in conjunction with partner health and social care organisations. Further work was underway to provide patient information at the point of admission, a standard operating procedure for criteria led discharge, a strategy for raising awareness of criteria led discharge, plus a ward score card for discharge key performance indicators Teams were due to co-locate in April 2016.
- The trust recognised a need for a change to the bed reconfiguration to support the management of the non-elective demand for beds. However due to the sustained demand, any reconfiguration or building works were completed in stages to minimise disruption to available beds. The immediate plan was to swap the location of the ACE OPU and the surgical assessment unit in order to address the inadequacies of the fire evacuation route on this ward.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of good quality care. For example, all serious falls that resulted in harm were investigated and discussed at the operational governance committee. Leaders shared reports across all three divisions.
- Leaders of the medical service demonstrated a holistic understanding of performance, which integrated the views of people with safety, quality, activity and financial information. Staff understood their roles and their areas of accountability.

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- There was a comprehensive assurance system. Safety data was monitored using a nursing quality indicators triangulation process. Exception reports were submitted to the board for discussion in the monthly quality report. This included a safer staffing report. The exception reports for November and December highlighted the staffing shortfall and the high acuity levels on the respiratory ward. It was evident that leaders had made sustained efforts to recruit to registered nurse posts at band five and six levels as well as train assistant practitioner band four posts to alleviate the demand for registered nurses, and recruitment initiatives had reached as far as Italy and Spain.
- This data was considered in conjunction with quality matrices for that month on that ward. These included a low friends and family score that indicated 75% of patients would recommend the service to family and friends, the occurrence of a grade two pressure ulcer, high staff sickness and low appraisal rates. Similarly, the medical assessment unit was highlighted due to low staffing levels of registered nurses. Executives considered quality matrices for this month on this ward such as a low friends and families test result that indicated 71% of patients would recommend the service to family and friends, negative feedback from patients and seven falls.
- There was a comprehensive programme of clinical audit for the coming year. Teams used data from clinical audits to monitor quality and to identify where action should be taken. For example, in October 2015, the trust had completed a gap analysis against the national Keogh recommendations for seven day services. This had identified several recommendations, for example, ensuring that all future developments such as staff appointments offer a significant contribution to seven day working. The trust intended to use weekend discharges as a key performance indicator to measure success of their improvements to seven day working.
- The director of nursing and midwifery chaired the discharge project board. This group met every four to six weeks. Other attendees included deputy director of nursing, head of nursing in surgery and in medicine, head of division in medicine, head of therapies, lead pharmacist plus other clinical managerial staff. This board considered the trust metrics and the project metrics to measure the success of the improvement plan. These included delayed transfers of care, readmission rates, transport, length of stay, weekend discharges and declared discharges by midday, patient engagement, continuing healthcare discharges within two days, completion of the discharge checklist.
- There were robust arrangements for identifying and managing risks and mitigating actions were recorded. The medical service had a divisional risk register that included mitigation and action plans. The risk register for medicine identified the following risks:
 - presence of medical patients on surgical wards and the probable consequence that this would lead to more cancelled operations, increased length of stay, later discharges and worse escalation status for the trust.;
 - risk of inequality of diabetes service for young patients transitioning into adult diabetes services;
 - Nursing staffing on the oncology ward
 - nursing staffing in cardiology both on the ward and on the medical therapy unit when this is used as an escalation area;
 - use of the medical therapy unit as an escalation area as impacting upon the referral to treatment times for cardiology;
 - Lack of neuropsychological assessment and support for patients with epilepsy, which resulted in trust non-compliance with NICE guidelines.
- Some risks impacting upon medical services were identified on the board risk register, including:
 - ACE OPU, Midford ward and Helena ward non-compliance with fire regulations;
 - the shortage of isolation facilities;
 - rate of non-compliance with safeguarding training;
 - Risk of wrong route administration of chemotherapy.
- The board risk register did not provide assurance that the fire safety risks were mitigated. There was a lack of pace to the trusts response to these concerns. The fire safety risk on ACE OPU was added to the board risk register in March 2013. The risks on Helena, Midford and the medical short stay unit were added to the board risk register in March 2015. A fire audit was completed in November 2015. Immediately after our inspection, we were told that further mitigation was being investigated, such as installation of 'misting systems' but we were not informed of a clear plan as to when and how this work would be completed nor how the risks were to be mitigated whilst awaiting completion of this work.

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- Risks identified on the risk registers were aligned to some of the concerns that staff identified. Managers discussed these risks at specialty clinical governance meetings. Learning from incidents was also discussed. For example, the discussions at the specialty clinical governance meeting for the gastroenterology specialty focussed on several areas of risk including feedback from patients' complaints. Actions were identified to address the priorities that emerged from the complaints.
- However, the specialty governance meetings were infrequent. In gastroenterology, neurology, cardiology, respiratory, dermatology, stroke and acute medicine, these meetings were every three months. In therapies and in oncology and rheumatology, meetings were planned for every one to two months. In rheumatology, meetings were held monthly.
- In one specialty, a senior sister said that the directorate meetings were too infrequent to foster effective governance and communication. For example, lack of staffing in cardiology was placed on the risk register in October 2015 and discussed at the clinical governance meeting in December 2015. Due to a lack of available staffing, the next meeting was delayed until April 2016. In dermatology, there had been no specialty governance meeting from July to December 2015 due to a lack of available staffing.
- The medical service had not responded effectively to the results of the Myocardial Ischaemia National Audit Programme (MINAP) 2013-2014. The trust identified inaccuracies in the data submitted for the 2014/2014 MINAP but had not sought to rectify this and could not provide us with alternative data. This lack of reliable information regarding outcomes for cardiac patients was an unmitigated risk not identified on the risk register.

Leadership of service

- The medical division leadership team consisted of the head of medical division, a divisional manager, the head of nursing and the clinical governance lead. Every specialty had a clinical lead, a governance lead, a specialty manager and a matron.
- Leaders of the medical service had the skills, knowledge, experience that they needed to do their

jobs. The role of senior sisters on the medical wards was supervisory. However at times of short staffing, these leaders were required to cover clinical duties and this limited their capacity to lead effectively.

- In July 2015, the trust had begun a twelve-month leadership programme working with the West of England Academic Science Network and other bodies to develop a teaching curriculum on the subject of patient flow, using local pathway improvements as real case studies. Two members of staff in the medical division were participating in the programme, specifically working on the development and implementation of the frailty pathway. These staff would become 'flow coaches' who would then coach their teams to own and implement improvements within the medicine division.
- Leaders demonstrated a thorough understanding of the challenges to good quality care and were able to identify the actions needed to address these challenges. For example, when faced with ongoing challenges of flow within the hospital, the trust had invited the Emergency care Intensive Support team (ECIST) NHS Interim Management and support team to evaluate their urgent and emergency care system during September 2015. This team had made several recommendations around discharge of patients and the medical service incorporated these into the improvement plan.
- Staff told us that members of the executive team had visited some wards. Ward leaders were visible and approachable and encouraged appreciative, supportive relationships among staff.

Culture within the service

- The culture of the medical inpatients service focussed on the needs and experience of patients. We saw that staff and teams worked collaboratively for the benefit of patient care. Both nursing staff and medical staff told us there were good working relationships between these staff groups. All the junior doctors we spoke with were positive about their experiences of working in medicine at the trust. Junior doctors described the consultants as excellent teachers who supported junior staff with their training.
- Staff told us that conflict was usually resolved quickly and constructively. Staff told us they felt respected and valued. Staff told us they felt a shared responsibility to deliver good quality care.

Public engagement

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- The medical service provided a limited range of forums for listening to the views and experiences of the patients in order to improve care in the medical service. The response rates for the friends and families test were variable across the medical service. In November 2015, the response rates ranged from 32.7% on the medical short stay unit to 86.2% on Combe ward.
- The trust had initiated several actions to address these low response rates, including the appointment of lead matrons as friends and families test champions, participation in an awareness week and production of posters communicating themes from friends and families feedback. Overall the trust reported a 7% increase in response rates during the last quarter.
- The medical wards used a multiple-choice style inpatient survey. During the period July 2015 to December 2015, 64 carers and 281 patients had completed this survey. Results showed that 91.4% of patients had rated their care as good.
- On the medical short stay unit, the ward sister had generated a word map to represent the feedback received from patients. She refreshed this every three months and used this to build staff morale
- The medical service engaged with patients, relatives and patient representatives to involve them in decision making about the planning and delivery of the service. For example, there had been patient and carer engagement events in July 2015 involving the local health-watch in the development and evaluation of the discharge passport. At the time of our inspection, this feedback was forming part of the evaluation of this project. On the acute oncology ward, patients and carers were involved in the choice of colour scheme and artwork for an annexe on the ward.

Staff engagement







- In January 2016, a report to the board identified poor staff attendance at staff engagement events and a lack of a forum for managers to engage with the executive team. The trust recognised that this affected staff understanding of the vision and strategy for the service. Plans to address this shortfall focussed on a variety of channels of communication including a 'ask James' email address and a monthly coffee morning with the chief executive; forums for specific staff groups and an online social network group.

- Staff told us their views were reflected in the planning and delivery of services and in shaping the culture but were unable to give examples of this.
- When staff raised concerns, leaders recognised the importance of this and took action in a timely way. For example, ward leaders addressed staffing concerns on a daily basis. However, long-term solutions to this challenge were not consistently evident to staff.

Innovation, improvement and sustainability

- When the medical service planned changes to service delivery, leaders assessed and monitored the impact on quality and sustainability. For example, leaders completed a thorough analysis of costs and benefits prior to approval of plans to reconfigure beds in the ACE OPU.
- There was evidence that leaders and staff strived for continuous learning, improvement and innovation. For example, one nurse we spoke with was part of a trust wide innovation panel that met monthly to consider ideas put forward by staff for improvements to patient care. This panel had access to a limited budget that they could allocate for small-scale projects. Examples of these projects included a trolley containing all the cleaning equipment required for preparation of bed spaces, and a hair-washing trough to use for patients unable to get out of bed. Staff evaluated the impact of their innovations.
- Staff focused on continually improving the quality of care. For example, in the OPU, the team submitted a business case for an activities coordinator. Prior to our inspection, this service was offered on the dementia ward and had resulted in a significant reduction in the need for one to one observation of patients with dementia.
- The trust recognised and rewarded improvements to quality and innovation. 'Celebrating success' awards were held monthly and presented to staff teams by the chief executive.
- The medical service achieved the quality mark for elder friendly hospital wards on Combe, a dementia ward in the OPU.

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

Information about the service

The Royal United Hospitals Bath NHS Foundation Trust provides surgery services at the Royal United Hospital. The trust provides care and treatment to a local population of over 500,000 people across Bath and North East Somerset, Wiltshire, Somerset and South Gloucestershire.

The Royal United Hospital provides the following surgery services; breast, colorectal, endocrine, upper gastrointestinal, ear nose and throat (ENT), general surgery, ophthalmology, oral, trauma & orthopaedics and urology.

There are 11 theatres in the main hospital and three at Princess Anne Wing. Each has a post-anaesthetic care unit (PACU) where immediate post-operative care takes place. There is a separate day eye unit with eight chairs where operations under local anaesthetic take place. There are six surgical wards. On the surgical admissions unit (SAU) the trust houses the GP referral unit known as the Emergency Surgical Ambulatory Care Unit (ESAC).

During this inspection on 16, to 18 March 2016, we visited all the surgical wards, pre-admission clinic, theatre suites and the sterile supplies department. We spoke with 40 staff, including theatre managers, the head of nursing, matrons, ward sisters, consultants, anaesthetists, doctors, junior doctors and nurses. We also talked with healthcare assistants, pharmacy staff, physiotherapists, occupational therapists, and members of the hotel services staff. We spoke with 27 patients and 12 of their friends and relatives. We observed care and looked at 20 sets of patient records. We reviewed data provided in advance of the inspection.

The trust as a whole had 20,444 admissions between September 2014 and August 2015. Of these, 37% were emergency, 21% were elective and 42% were day cases.

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Summary of findings

We rated surgery services as good because:

- The trust encouraged openness and transparency about incident reporting and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents. However, not all staff reported receiving feedback following the reporting of an incident.
- The trust encouraged an open culture. Staff were aware of the principles of Duty of Candour and apologised to patients when things went wrong.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies.
- Reporting on the Safety Thermometer between December 2014 and December 2015 indicated the number of reported harms to patients were low.
- The majority of feedback we received from patients and their relatives about their treatment by staff was positive. Patients gave us individual examples of where they felt staff 'went the extra mile' and exceeded expectations with the care they gave. Patients felt staff maintained their privacy and dignity at all times and provided them with compassionate care.
- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. However, we did find one incident where part of the care and treatment of a patient who lacked capacity to make a decision was not recorded on the consent form.
- Staff supported people living with a learning disabilities and those living with dementia to have a better experience of being in hospital. Staff were kind and patient with people living with dementia and a learning disabilities. We observed one-to-one care taking place and activities planned on their assessed needs. A specialist team of staff in the hospital provided support to patients living with a learning disabilities, dementia and for staff caring for them.
- Patients care was coordinated when a number of different staff was involved in their care and

treatment, for example physiotherapists and occupational therapists. All relevant staff were involved in the assessing, planning and delivery of patient care and treatment. Staff worked collaboratively to meet patients' needs.

- The hospital performed better than the England average in some national audits, for example, the national hip fracture audit 2015.
- The trust monitored the number of bed moves after 10pm on the surgical wards. The numbers had reduced in November 2015 compared to October 2015. However, two patients told us they had been moved very late at night and found it very disruptive.
- The service leadership was good and a cohesive clinical governance structure showed learning, change and improvement took place. Managers regularly reviewed the approach to risk management in the departments. A number of specialty meetings fed into the overall clinical governance and provided board assurance.

However:

- Patient records were not being stored securely on the admissions suite, so there was a potential risk of access by unauthorised people.
- The trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment 18 week standard) performance was worse than the England average for all but one of the six months to May 2015, when the target was abolished. Between March 2015 and November 2015 the percentage of admitted surgical patients that started consultant-led treatment within 18 weeks of referral was consistently lower than the England average.
- The hospital performed worse than the England average in some national audits, including the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015, which is based on patients reporting to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. In relation to groin hernias for both indicators and a mixed response in the varicose veins. However, the trust were able to provide mitigating reasons for this.

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- There were periods of understaffing on the surgical wards where the trust's safer staffing numbers of qualified nurses were not met. Additional non-qualified staff were used at times to cover any gaps in the rota.

Are surgery services safe?

Good



We rated the safety of surgery services as good because;

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- There was a clear and well-followed process for responding to acutely ill patients.
- Staff recognised and responded appropriately to changes in risks to patients.
- Reporting on the Safety Thermometer between December 2014 and December 2015 indicated the number of reported harms to patients were low when compared to other trusts.

However:

- Patient records were not being stored securely on the admissions suite, so there was a potential risk of access by unauthorised people.
- The trust did not always achieve its planned qualified nurse staffing numbers on some shifts.

Incidents

- Staff were encouraged to report incidents using the trust's electronic recording system. The appropriate ward manager and matron saw all incident reports. Staff told us they received an e-mail informing them their incident report had been received but not all said they had actual feedback about the incident they had reported. A senior member of staff told us they were involved in the investigation of incidents reported in theatre and they always fed back to the member of staff involved. The vast majority of their incidents in theatres related to delayed discharges from the post anaesthetic care unit (PACU) and equipment, for example, not working or missing from theatre kits. Following reports of incidents involving patients being kept in PACU due to lack of critical care unit (CCU) and high dependency unit (HDU) beds, a senior member of staff told us an extra member of staff was going to be added to the night staffing numbers for PACU. All incidents reported in

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surgery were monitored and recorded on the surgical score card. We were shown a score card from February 2015 to November 2015 which included this information.

- Staff told us there was a 'no blame' culture and incidents were viewed as an opportunity for learning by the trust. The ward managers in the Surgical Short Stay Unit (SSSU), Admissions Suite, Surgical Admissions Unit (SAU) and Forrester Brown ward had developed newsletters, which were attached monthly to staff payslips. In these newsletters, incidents and complaints were discussed and key learning points shared. All staff we spoke with said these were very valuable resources.
- Staff in the Central Sterile Stores Department (CSSD) told us they reviewed any incident forms completed by theatres that involved equipment processed by them. They would complete an investigation as required and provide feedback.
- The trust notified us of an incident involving theatres and wound dressings prior to our inspection. An initial investigation had taken place and some safeguards for staff to follow were introduced until a more depth investigation was completed. This was ongoing during our inspection.
- From data provided by the trust for the period between February 2015 and January 2016, we saw there had been eight serious incidents reported under the Strategic Executive Information System (STEIS). These included slips/trips and falls, sub-optimal care and infection. There was one infection control-related serious incident. This was the closure of six wards across the trust, to include surgical wards in November 2015 due to an outbreak of norovirus.
- Surgery was the third highest reporting service with 1,395 incidents (20% of all incidents). The majority of incidents reported in surgery (1,096 or 79%) resulted in no harm. The most commonly reported incident category related to treatments or procedures (297 or 21%). This category accounted for most of the severe harms (eight out of ten) and moderate harms (57 out of 72 or 79%). The second most commonly reported category was infrastructure-related incidents (231 or 17%). All of these were no or low harm. Surgery accounted for 31% or nearly a third of infection control incidents across the trust (69 out of 220). However, none of these resulted in severe harm or death.

- Eighty nine percent of surgical incidents were reported to the National Reporting and Learning System (NRLS) within 30 days of occurrence. This was the same proportion as at trust level.
- The trust had identified an increase in the number of surgical site infection rates in breast and orthopaedic surgery and these were being monitored monthly.
- In 2014/15 the inpatient surgical site infection (SSI) rates for patients undergoing hip replacements and repair of neck of femur were both higher at the trust than the England average when readmissions were taken into account. In 2014/2015 there were no inpatient SSI's for patients undergoing knee replacement and this was better than the England average. When readmissions for knee replacements were taken into account, the infection rate in 2014/15 was slightly higher than the England average. A senior member of staff told us plans were in place to change the air-handling units in theatres as this may have been a contributing factor. Changes had also been made to the cleaning of theatres and this was being audited. A senior member of staff from theatres was also reviewing the cleaning audits to assist in identifying any issues.
- Mortality and morbidity meetings occurred within surgical specialities either monthly or every two months. We saw meeting minutes for ear, nose and throat, general surgery and urology, showed discussion of individual cases and opportunity for teaching and learning for those staff present.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour.
- We were shown letters where senior staff wrote to the patient, or the patient's representative acting on their behalf, when an incident had occurred and the patient had suffered moderate to severe harm (being the threshold for action set out in the regulation). These letters apologised to the patient, or their representative,

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and told them how long the investigation into their incident would take, invited them to attend a meeting (if they wanted) and provided a named member of staff as their point of contact.

Safety Thermometer

- Surgical wards had information about harm free care on display using the safety cross system.
- Safety crosses were developed from the Productive Ward Programme. This programme devised by the NHS Institute Worldwide looked at improving ward processes and the environment for better patient care and it provided tools for nurses to make changes to their physical environment. Safety crosses was one of them. This visual tool used a 'green cross' for no harm and 'red cross' to indicate harm. It monitored the rates of hospital acquired, methicillin resistant *Staphylococcus aureus* (MRSA), falls, commode cleanliness, pressure ulcers, complaints and *Clostridium difficile* rates. These were completed daily and displayed on the ward noticeboards.
- Each ward completed Safety Thermometer monitoring each month but the results were not on display for patients or the public to view as they chose to use the safety cross system. On a set day, each month staff recorded the required data on avoidable patient harm to the NHS Health and Social Care Information Centre. This is nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included all and new pressure ulcers (grade two and more serious categories: grade three and four) and patient falls with harm. The report also included catheter and urinary tract infections (UTIs). Between December 2014 and December 2015, the number of reported harms to patients were low and there were no discernible trends in prevalence. For example, during this time period only one catheter and UTI was reported.
- Pulteney ward reported one fall and Robin Smith ward reported one dirty commode to the time of inspection in the month of March 2016. The remaining safety crosses were all green. The Surgical Short Stay Unit (SSSU) displayed all green for the month to date except one fall, which was displayed in red.
- Trust data showed that venous thromboembolism (VTE) compliance with risk assessment from February 2015 to November 2015 was rated as 'green' above the target of 95% across the surgical division.

- Between February 2015 to November 2015, the surgical division reported no catheter and urinary tract infections (UTIs).
- We saw evidence of techniques to help patients avoid harm. This included air mattresses, comfort rounds and magnetic labels on the patient board to identify them to staff as having specific risks such as falls and vulnerable pressure areas.

Cleanliness, infection control and hygiene

- Cleanliness and control of infection was managed effectively.
- The operating theatre and PACU areas we visited were visibly clean, well maintained and organised. The wards and units were also visibly clean and maintained.
- Clinical waste was managed in line with the trust's policy. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. Staff in theatres told us how they managed all their waste. We saw different coloured bags used for waste. Staff transported these around on trolleys. A procedure was in place for the disposal of radioactive material.
- We observed staff in theatres maintaining strict infection control procedures, for example, we observed scrub staff 'scrubbing' (this was where staff washed their hands up to their elbows in using specialist soap and single use scrubbing brush) and wearing sterile gloves and theatre greens. All staff in the theatre made sure they did not touch these members of staff so they were as sterile as possible to prevent the risk of cross infection.
- We observed the majority of staff following the infection control policy. This included being bare below the elbow and ensuring long hair was tied back. However, some staff on SSSU and Forrester Brown ward had hair that was not off the collar. Information reminding staff about hand washing procedures was displayed clearly on all wards.
- Monthly hand hygiene and cleaning audits took place. For example, on Robin Smith ward the result for February 2016 showed a compliance of 100% for hand hygiene and only 89% for cleaning.
- Patients who were known to be cross infection risks were placed in rooms with clear labelling to indicate

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that appropriate cross infection procedures should be carried out prior to entering. We saw all staff wearing aprons and washing their hands before entering the room. This was in line with infection control policy.

- Staff were seen to follow hygiene standards when distributing food, which included wearing different coloured aprons to those used for medical or cleaning purposes. Hand wipes were also provided to each patient prior to mealtime.
- One patient told us they were impressed with how thoroughly the staff on the ward cleaned bed areas prior to new patients being transferred to them.
- We observed staff in the PACU removing intravenous lines from patients that were no longer needed to reduce the risk of infections.
- Surgical Division Clinical Governance Meeting minutes from November 2015 stated the Surgical Division had reported six cases of *Clostridium difficile* (C.diff) and three Methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemia since June 2015.
- Patients recognised good cleaning. The Department of Health and the NHS England recommend that all hospitals, hospices and independent treatment centres providing NHS funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. The hospital trust score for cleanliness was similar to the England average in the patient-led assessments of the care environment. All patients we spoke with told us the standard of cleaning on the wards was very good.
- The trust sent us details of an MRSA audit they undertook in December 2015 and January 2016. This concentrated on reviewing 115 patients' records across all wards. There were 100 emergency admission patients and 15 elective patients. The audit found that staff were not routinely commencing skin washes for high-risk patients. An action plan had been devised with a completion date of 30 April 2016. This included disseminating the information of the findings to staff at ward level and reminding them of the policy.

Environment and equipment

- There was safe provision of resuscitation equipment. There was a requirement for trolleys and equipment, including defibrillators, in all areas to be checked daily. Records from January 2016 to March 2016 showed this was mostly done. Records for the Surgical Short Stay

Unit showed daily checks had been missed on the 9, 10, 11 and 16 January, the 6 February and the 7 March 2016. There was no evidence that this had been identified by other staff on the unit and action taken.

- The trolleys were well located within wards, units and theatre areas so they stood out and were easily accessible. All the resuscitation trolleys were locked with a tamper evident seal. This was to make sure all the trolleys had not been opened or equipment used since they were last used. There was no resuscitation equipment on the Admissions Suite, as they used the equipment on Robin Smith ward, which was through the unlocked double doors. Staff felt this was not an issue; however this could compromise patient safety.
- All commodes checked on all wards were clean and had dates when they had been cleaned.
- Sluices were clean on all wards but were not locked. The sluice on SSSU had patients' lost property spilling onto the floor and the sharp bin (used for used intravenous lines and fluid bags) had no lid on it and would have been easy to access, as the sluice area was unlocked. This was a potential health and safety risk as a visitor or patient could have put their hands into the sharp bin and received an injury.
- We also found chemicals covered by the Control of Substances Hazardous to Health (COSHH) Regulations. For example, Actichlor cleaning tablets and mixed solution were left on the worktop in all the sluices we visited. This was unsafe practice because the sluice rooms were unlocked and patients and visitors were at risk of touching or drinking these chemicals. We informed ward managers who said they were aware of this and the trust.
- The Admissions Suite had a lockable sluice but this was only used for storing patient's belongings before transfer to the admitting ward. When a commode was required staff would go across the main corridor to SSSU and bring one back to the department. When this had been used, the soiled commode pan was placed in a sealed bag and the commode wheeled back to SSSU. This was potentially an infection control risk and was not very pleasant for patients and visitors using this corridor to witness. The ward manager was aware of this and felt it was not ideal but commodes were used infrequently on the admission suite.
- Theatres and PACU were supplied and fitted with the appropriate equipment. PACU areas had oxygen and

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suction at each bed space and a selection of equipment that staff required when caring for a patient. Emergency call systems were in place, which we were told were tested regularly.

- The trust sent us details of equipment logs for the surgical division. This listed all medical equipment in theatres, wards and units and who serviced and maintained them in line with manufactures guidance. The manufacturer or the hospital's medical engineering department maintained equipment. In theatres we saw equipment with stickers indicating when it was last serviced. However in theatres five and seven not all equipment had a service date on it, for example, a nerve stimulator. A fluid warmer cabinet in theatre five was reported faulty in September 2015 but was still out of use waiting for spare parts. In theatre seven a fluid warming cabinet was not working properly. The service date on this equipment was 1995. Staff told us they had put in incident forms for the two pieces of equipment that were not working.
- We checked the recording of the daily safety checks of anaesthetic machines in some of theatres undertaken by theatre members of staff prior to the start of operating lists. We saw these had been completed.
- The bay areas in the Surgical Short Stay Unit (SSSU) were cluttered due to an excess of chairs stored in unused bed areas. This day unit was being used as a temporary escalation area for inpatients since 26 December 2015 and the chairs were stored in such a way as to create more space between the beds. This looked untidy.
- In the Admissions Suite the chairs were all the same height and the majority did not have arms making it difficult for patients with limited mobility to get in and out. The ward manager told us they were able to fit in more chairs if they did not have arms on them.
- The Central Sterile Stores Department (CSSD) had clear procedures in place for the management of dirty and clean equipment to make sure patients were not at risk of cross infection. They had a procedure in place to manage equipment that may have been used on patients known to have the rare and fatal brain condition, Creutzfeldt-Jakob disease (CJD).
- CSSD had a system in place for monitoring issues identified with the equipment they processed. A form was placed in all theatre kits for staff in theatres to complete if any issues were identified. The form was returned to CSSD and would be reviewed and details

put into their database. Action was taken, for example, if a piece of equipment was faulty it would be removed from service to be repaired if possible or a replacement obtained.

- External bodies, for example, the British Standards Institution (BSI), assessed CSSD and we were shown their latest report following a visit in October 2015, which had a few areas needing improvement. Staff told us any areas that were highlighted as needing improvement had been completed.
- The trust monitored the productivity of CSSD on a monthly basis and we were shown the information for February 2015 to November 2015.
- Equipment provided by CSSD was traceable. We saw the tracking stickers from this equipment in patient notes. This was in case in the future if any issues were identified with the equipment it could be traced to each patient.
- Patients' notes had records of the surgical equipment or prosthesis used to enable them to be tracked and traced. This is important if any issues with patients or the equipment after surgery are identified in order that they can be followed up.
- The Department of Health and the NHS England recommend that all hospitals, hospices and independent treatment centres providing NHS funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. Patient-led assessments of the care environment (PLACE) took place in 2013, 2014 and 2015. The trust scored lower than the England average for facilities in 2014 and 2015. The 'dementia friendly environment' was a new scoring category for the 2015 assessments and the trust scored below the England average. The trust felt some of this was due to the questions used as part of the assessment and they provided feedback regarding this. An action plan had been devised by the trust.

Medicines

- Medicines were safely and securely stored and managed on both the surgical wards and theatres.
- There was a pharmacy top-up service provided by the on-site pharmacy team to maintain medicines and check stocks for shortages or expiry, and medicines audits were regularly completed and actioned. However, there was limited clinical pharmacy support to

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this department; for example, there were no regular pharmacist visits to the Surgical Short Stay Unit (SSSU). This was identified as a risk on the pharmacy risk register.

- Controlled drugs (CDs being medicines that require additional security) were mostly well managed. We saw all storage was locked and keys held by an appropriate member of staff. Accurate records were maintained and regular checks completed. However, we saw that CDs had been transferred between theatres on the morning of inspection, which was not in line with trust policy. Furthermore, records were not being made at the time of administration in theatres, as detailed in the trust's policy on controlled drugs; the nurse manager reported that this was not operationally possible, and therefore the policy was currently under review in consultation with the pharmacy department.
- We looked at six prescription charts on surgical wards, and found them to be clear, legible, and completed appropriately. Allergies were documented where necessary, and antibiotic prescribing was in line with Trust policy. However, we found one patient who was having oxygen therapy had not had this prescribed. We spoke with a doctor who told us oxygen must be prescribed. This was reported to the nurse in charge.
- A system was in place to share medicine alerts at the safety briefing, through the noticeboard and on the trust's intranet.
- In addition to a study day on induction, there was a competency-based nurse training in medicines administration, and preparation of intravenous medicines which was delivered on the wards. Training from pharmacy for the issuing of pre-packs medications for patients being discharged was provided where required.
- Day surgery patients were encouraged to bring in their own regular medicines and self-administer. A checklist was undertaken at pre-admission clinic. However if the patient was not able to self-administer their medication was written on a medication chart and administered by nurse.
- Fridges were locked and regular temperature recording were seen and these were within the safe range for storage of medicines.
- Oxygen cylinders were stored safely.

- A patient told us they felt "supported with their medicines" by the nurses on the ward. Another patient told us the nurses had not told them about the side effects of their medication which they would have liked to know in advance of taking them.

Records

- Patient records were mostly stored securely and were in line with their nursing needs and medical reviews.
- Medical records for patients were stored in notes trolleys close to nursing stations on wards. Nursing records were stored at the end of patients' beds and some assessments of patients' needs were held on the trust's computer system.
- Notes on the Admissions Suite were stored on open shelves out of view of the nurses' station but in full view of patients and could easily be read and removed. This was a further problem after 2:30pm as staffing levels reduced to one nurse and potentially no receptionist. Notes would then be totally unsecured. The ward manager recognised this was a problem and they would review their storage arrangements.
- Patients' medical records on SSSU, Forrester Brown ward and Robin Smith wards were all stored in notes trolleys with closed lids in areas of high staff activity and visibility. We observed one incidence of a patient's record being left unattended on top of a records trolley. This compromises patients' private and confidential information.
- The trust's computer system was used to record risk assessments, such as the malnutrition screening tool (MUST). Staff on all wards showed their frustration with the system and reported it as often having problems. We witnessed an occasion on Robin Smith ward when a member of staff wanted to show us a recently updated MUST score. However this was not on the system and the member of staff was not sure why as they had completed it. The ward sister was informed, investigated and stated she would submit a risk incident form about it. On another occasion, staff were not able to log into the system and they were unaware of any routine maintenance being carried out to explain this. This meant that all staff were unable to access and update patient risk assessments.
- We reviewed the medical and nursing notes of 20 patients on all the surgical wards. The records were up to date and had clear information regarding the

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patients' medical care and treatment plan. All records identified clear signatures and dates indicating when medical staff had reviewed the patient and showed evidence of appropriate and timely assessments.

Safeguarding

- Staff were aware of their responsibilities to investigate and report any safeguarding concerns about children or adults.
- All staff we spoke with had a good insight into safeguarding and how to escalate to the trust's safeguarding team. Staff commented on how helpful the team were and there were posters of who the safeguarding team were and how they could be contacted.
- The trust provided us with safeguarding training figures for medical, nursing and allied health staff safeguarding training in the Surgical Division. Each group of staff were rated red, amber or green. Green being met the trust target of 90%. Allied health staff had met the trust target for safeguarding adult's level one and two and children level one and two. They were not required to undertake level three safeguarding training for children. Nursing staff had met the trust target for safeguarding adult's level one and three and safeguarding children in level one and three. Medical staff had met the trust target for safeguarding adults in level one. They were rated as 'amber' just below the trust target for safeguarding adults level two and safeguarding children level one.
- On Forrester Brown ward (orthopaedics) there was a dedicated ortho-geriatrics team who reviewed the medical needs of patients over the age of 70 years. The staff on this ward reported it worked very well in making sure all patients' needs were met.

Mandatory training

- Staff except for medical staff were mostly up to date with training in safe practice, processes and systems.
- We were given the training figures for mandatory training as of December 2015 for medical and dental staff, nursing and allied health staff. Each was rated red, amber or green. The trust target was 90%, which was green. The medical and dental staff were rated as 'red' (below 80%) in seven areas of the 15 mandatory areas. These included blood transfusion, infection prevention and control level 2. The nursing staff were rated as 'red' in only equality and diversity training as were allied health staff.

- Staff across all wards and theatres reported being given study days to complete mandatory training.
- A senior staff nurse on the Admissions Suite said they had an audit afternoon once a month when there were no planned operations they used this time for training sessions and update on line learning.
- The mandatory training figures in main theatres were below the trust target of 90%. The band 7 training and development lead was responsible for reminding staff to book on to training.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained.
- Patients for some elective surgery attend a pre-operative assessment clinic where all required tests were undertaken, for example, MRSA screening and any blood tests. If required, patients could be reviewed by an anaesthetist in the afternoons. Nurses and consultants were able to refer patients to the anaesthetists for review prior to booking of their surgery.
- The hospital had a policy for monitoring acutely ill patients. The hospital used the national early warning score (NEWS) system for the monitoring of adult patients on wards. This used a system of raising alerts through numerical scoring of patient observations. The system was in use on wards and in recovery rooms.
- Use of early warning scores was in evidence across the surgical wards. The Surgical Admissions Unit (SAU) displayed that they were 100% compliant with NEWS scores in the last audit undertaken. All staff spoken with were aware of how to use the NEWS to escalate a deteriorating patient.
- Audits of the use of NEWS were undertaken on all wards each month. Two measures were taken; one was the percentage of NEWS recorded and the other measured the accuracy of the score. The surgical wards had been audited for its completion of NEWS from February to December 2015 and they were rated red (below 80%), amber (80% to 89%) or green (90% and above) for compliance. Forrester Brown, Pulteney and surgical short stay unit (SSSU) wards had been mostly fully compliant (rated mostly green with some amber). Philip Yeoman and Robin Smith wards were rated as green fully compliant with recording a NEWS score during the audit period. However, the surgical wards had not been fully compliant with accurate scoring of NEWS during

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this period. Forrester Brown, Philip Yeoman and Pulteney wards were rated between red to green during this period. Robin Smith ward was mostly rated as amber and SAU and SSSU varied between green to amber rating.

- The hospital was using the five steps to safer surgery guidance, which included the World Health Organisation (WHO) surgical safety checklist in all surgical procedures (this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications). As recommended by the NHS National Patient Safety Agency (NPSA) the tool had been adapted for more specific use in areas such as ophthalmology and interventional radiology. The hospital adopted the use of the checklist as part of the introduction of the NPSA 'Five Steps to Safer Surgery 2010' guidance.
- WHO checklist completion was being audited each month from January 2013 to December 2015. The number of patients ranged each month between 1300 and 1600. The audit results varied over this period but they were mostly above 99.5%. For December 2015, they were almost at 100% compliance.
- We observed in theatres all parts of the WHO checklist being completed in full and all staff in the theatre were present. The times were added in the computer system, as this was able to provide theatre staff details of where all patients were.
- Eye theatres and interventional radiology used a modified/adapted WHO surgical safety checklist pertinent to the operations/procedures they undertook.
- The trust had identified lack of compliance by theatre staff in meeting a part of the WHO checklist. A senior member of staff told us this had now been addressed with all staff.
- At the end of operations, we observed the final count of instruments and swabs used to make sure they all tallied with the number at the beginning of the operation. This was to make sure no instruments or swabs were left inside a patient. This was also recorded.

Nursing staffing

- There were vacancies for nursing staff in some of the surgical wards. Ongoing recruitment was taking place and bank and agency staff were used to fill any gaps in the rotas. We saw the trust data for actual figures from August 2015 to November 2015 for qualified nurses and the wards worked under their safer staffing numbers when they were not able to fill their vacancies.

- Qualified nurses from overseas had been recruited to fill vacancies on the wards.
- The trust undertook six-monthly review of acuity using the Shelford Safer Nursing Care Tool (SNCT), the purpose of which was to determine whether the pre-agreed planned establishment and skill mix per shift reflected the acuity and dependency needs of the patients. The trust found some limitations with the tool, for example, not capturing weekend working, day surgery and emergency admission/assessment areas. Therefore it was only used for the general surgical wards. The findings from the SNCT report from February 2015 demonstrated that the funded establishment reflected the acuity and dependency requirements of the wards across the Surgical Division. Forrester Brown Ward was identified as needing some extra staffing hours.
- We saw trust data on planned verses actual staffing figures for August 2015 to November 2015. Most of the surgical wards were under their actual staffing figures for trained staff but SAU and SSSU were on target. We saw there were more health care assistants in the actual staffing levels and these may have been used to cover for trained staff.
- We observed on the noticeboards outside of the surgical wards that they were below the actual staffing numbers for qualified staff on duty for some shifts. We saw added to this band 4 assistant practitioner (AP) as a plus number. For example, on Forrester Brown ward on the 16 March 2016 for early shift they should have had 10 qualified nurses on duty, but only had eight with a plus two band 4 assistant practitioner. On the afternoon shift, they should have had nine qualified nurses on duty but only had six plus two band 4 assistant practitioner. These members of staff were being used to fill the qualified staff vacancies as they were trained to undertake additional duties.
- The use of agency staff on the wards and theatres from January 2015 to October 2015 was showing as 'red' above the trust target of 5%. The main theatre area was the only area to be meeting the trust target for agency use as they were below the 5% target. The eye unit had the most agency usage at 30.4% for January 2015.
- After 2.30pm, admissions suite staffing reduced to one trained nurse. If the nurse was in one of the rooms with a patient there would only be a receptionist to observe the patients in the waiting room (if one was on shift). We

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discussed this with the ward manager who informed us another receptionist with a dual role of a health care assistant had just been employed and was awaiting a start date.

- The vacancy rate for the surgical division from February 2015 to January 2016 for nursing staff was 4.4% which was above the trust target of 3.7%.
- The sickness rate for the surgical division for nursing staffing from January 2015 to December 2015 was 4.6%, which was just above the trust of 4.1%. We saw the minutes from the surgical sisters meeting from December 2015 and it was reported they had 60 short-term cases of sickness and 10 long-term cases. This was an improvement on the position previously.
- There was no turnover target but from February 2015 to January 2016, nursing staff had a low turnover rate of 1.4%.

Medical staffing

- Surgical staffing numbers meant patients received safe care and had access to consultant-led care and treatment, but out of hours, this was not always by a consultant for that speciality.
- The proportion of consultants was slightly lower than the England average at 37% compared to 41%.
- The proportion of middle grade, registrar and junior doctors was similar to the England average.
- There was a low use of locums in the Surgical Division.
- The theatre lists we observed were consultant-led.
- We were sent the on call rotas for all surgical specialities. There was access to a consultant who was on-call out of hours, at weekends and bank holidays. For some specialities, this was shared with other hospitals, for example, a nearby eye hospital. Junior doctors and more senior doctors (registrars) were on-call to review patients during out of hours, weekends and bank holidays. At night, they were also supported by the night sisters.
- We saw in some patients' notes that they saw a doctor most weekdays but not always the consultant. Patients told us they saw doctors and were able to ask questions about their treatment.
- The turnover rate for all staff in the surgical division from March 2015 to March 2016 was between 10% to 14%, which was above the trust target of nine percent or less.
- Vacancy rates from February 15 to January 2016 for medical staff was 3.7% which was at the trust target level.

- Sickness rates from January 2015 to December 2015 for medical staff were 0.8% which was well under the trust target of 4.1%.

Major incident awareness and training

- Staff told us they knew the procedure to follow if a major incident was to have taken place.
- In the event of a major incident all elective surgery would be stopped.
- The ward teams recognised the challenges, which the trust experienced during 'black' escalation and winter pressures and were working as hard as they could to make sure patients received good care.
- At the time of our inspection theatres had recently experienced a serious power failure, which had resulted in operations being cancelled, and incident arrangements being out into action. A senior member of staff told us each member of staff had been allocated a role during this time. The trust reported that no patients suffered harm because of this power failure.

Are surgery services effective?

Good



We have judged the effectiveness of surgery services as good because:

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- When patients' received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering their care and treatment. Staff worked collaboratively to understand and meet the range and complexity of patients' needs.
- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and, where appropriate, their mental capacity was generally assessed and recorded.
- The trust had good performance in the national hip fracture audit for 2015.

However:

- The hospital performed worse than the England average in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015, which is based on patients

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reporting to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. In relation to groin hernias and it varied for varicose veins. However, the trust were able to provide mitigating reasons for this.

- Not all venous thromboembolism (VTE) assessments were being reviewed as per trust protocol.
- We identify one patient who lacked capacity where their consent form did not contain all the required treatments they received.
- The first patient National Emergency Laparotomy Audit (NELA) 2015 results were varied with only two of the 11 areas assessed being rated as 'green'. However, the trust told us their latest data had shown an improvement.

Evidence-based care and treatment

- Policies and guidelines were readily available on the trust intranet. These were seen to be up-to-date and meeting national guidance.
- On SAU, clear documentation of NEWS scores and sepsis assessment were evident and the appropriate escalation of patients showed adherence to National Institute for Health and Care Excellence NICE guidelines CG 50 Acutely ill adults in hospital: recognising and responding to deterioration.
- PACU was meeting NICE guidance CG65 - Hypothermia: prevention and management in adults having surgery. This guidance is about the importance of maintaining a patient's body temperature above 36 degrees centigrade. Staff told us they did not discharge patients to the wards without their body temperature being above 36 degrees centigrade. We observed in theatre the anaesthetic nurse checking patients temperature prior to and during the operation to make sure it was above 36 degrees centigrade. Staff in PACU had access to warming devices if required.
- Patients were assessed for risks of venous thromboembolism (VTE) prior to surgery, in line with the NICE guidance. There was evidence in patient records of the use of prophylaxis injections or tablets (proactive prevention) for VTE. VTE assessments were recorded on the medication administration records and were clear and evidence-based, ensuring best practice in assessment and prevention. We saw these had mostly been completed as per the trust's protocol. The area we

found where they were not being met as per trust protocol was the 24-hour review. Out of eight patient records where we looked at VTE assessments, four had not been reviewed at 24 hours.

- CSSD worked in line with NICE guidance for example, IPG 196 for patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD).
- The trust had enhanced recovery programmes in place for orthopaedics. Enhanced recovery is a modern, evidence-based approach that helps patients recover more quickly after having major surgery. Once patients were discharged, they received follow up telephone calls to find out how they were progressing. The purpose of this was to enable patients to be discharged on the set day as directed in the pathway but they still had contact with the hospital.
- A senior member of staff was involved in the South West Patient Safety Programme. This programme involved a number of trusts from the south west. This included a peri-operative work stream (peri-operative means care that is given before, during and after surgery) to improve patient safety in theatre and to reduce the number of harms to patients. The trust had completed work on improving its compliance with WHO surgical safety checklist to embed the process with all staff.
- The trust was undertaking a number of internal audits. These included anaesthetic framework for fractured neck of femur, total knee replacement surgery and colorectal surgery. These audits were looking at a number of areas to include type of anaesthetic being administered, analgesia and temperature management. These were ongoing at the time of our inspection. Another internal audit was focussed on patient consent. The trust had been undertaking this annually since 2011. The results were compared each year. The objective of this audit was to ensure written consent was appropriately taken and documented accordingly. The findings were to be shared with the Surgical Divisional Clinical Governance Meeting and actions put in place to address the areas where they felt improvement was needed.

Pain relief

- Patients' pain was assessed and managed effectively.
- Patients told us they would ask staff for pain relief if required and they told us their pain was well controlled.
- The acute specialist pain team were available seven days a week. During the week a consultant and

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specialist nurses were available and they routinely visited wards to see post-operative patients as required. They would team review patients and the records staff made to assess the effectiveness of patients' analgesia. At weekends, a specialist registrar would review patients.

- The acute pain team followed up patients who had a spinal or epidural, patient-controlled analgesia machines and peripheral nerve blocks to make sure they were effective in reducing their pain.

Nutrition and hydration

- Patients had their nutrition and hydration needs assessed and actions were put in place to manage these needs.
- Patients were screened using the malnutrition universal screening tool (MUST) to identify those who were malnourished or at risk of becoming malnourished. This is a validated national nutritional screening tool and was designed to identify adults at risk of malnutrition and to categorise them as low, medium or high risk. We saw this had been completed at preadmission clinic for a number of elective patients. This tool was inputted into the trust's computer system and it alerted the nurse when the patients' scores need to be re-assessed
- Patients were told when they needed to stop eating and drinking prior to their admission to hospital. This was dependant on their time of admission.
- We observed some patients had intravenous fluids post-operatively to maintain their fluid levels.
- We saw the management of patients' fluid balance was good. Fluid charts were in place and those we reviewed for patients who had undergone major surgery were very detailed and had totals for input and output. These also included measurements from any drains or other equipment they had in place.
- Patients told us they were offered medication to prevent their nausea and vomiting post operatively.
- Staff told us patients were referred to dieticians if they required additional support with their nutrition.

Patient outcomes

- The hospital had mixed performance in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015. Under this scheme patients reported to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The trust performed worse than the

England average for both groin hernia indicators. It performed better than the England average for three of the knee replacement indicators. Performance in for varicose veins was varied. The trust told us hernias repairs up until April 2016 were performed by an independent provider on their behalf as a sub contracted activity. The patients seen by this independent provider were given PROMS forms which were linked to them and not the RUH. Therefore, PROMS reporting had taken place but it was not attributed to the RUH. The large majority of simple hernias were subcontracted to the independent provider to perform under local anaesthesia in a community setting. This adjusted the RUH case mix towards complex hernias in unfit patients, who were likely to have a worse outcome. Despite this, outcomes were only slightly below the national average. The NHS Choices website, using PROMS data, states that the health improvements reported by patients after groin surgery is 'OK' and in the 'Middle range'.

Varicose vein surgery is no longer commissioned at the RUH. The trust undertook too few varicose vein operations to produce any meaningful outcome data as they completed just eight varicose vein operations in the most recent 12 month period. This is because organisations that perform under 30 records do not have their data analysed.

- Hip fracture performance for the year 2015 was good. Out of the 10 areas assessed where two were not rated the trust performed better than the England average in six of these. For example, patients developing pressure ulcers was 0.2% compared to the England average of 2.8%, the total length of stay was 14.9 days, compared to 20.3 days for the England average and pre-operative assessment by a geriatrician was 99.4% compared to the England average of 85.3%. Although the hospital performance in this audit had decreased since the previous year, the results were still better than the England average. The trust had mixed performance in national cancer audits for 2015. In the lung cancer audit the trust was better than the England average for reviewing patients at a multidisciplinary level. In the bowel cancer audit, the trust was better than the England average for attempting laparoscopic surgery and lengths of stay greater than five days was below the England average. The trust was above the England

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average for the quality of its completed data in the bowel cancer audit. The trust performed just under the England average for patients seen by a clinical nurse specialist.

- The trust responded “not available” for 10 of the 28 relevant indicators in the organisational National Emergency Laparotomy Audit (NELA) 2014. For example, the critical care outreach service was not available 24 hours a day, there was no policy for anaesthetic seniority according to risk and there were no explicit arrangements for review by Elderly Medicine. However, the trust had available fully staffed operating theatres 24 hours a day, Consultant pathology advice at all times and a critical care unit with cover by consultant intensivist at all times.
- The trust provided data for the first patient report of the NELA 2015. The audit results were rated green, amber or red based on 11 measures. Out of the 11 areas, four were rated as red, five were rated as amber and two were rated as green. The ‘red’ ratings included review of patients older than 70 years by specialists in Medicine for Care of the Older Person (MCOP). This meant the trust only scored between 0-49% (red rating) of cases for patients over 70 years assessed by MCOP, and consultant surgeon and anaesthetist present in theatre for operations. The trust was rated as ‘green’ for arrival in theatre in timescale appropriate to urgency for 80-100% of cases.
- The emergency laparotomy pathway was re-launched in August 2015 and this has shown an improvement in all measures and the subsequent mortality rate had decreased as a result. The NELA report references data from 2014. The trust provided us with the following data to show where improvements had taken place. For example,
 - Risk documentation preoperatively (NELA 1 rated as amber), this was green by March 2016 (i.e. 80%)
 - Postoperative admission to critical care (NELA 1 rated as amber) was green by March 2016 (over 85%)
 - Consultant anaesthetists in theatre (amber in NELA 1), still amber in March but improving and now green
 - Consultant surgeon in theatre (amber in NELA 1) green in March 2016 (80%)
 - Time to theatre was green in NELA 1 and is still green

- Both consultant anaesthetist & surgeon in theatre (red in NELA 1) was amber in March 2016 (now 60%)

At the time of our inspection, the Trust was collecting baseline data on all patients over 70 and had a plan in place to commence Care of elderly consultant review from June 2016.

- Patient readmission rates after surgery between August 2014 and July 2015 (due to corrective measures being needed or infections) were worse than the England average for elective (planned) surgery but lower than the England average for non-elective surgery (emergency).
 - Trauma and orthopaedics had the highest elective surgery relative risk of readmission rate.
 - Trauma and orthopaedics non-elective (emergency) had the lowest rate of readmission compared to the England average.
- The Trust’s Anaesthetic Department was one of the pilot sites when the Anaesthesia Clinical Services Accreditation scheme (ACSA) was set up. Staff told us the trust had not proceeded with accreditation.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- Forrester Brown ward appraisal rates as reported by the ward sister were 94% complete.
- SSSU were 90% complete. Senior staff felt their numbers of appraisals were low due to long-term sickness.
- Staff reported that the hospital proactively manage the revalidation of its staff. Staff reported that there had been working groups and study sessions available to everyone.
- In theatres, staff were allocated in teams to each theatre and speciality and senior staff ran these. Some staff in these teams were multi-skilled for example; they were trained in ‘scrub’ and anaesthetics, which enabled them to undertake more than one task. The theatre manager had a list of all staff and their skills.
- Theatre appraisals rates were 100% for day surgery and 89.4% for the main theatres.
- The appraisals rates we given by the trust were up to January 2016 and included the whole of the surgical division. The trust target was 90.0% and the surgical division was 82.3% just below the trust target.

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- On Forrester Brown ward, surgical admissions unit (SAU) and surgical short stay unit (SSSU) band 4 AP had been introduced. These staff were able to undertake additional duties to health care assistants due to their training.
- On SSSU, the Band 4 AP was responsible for admitting and discharging day case patients. Any medications for these patients during their stay and on discharge were checked with a staff nurse.
- On Forrester Brown ward the APs were responsible for a bay of patients and a side room where they co-ordinated all of their care except administering medications. One of the APs that we spoke to stated they felt supported and enjoyed the autonomy, responsibility and challenge of the role.
- We were told APs were recruited to bridge the band five gaps in nurse recruitment.
- The wards had link nurses for specific areas, for example, dementia, sepsis and falls, other staff on the wards were able to learn from them.
- Junior doctors within surgery all report good surgical supervision, which they felt enhanced their learning.
- New staff had induction training and were supported by other staff until they felt confident in their new role.
- Patients had access to consultant cover seven days per week and other support services were available if required.
- An on-call rota was in place for all surgical specialities for out of hours, weekends and bank holidays. Some consultant cover was shared with other hospitals, for example, Bristol Eye Hospital.
- Physiotherapists were present from 8.30am to 4.30pm Monday to Friday, with weekend cover being provided from 8.30am to 3:30pm.
- Surgical Admissions Unit (SAU) were open and admitting patients 24 hours a day, seven days a week.
- The SAU operated an Emergency Surgical Ambulatory Care Unit (ESAC). As part of a Quality Improvement Project (QUIPP 5.8) it was recognised that patients waiting for emergency surgical procedures such as hernia and abscesses were not always being managed properly. These patients were often starved and cancelled at the end of an emergency theatre lists due to running out of theatre time. The ESAC had two dedicated surgeons, which operated a booked emergency list, which focuses on patients of this level and had eight spaces (when not being used for escalation inpatients). It had its own dedicated ultra sound equipment, room and a sonographer who had a dedicated inpatient clinic for two hours a day, Monday to Friday.
- The ESAC unit was run by two band seven nurse practitioners, Monday to Friday. The nurse practitioners also ran a nurse led clinic, which managed complex dressings, and an accelerated discharge programme, which aims to get patients home sooner but still give them the support and treatment required as an outpatient rather than inpatient.
- The NELA audit 2015 stated the trust had access to interventional endoscopy and endoscopy at all times.
- Interventional radiology was available out of hours.
- There was access to emergency theatre at all times to include weekends and out of hours.
- X-ray, scanning and diagnostic testing was available 24 hours, seven days a week. Urgent blood tests could be available out of hours.

Multidisciplinary working

- Staff from all disciplines both within the hospital and from other health care locations worked together to deliver effective care and treatment to patients.
- Occupational therapists and physiotherapists on surgical wards reported good MDT working to maximise the patients opportunities for recovery.
- We saw multidisciplinary teamwork in theatre in relation to the use of the World Health Organisation surgical safety checklist. Each member of the team had a recognised role.
- There was multidisciplinary input involved with all patient care. Patient records demonstrated input from therapists, including dieticians, physiotherapists, and occupational therapists, as well as from the pharmacist team and the medical team.
- There was evidence of a strong multidisciplinary approach from national cancer audits. In the 2015 lung cancer audit, there was 96.0% compliance for a multidisciplinary discussion in the 224 cases reviewed. This was above the England average of 93.6%.

Seven-day services

Access to information

- Staff had access to all the information they needed to deliver effective care and treatment to patients.

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- Ward clerks requested patients' notes from the hospital record system and these were received within a good timescale.
- Nursing staff told us when a patient was transferred to their ward from the critical care unit (CCU) records were maintained of their stay. These were stored in the patient's notes. Staff also said they received a verbal handover.
- Patients who were transferred between wards also had a handover of their care and treatment verbally from the staff of the previous ward to the new ward.
- We observed a patient being handed over from PACU to a ward member of staff. We heard the staff member from PACU inform the member of staff about the operation and when they had last had pain relief.
- Discharge summaries were promptly sent to GPs. We observed a consultant completing a discharge summary following an operation.
- Junior doctors told us they completed the discharge summaries as soon as possible to prevent the patient from having their discharge delayed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of the appropriate legislation and guidance.
- The trust had four consent forms in use, which was common across trusts. There was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures not under a general anaesthetic.
- Patients we spoke with told us they had signed consent forms prior to their surgery. They said the consultant or senior doctor had explained about the process and it was discussed in language patients said they could understand.
- The trust had a policy for staff on consent. It provided guidance and support for staff on how to obtain consent from patients.
- Whilst reviewing a patient's records we found one episode of undocumented consent on Forrester Brown ward. A patient who lacked capacity to make certain decisions and was living with learning difficulties had been consented for a specific operation. The consent form had been signed appropriately by two consultants and discussed with the patient's independent mental

capacity advocate. Before they went to theatre, the patient developed an urgent medical condition. This was appropriately documented in their medical notes as a medical emergency and that it would be rectified under general anaesthetic during the planned operation. The planned and the emergency procedures successfully took place at the same time; however, the emergency procedure was not included on the consent form, or discussed with the IMCA. We reported this to the ward sister who escalated to the matron for the unit. It was recorded as an incident and the staff involved were involved in discussion. An investigation was going to be started.

- Forrester Brown ward had two bays dedicated to caring for patients living with dementia. We witnessed an independent mental capacity advocate visiting one patient while a 'best interest decision' was made.
- Among those staff we spoke with there was a good understanding of Deprivation of Liberty Safeguards (DOLs) and managing patients under the Mental Capacity Act. The hospital had recently started using computer based assessments for DOLs and staff knew when and how to make an application.
- Training for staff in Mental Capacity Act which included DOLs was rated as green (met trust target of 90%) for allied health staff and amber for medical and nursing staff below trust target (between 80-90%).

Are surgery services caring?

Good



We have judged caring of surgery as good because:

- Patients were supported, treated with dignity and respect and were actively involved in their care.
- Patients and their relatives/carers were involved and encouraged to be partners in their care and in making decisions, with any support they need. Staff spent time talking to patients and those close to them. Patients and their relative/carers were spoken with in a caring manner and received information in a way that they could understand. Patients understood their care, treatment and condition, worked with staff to plan their care, and shared decision-making about their care and treatment.

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- All staff responded compassionately when patients needed help and supported them to meet their needs. Staff anticipated patients' needs and maintained their privacy and confidentiality at all times.

Compassionate care

- We observed staff introduce themselves to patients if they had not met them before. One patient told us that on Surgical Admissions Unit (SAU) staff had shift handover meetings at the end of their bed and included them. New staff coming on duty introduced themselves so they knew who to call for help and assistance. Patients told us this did not happen on all surgical wards.
- Staff interactions with patients were friendly and welcoming. Where patients had built relationships with staff, first names were used. We also observed this where staff knew the patient's family/carers.
- Patients told us their call bells were usually answered quickly. Some patients said it depended on how busy the staff were.
- All of the patients we spoke with told us the staff treated them very well. All praised the staff for the work they did. They told us the staff were compassionate and caring: "nothing is too much trouble", "they are wonderful", "they are all very kind", "I cannot fault anyone here" and "I could not have received better care". One patient reported, "All the staff are my friends".
- Staff were seen to respond well to patients' requests. We observed a member of staff being polite, kind and patient and explaining each step of what they were doing when assisting a patient walking.
- When patients received care or treatment, we saw the staff treat them with dignity and respect. Staff closed the curtains around their bed or closed the door when in toilets/bathrooms in order to maintain privacy.
- In theatres, we observed staff maintaining patients' dignity once they had been anaesthetised by keeping them covered with blankets until the surgeon was ready to start the operation.
- Staff spoke with patients and their relatives/carers in a respectful manner, taking time to explain what they were doing and the care and treatment they were receiving.
- We observed on one of the wards where staff 'had gone the extra mile' to encourage a patient to eat. The staff

had agreed an individual menu for this patient and kept certain food on the ward to encourage them with eating when they did not like the food on the main hospital menu.

- The friends and family test (FFT) is a feedback tool that gives people who use services the opportunity to provide feedback on their experience. Performance from December 2014 to November 2015 for the number of patients who recommended the surgical wards as a whole was between 84% and 100%. The response rate of patients who completed the test between these dates was between 39% to 61%.
- The Surgical Division had completed an inpatient survey between July 2015 and December 2015. A total of 153 questionnaires were returned. One of questions asked overall whether the staff are kind and friendly. Over 97% responded positively.

Understanding and involvement of patients and those close to them

- Patients and their family/carers were mostly included in the discussions about their care and treatment. Not all patients felt they were given accurate information, for example, one patient told us their procedure was postponed twice, no reason was given, and they were not sure, when it was going to happen.
- All the patients and relatives we spoke to reported they understood the information provided to them about their care and treatment. They reported staff took the time to explain everything to them, and that they felt involved, and able to ask questions in regards to their choices and opinions. One relative informed us, "We have been involved in the decision making every step of the way".
- We observed staff take the time to sit and draw with a patient living with learning disabilities. We overheard them ringing the patient's care home to ask for more colouring books and pencil crayons as this was something the patient enjoyed.
- We witnessed staff taking the time to dye a patient's hair, who had been there for a long period. The patient reported, "Staff always tried to keep my spirits up and make me feel normal".
- On Forrester Brown ward, we witnessed positive caring interactions with staff and a patient living with learning disabilities and dementia. The nurse spent time holding their hand and talking to them and made sure they were

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always close by and this reduced the patient's anxiety immediately. For another patient who liked to watch the television and DVDs, staff obtained a television and DVDs for them to watch by their bedside.

- The Surgical Division inpatient survey asked patients if they were involved in the decisions about their care and treatment. Over 75% confirmed they were.

Emotional support

- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- There was spiritual support available from within the hospital as the chaplaincy and a team of spiritual advisors could be contacted. Patients were able to have support from their own local connections and networks.
- We witnessed two members of staff sit and comfort a patient who had become distressed. They sat and engaged with the patient for 45 minutes talking through their concerns in a compassionate way until the patient felt better.
- Patients had support from nurses with additional knowledge. For example, there were nurses with link roles in matters relating to mental health, learning disabilities and dementia.
- The Surgical Division inpatient survey asked patients if they found a member of hospital staff to talk to about their worries or fear. Almost 88% confirmed they had.
- We saw information on a noticeboard about a Carer Hub at the hospital. The Carer Hub was where carers of all ages could find information and advice that would help them in their caring role and be signposted to further support.

Are surgery services responsive?

Requires improvement



We rated the responsiveness of surgery services as requires improvement because:

- Some patients were not able to access services for assessment, diagnosis or treatment when they needed to. There were long waiting times, delays or cancellation. The trust breached the 18 week referral to treatment target across surgical specialties for all but one of the six months to May 2015, when the target was

abolished. Between March 2015 and November 2015 the percentage of admitted surgical patients that started consultant-led treatment within 18 weeks of referral was consistently lower than the England average

- Due to pressure on services patients were being moved at night. The trust was monitoring the number of moves patients had after the hours of 10pm and it had reduced in November 2015 compared to October 2015.
- The Short Stay Surgical Unit (SSSU) had been used as an escalation ward since 26 December 2015 and was operating as ward to accommodate the demand on services across the hospital. This impacted on elective operations.

However:

- The Emergency Surgical Ambulatory Care Unit (ESAC) was reducing the need for all GP referred surgical patients to be admitted to hospital.
- Reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. We observed staff meeting the individual needs of patients living with learning difficulties and dementia.

Service planning and delivery to meet the needs of local people

- The trust worked with commissioners to plan for, and meet, the needs of the local population. There were regular meetings and an open relationship between them and other stakeholders. The Surgical Division management team were working with the commissioners on how to address their referral to treatment times (RTT) for all surgical specialties to meet the national target.
- Some surgical services were not provided at the hospital and patients had to be transferred to another provider, for example, in the case of bariatric and vascular surgery. Out of hours cover was also shared with other providers.
- The SAU operated an Emergency Surgical Ambulatory Care Unit (ESAC). This was for patients referred by GPs who needed a review by a surgical consultant but did not always require emergency surgery. Prior to this unit being set up, patients were often 'nil-by-mouth' and cancelled at the end of an emergency theatre lists due to running out of theatre time. Patients were reviewed

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and then booked on to special list theatre list for the ESAC service. They were often able to go home whilst waiting for surgery and then not taking up an acute surgical bed.

Access and flow

- The trust had mixed performance in the national audits they provided data for.
- The average length of stay was below the England average for elective care. It was similar to the England average for non-elective care.
- The percentage of patients whose operations were cancelled and who were not treated within 28 days was worse than the England average April to June and July to September of 2014/2015. Otherwise performance was better than the England average between July 2013 to July 2015 and it has shown a trend of improvement since October 2014.
- The number of cancelled operations as a percentage of elective admissions was similar to the England average, apart from a spike in January to March 2015.
- The trust breached the 18-week referral to treatment target across surgical specialties for all but one of the six months to May 2015, when the target was abolished. Between March 2015 and November 2015 the percentage of admitted surgical patients that started consultant-led treatment within 18 weeks of referral was consistently lower than the England average. The trust told us it is required to report performance against the RTT incomplete pathway with a target of 92% and the divisional performance in March 2016 was 88.5%.
- We observed a meeting between some senior staff on the surgical unit where they looked at their capacity to prevent elective patients having their surgery cancelled. Staff worked very hard at locating beds so that on the day we observed the meeting no patients were cancelled. These meetings took place every weekday.
- There was round-the-clock provision for emergency surgery, as recommended by the National Emergency Laparotomy Audit 2014. A specially reserved and dedicated emergency theatre was used.
- Emergency surgical Ambulatory Care Unit (ESAC) prevented unnecessary surgical admissions and patients being kept in hospital whilst waiting for operations. However, this was under constant pressure to meet the needs of patients due to many beds on the unit accommodating patients from the medical teams/division. There was concern from senior ward leaders and a consultant that the problems with patient flow were not being addressed, especially about timely medical team reviews.
- Two patients told us they moved wards a number of times since they had been admitted. One patient had been in hospital for a week and had been moved five times and one of these moves was in the early hours of the morning. Another patient told us “it is usually midnight when they move you”. The trust was monitoring their bed moves on the surgical wards after 10pm at night. We saw that data from October and November 2015 showed the numbers of night time ward moves on all surgical wards had decreased in November compared to October.
- On Forrester Brown ward discharge coordinators had been introduced to help with the planning and discharge of patients. Staff told us this had reduced the length of stay of patients and they felt communication with relatives/carers had been greatly improved. However, they had no data to support this.
- Escalation wards were being used when the demand for hospital services put pressure on beds. The Surgical Short Stay Unit (SSSU) had been turned into a ward since Boxing Day 2015. The Eye Day Unit was also used to accommodate patients when required.
- The management of medical outliers on surgical wards was reported as causing flow problems on the Surgical Admissions Unit (SAU). After an initial ward round all medical patients on surgical wards were cared for under zones. SAU falls under the zone of the Gastroenterology Team. It was reported to us that patients were reviewed by a decision maker (registrar or above) twice weekly and not over weekends and so timely discharge was often a problem. Consequently, surgical emergency beds were occupied by medical inpatients for longer periods.
- A senior member of staff on SAU spoke of the impact of patients on surgical wards who were under the care of the medical team. Medical patients were reviewed on a daily basis during the week; however, this affected the availability of surgical beds on the unit for the emergency surgical admissions.
- A senior member of staff in theatre told us they had weekly meetings to look at the utilisation of theatres. This involved looking at any theatre lists that were free and allocating them to other consultants and

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specialities to fill. They told us flow issues within the hospital had affected their capacity to use theatres efficiently. Waiting list initiatives were taking place in some surgical specialities with a backlog of cases for example, urology and oral surgery. A senior member of staff for each surgical speciality reviewed the theatre lists for the following week to make sure all the equipment needed was in place to prevent cancellations. Any changes to theatre lists were notified to theatre two days prior to operation so that theatre staff were able to make sure equipment and operating kits were in place.

- Patients who were having day surgery and were assessed as being 'low risk' were able to be discharged directly from post-anaesthetic care unit (PACU). This was done to prevent operations being cancelled if the trust had lack of beds due to capacity issues within the hospital. The average length of stay for surgical patients within the hospital was below the England average for elective and non-elective patients.

Meeting patients individual needs

- Patients' were having their individual needs assessed and met by staff.
- The trust used a 'red tray' system to identify patients who required assistance with their meals. Staff gave red trays to patients who needed support with eating and we observed this on a number of surgical wards we visited. Patient's family/carers were able to visit at mealtimes to assist with supporting their relatives with eating and drinking. Staff told us they served the food each day so were aware of patients' needs in relation to food. We had a mixed response from patients about the food provision as some patients felt it was good whereas others felt it needed improving. Therapeutic diets and religious needs were catered for. One patient who was vegetarian felt the choice for them was limited and they relied on members of their family to bring in meals for them.
- The menu available to patients identified if the meal was suitable for vegetarians and other specialised diets. Staff were aware which patients were nil by mouth and those that required a specific consistency of food.
- Meals were obtained from the main hospital kitchen and brought to the ward on a heated trolley. Patients were able to choose what they wanted to eat from a selection of dishes on a menu that was sent around the day before. The staff would try to accommodate patients who changed their mind about what they wanted to eat on the day.
- The PLACE audit showed the trust was above the England average for food at 94%. For the years 2013 and 2014, the trust was also rated above the England average.
- In the surgical services inpatient report 69% of patients rated the food as 'very good or good'.
- Staff told us about Challenging Behaviour Escalation protocol. This was used when patients became aggressive and violent towards staff and involved security staff and extra staff on shift to provide one to one care.
- All staff spoken with were able to name the hospital learning disabilities (LD) team lead nurse. We witnessed excellent care of patients living with a learning disability on SAU and Forrester Brown ward. We discussed with the ward manager for the Admissions Suite and SSSU how they were actively planning the admission of a female patient living with learning disabilities who was afraid of men. The team was going to deal with this by making sure a side room was available.
- Staff told us they had access to mental health support seven days per week to support patients with mental health conditions.
- There were two full time dementia coordinators who were available seven days per week to provide support and guidance to staff caring for patients living with dementia
- Forrester Brown ward had a dedicated room or 'parlour' for patients with dementia. This was set up for patients and their relatives to visit and be surrounded by items that may relieve anxiety like twiddle muffs. The occupational therapy teams also used it to reduce anxiety during assessments.
- Staff reported translation services were easily accessible and often used. Staff in theatres told us they had a patient on the operating list the next day who required a translator. They said this had been booked in advance and was documented on the theatre list so all staff were aware.
- A number of information leaflets were available for patients and their relatives/carers to read. For example, information about anaesthetic and pain relief following surgery.

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Learning from complaints and concerns

- The patients we spoke with were not always aware how to make a complaint. However, they all reported that they would feel confident in doing so. One patient informed us that a clinician had informed them of the complaints procedure they should follow.
- One relative we spoke with told us they had raised a concern with the senior sister on one of the wards and they had dealt with it to their satisfaction.
- Trust data indicated the Surgical Division had received 89 complaints from February 2015 to November 2015. There was no target included.

Are surgery services well-led?

Good



We have judged well-led for surgery services as good because:

- The leadership, governance and culture promoted the delivery of high quality person-centred care.
- There was a clear statement of vision and values, driven by quality and safety. Staff were aware of the trust's vision, values and strategy.
- There was effective and comprehensive processes in place to identify, monitor and address current and future risks. Performance issues were escalated to the trust board through clear structures and processes. Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of actions needed to resolve concerns.
- There was good leadership and local support for staff. All the staff we met showed commitment to their patients, their responsibilities and one another.

Vision and strategy for this service

- The management team for the Surgical Division had a plan in place for the immediate future. This included improving the flow of patients through the hospital to make sure elective surgery could be undertaken and to reduce the number of medical patients outlying on surgical wards.
- They also needed to reduce their referral to treatment times (RTT) to meet the standard of 90% for all surgical

specialities. The trust was working with the local clinical commissioning group (CCG) on an action plan and the trust felt it would not meet this target within the next year.

- Other areas of focus were the Central Sterile Services Department (CSSD) that needed investment and redesigning as it was old and needed upgrading.
- A longer-term business plan had been developed and this included how to expand some of the initiatives they already had in place.
- The trust had adopted a set of values developed in collaboration with the staff. All staff we spoke with were aware of these values. Some staff were also aware of the patient safety priorities, such as falls, Clostridium Difficile and venous thromboembolism.

Governance, risk management and quality measurement

- An effective governance framework was in place to monitor performance and risks and to make sure the executive board were aware of these via the trust wide governance reporting.
- Each surgical speciality had their own clinical governance meetings and these fed any risks into the surgical division governance meetings.
- The Surgical Division had its own risk register and staff spoke with us about some of their risks, for example, surgical site infection rates. We saw one of the main risks, other than their RTT was the increased in surgical site infection rates. This was being monitored and actions were being taken.
- We saw the senior management team for the Surgical Division had an oversight of all incidents as the number of these was recorded on the surgical dashboard. Learning from these was shared with all staff via meetings.
- We saw incidents were discussed at each surgical speciality governance meeting.
- Interventional radiology had its own governance systems that fed into its management structures. Serious risks were identified on its risk register and shared with the executive team when required.
- CSSD was internally and externally audited and regulated to enable it to provide services to other health care providers, for example, GPs.

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- There was a programme of audit within the surgical division and we saw in the minutes of the Surgical Division clinical governance meetings discussions about some of these.
- Junior doctors told us mortality and morbidity meetings occurred regularly in all surgical specialties, with cases being discussed openly and candidly with junior doctors and consultants. They felt that there was beneficial learning from these meetings. We were shown minutes of some of these meetings.

Leadership of service

- The leadership within the surgical division reflected the visions and values of the trust, which promoted good quality care.
- The Surgical Division leadership team consisted of the head of division, a divisional manager, the head of nursing and the clinical governance lead. Every specialty had a clinical lead, a governance lead, a specialty manager and a matron.
- Leaders of the surgery service had the skills, knowledge, and experience that they needed to do their jobs. The role of senior sisters on the surgical wards was supervisory.
- Staff on the wards, units and in the clinic told us they had very good leadership from their immediate line managers. All staff said they felt well supported and could speak to them about any concerns they had.
- Junior doctors in surgery reported consultant surgeons as supportive and encouraging. One junior doctor said their senior colleagues were “excellent”.
- The Chief Executive was visible to staff in the organisation and had met with staff.

Culture within the service

- Staff on the wards were all enthusiastic about working for the trust and how they were treated.
- Staff told us they felt “valued”, “respected” and “trusted” by their line and wider hospital management teams.
- Staff were told of compliments and feedback about their care and treatment. We saw thank you cards on wards for staff to read.
- SSSU and SAU had Project Search Students. This programme provided a mixture of structured work placements and classroom learning for young people living with learning disabilities. On SSSU, it was evident that the student was part of the team and had a clear set of tasks and structure to their daily routine.

- SAU had recently employed one Project Search Student as a permanent health care assistant. They reported feeling a valued member of the team and felt fully supported in their transition from student to employee.

Public engagement

- Patients were encouraged to give their views on the services provided to help improvement and with the planning and shaping future services
- Patients were able to feed back their views on the ward via the Friends and Family Test. They were asked whether they would recommend the ward to their friends and family. We saw results of these on display in the wards. The overall response was the vast majority of patients recommended the wards.
- The trust had completed an inpatient survey where patients were asked a set number of questions. We have used some of the results of this survey in our report.

Staff engagement

- In theatres, staff attended meetings for their area of speciality. We were shown the minutes of meetings from the general surgical theatre team.
- A report to the board in January 2016 identified poor staff attendance at staff engagement events and a lack of a forum for managers to engage with the executive team. The trust recognised that this affected staff understanding of the vision and strategy for the service. Plans to address this shortfall focussed on a variety of channels of communication including a ‘ask James’ email address and a monthly coffee morning with the chief executive; forums for specific staff groups and an online social network group.
- Staff told us their views were reflected in the planning and delivery of services and in shaping the culture but were unable to give examples of this.
- When staff raised concerns, leaders recognised the importance of this and took action in a timely way. For example, ward leaders addressed staffing concerns on a daily basis. However, long-term solutions to this challenge were not evident to staff.
- Some areas had newsletters for staff to keep up to date on events and they shared learning from incidents. Staff told us they were worthwhile.







Innovation, improvement and sustainability

- Staff were encouraged to help with the continuous improvement and sustainability of the trust.

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- A senior member of staff in theatres told us they had plans to review the day surgery unit to allow for more capacity.
- Forrester Brown ward identified the need for a dedicated discharge service and in November 2015 employed a Band 3 nurse dedicated to reducing delayed discharges. The ward recently employed a further nurse to help with this service
- The ESAC unit was set up in response to a Quality Improvement Project to reduce theatre cancellation times for category C and D patients.
- The trust had won an award from the Health Service Journal (HSJ) patient safety award for the prevention of perioperative hypothermia.

Critical care

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

Information about the service

Critical care at the Royal United Hospital Bath provides a service to patients who need intensive care (described as level three) or high dependency care (described as level two). Patients were admitted following complex and/or serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities within the acute hospital, and to the emergency department. A consultant intensivist (a consultant specialising in intensive care medicine) led the service with support from the consultant team, junior doctors, and a team of nurses and support staff.

The unit had 13 bed spaces used flexibly between intensive care and high dependency patients. The bed numbers had increased by two since the autumn of 2015. The requirement for more beds had been recognised by the trust and the business case approved in March 2015. The unit had four single occupancy rooms to provide a degree of isolation or privacy, and the other nine beds were in the main unit area, four on one side of the entrance and five on the other side.

The department admitted around 48% of patients from elective (planned) and emergency surgical procedures. The other 52% were non-surgical patients. Of the surgical procedures, around 15% were high-risk elective surgery, and 32% were following emergency or urgent surgery.

The hospital was experiencing a high level of pressure on the service at the time of the inspection. The unit was regularly at full capacity as a result. This reflected issues

seen nationally. The number of patients treated had fluctuated over the past five years between 150 and 200 patients each quarter. In 2015, the critical care team cared for approximately 800 patients.

On this inspection we visited the critical care unit on Wednesday 16, Thursday 17 and Friday 18 April 2016. We spoke with a range of staff, including consultants, doctors, trainee doctors, nurses and healthcare assistants. We met with the clinical lead for the service, the senior manager overseeing the service, and the senior sister who was running the unit. We spoke with physiotherapists, the nurse managing the outreach team, pharmacist staff, and the ward clerks. We met with patients who were able to talk with us, and their relatives and friends. We checked the clinical environment, observed care and looked at records and data.

Critical care

Summary of findings

We rated this service as requires improvement because:

- Not all incidents were reported. Some had become 'everyday events' and staff were not discussing or formalising what incidents should always be reported. Staff were not receiving feedback or follow-up from reporting incidents. Not all staff were able to describe the Duty of Candour.
- The visible quality of cleaning on the unit in some areas did not meet acceptable standards for a high-risk area. There was a shortage of storage space, which did not help with effective cleaning.
- Servicing records for equipment did not provide assurance that everything was being regularly maintained. There was insufficient security of resuscitation trolleys, with no facility to show if they had been tampered with between checks. They had not been checked every day. The medicines refrigerator was not locked as it should be, and the temperature had not been checked every day. Some fluids and other consumables on the unit were not securely stored.
- There was a lack of security of some patient confidential information.
- Nurses were too often moved to other wards and this was often in contravention of the critical care unit's approved operating policy. The senior supernumerary nurse, shift coordinators, clinical nurse educators and nurses to take emergency admissions were too often being transferred from their duties to provide direct patient care.
- There were insufficient physiotherapists to meet best practice in terms of the rehabilitation needs of patients, and not a full service from other allied health professionals.
- There was some support for patients who stayed on the unit for a long time in order to keep them in touch with life going on around them. The unit did not, however, actively support a quality patient diary. There was no follow-up clinic provided to patients and limited psychological support for patients or those close to them.
- Services did not always meet patients' needs. There were bed pressures in the rest of the hospital and too

many patients were delayed in their discharge from critical care to a ward, and too many were discharged at night. These delays were worse than the national average for critical care units.

- The critical care unit facilities did not meet some of the recommendations for modern units, such as natural light, separate toilet facilities, separate entrances for patients and visitors, limited facilities for visitors including no toilets within the unit.
- There was a limited amount of printed or web-based information for patients and visitors. The unit had a higher level of noise at times.
- There had been no matron in post in the unit for 15 months. There had been active recruitment, but no candidate had been appointed in this time. Although there was support, strength and guidance from the clinical lead, the senior sister, and the senior manager providing temporary oversight of the service, the unit was not performing as it should without the guidance of its most senior nursing post.
- There was sometimes a lack of sharing and inclusion both with, and sometimes by, the critical care unit and the wider hospital. The unit was not always benefitting from the wider expertise and skills of trust-wide teams and sometimes not inviting these skills onto the unit and into patient care.
- There were some areas of quality measurement and governance needing improvement. This included effective use and management of the risk register, a lack of direct general feedback requested and gathered from patients and visitors to use to improve practice, and a strong vision and long-term strategy for the unit.

However:

- There was a good record on safety and people were protected from abuse and avoidable harm. Rates for unit-acquired infection were relatively low. There was a good response to the deteriorating patient, although the risk scoring needed improvement. There were daily ward rounds and good handover between staff teams to identify deteriorating patients.
- There was a good level of mandatory training among the nursing staff, although the medical staff were not meeting trust targets. Almost all staff working on the

Critical care

unit had been assessed for their performance to meet trust targets. There was good support to new nursing/healthcare staff and junior and trainee doctors.

- There were safe levels of nursing staff delivering direct patient care, although supplemented by bank staff. There was, however, a shortage of healthcare assistants and the level of supernumerary nurses on the unit did not meet recommended levels.
- There was wide-ranging experience and skills among the medical team and a strong commitment from the experienced consultant intensivists. The level of cover from the doctors met the recommended levels.
- The provision for physiotherapist services did not wholly meet the recommendations of the Faculty of Intensive Care Medicine Core Standards in terms of cover, but the dedicated teams prioritised critical care patients and provided a safe service. A business case to increase this service was to be presented in 2016.
- Patients had good outcomes as they received effective care and treatment to meet their needs. There was delivery of medical treatment and care in accordance with best practice and recognised national guidelines. There was good management of patients' needs in relation to pain, nutrition and hydration. There had been a programme of audit and research leading to reduced infection rates and improved outcomes for patients. The mortality rates within the unit showed, over time, more people than would have been expected survived their illness due to effective care.
- There was a strong multidisciplinary approach within the unit in assessing and planning care and treatment for patients, although more skills and experience could be used. Services required to meet patient needs were available across all seven days of the week.
- There was a dedicated and successful contribution to the national organ donation programme.
- People were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients and visitors had been positive. Patients, their family or friends were involved with decision-making. We observed staff treating patients with kindness and warmth.

- There were fewer urgent operations cancelled due to the lack of a critical care bed than the national average. There was a much-reduced level of cancelled planned operations, specifically since the provision of two more beds on the unit.
- There was good evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC). Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance.
- There had been measurable and valuable innovation and change within the unit following audit, research and investigations into best practice.

Critical care

Are critical care services safe?

Requires improvement



We rated safety as requires improvement because:

- Not all incidents were reported. Some had become 'everyday events' and staff were not discussing or formalising what incidents should always be reported. Staff were not receiving feedback or follow-up from reporting incidents. Not all staff were able to describe the Duty of Candour.
- The visible quality of cleaning on the unit in some areas did not meet acceptable standards for a high-risk area. There was a shortage of storage space, which did not allow areas to be cleaned easily, and some were untidy. The sluice was unlocked and hazardous substances were stored in unlocked cupboards.
- The servicing records for equipment did not provide assurance that all equipment was being regularly maintained.
- There was insufficient security of resuscitation trolleys, with no facility to show if they had been tampered with between checks. They had not been checked every day. The medicines refrigerator was not locked as required, and the temperature had not been checked every day. Some fluids and other consumables on the unit were not stored securely.
- This was an older critical care unit, and as such the facilities on the unit were not built to the latest modern building standards. This meant bed spaces did not provide recommended degrees of room around the patient, and bed spaces did not have the recommended levels of electrical switches, oxygen or air provision. None of the side rooms had modern facilities to isolate a patient.
- There was a lack of security of some patient confidential information, which was left unattended on the unit.
- Most patient records were well completed but some observations had not been recorded.
- There was a critical care outreach team providing a hospital-wide support service, although this was only from 8am to 8pm seven days a week, and not 24 hours as recommended by the Faculty of Intensive Care Medicine. There were concerns with the experience in

managing deteriorating patients among the hospital-at-night team who were not critical care trained nurses and had other responsibilities to manage at night.

- Nurses were too often moved to other wards and this was often in contravention of the critical care unit's approved operating policy. The senior supernumerary nurse, shift coordinators, clinical nurse educators and nurses to take emergency admissions were too often being transferred from their duties to provide direct patient care.
- The major incident policy in the unit's folder was significantly out of date and there were limited business continuity plans.

However:

- People were protected from abuse and there were low levels of avoidable harm. There was a good knowledge of safeguarding and how to report suspected abuse.
- There was a good review of mortality and morbidity and an annual summary report produced. However, actions to be taken from lessons learned were not always clearly documented or showed who was responsible for their delivery.
- Rates for unit-acquired infection were relatively low.
- There was a good level of mandatory training among the nursing staff, although the medical staff were not meeting trust targets.
- There was a good response to the deteriorating patient, although the risk scoring needed some improvement. There were daily ward rounds and good handover between staff teams to identify deteriorating patients.
- There were safe levels of nursing staff delivering direct patient care, although supplemented by bank staff. There was, however, a shortage of healthcare assistants and the level of supernumerary nurses on the unit did not meet recommended levels.
- There was wide-ranging experience and skills among the medical team and a strong commitment from the experienced consultant intensivists. The level of cover from the doctors met the recommended levels.
- The provision for physiotherapist services did not wholly meet the recommendations of the Faculty of Intensive Care Medicine Core Standards in terms of cover, but the dedicated teams prioritised critical care patients and provided a safe service. A business case to increase this service was to be presented in 2016.

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Incidents

- From a review of reported incidents, the safety performance of the critical care unit was good. There were low numbers of reported incidents of avoidable patient harm, unit-acquired infections, and errors leading to patient harm. There were no serious incidents reported between February 2015 and January 2016.
- Staff were open and honest about incidents, but there were times when they were not always reported. Staff told us this was due to incidents not always recognised as being reportable, staff under pressure of work and not having time to complete incident reports, or oversight. There was no intention from staff to hide incidents, but there was no system to make sure they were all being captured. From a review a patient's notes we saw, for example, the removal of a medical device by the anxious patient had not been reported. There was also an incident involving a post-operative patient, which was not reported in good time, and the investigation was subsequently delayed by around six weeks. The unit was also not reporting patients being discharged from the unit at night, or extensive delays in discharge. All staff we spoke with said there were no barriers to reporting incidents or near misses, but they agreed there was no trigger list to remind them of what issues would be a reportable incident.
- There was good teamwork on the unit and this meant staff were not blamed for errors or omissions leading to incidents or near misses. All staff we asked said they were not afraid to speak up when something went wrong, or should have been done better.
- The report produced of incidents was not easy to analyse, and staff were manually tracking trends or patterns of incidents. There was an electronic incident reporting system to record incidents, and staff said it was simple to use. It was, however, too basic for useful analysis. From the report of incidents, we were unable to determine if both incidents taking place and near misses were reported, as they were not categorised in this way. Incidents were not classified by their type and staff were not able to grade them by their seriousness. Trends of incidents were looked at by the unit, but this was done by a manual tally of the type of incident reported. There was evidence in some (but not all) staff meeting and governance minutes of discussions of these incidents where there had been a developing trend, or specifically unusual or significant incidents.
- Although the system for reporting incidents was not easy to analyse, a review showed staff reported a wide range of different events. Entries included reports from both medical and nursing staff, and covered incidents from medicine errors, equipment failures, avoidable patient harm, and staffing problems. It was not possible to tell from critical care or hospital data if the unit was a strong reporter of incidents but the trust, overall, was above the NHS England average for reporting incidents. Within the trust there were 11.5 incidents reported for every 100 patient admissions, against an NHS average of 8.6 incidents reported within the NHS. This could be an indicator of a strong reporting culture among trust staff.
- Staff had not been receiving feedback from reporting incidents. As described elsewhere in this report, critical care had not had a matron for around 15 months. There had also been staff changes among the senior team, and limited time for senior staff to complete their managerial roles and supernumerary time due to pressures to provide direct patient care. The senior team recognised that one of the areas that had suffered and needed to improve was giving feedback to staff when they reported incidents. A number of staff we spoke with said this did not deter them from reporting incidents, but they were concerned that important issues they had raised had not been responded to directly with them.
- The Duty of Candour had been introduced and implemented, although not all staff were aware of the new regulation, or at least of the term and requirements of the Duty of Candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation, which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. The trust had introduced this new legal requirement to staff, but the information had not cascaded to all the staff in critical care, including medical and nursing staff. The senior staff were aware of the Duty of Candour requirement upon them to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. The terminology was, however, not familiar to some of the junior nursing and medical staff. There was a poster in the staff room about Duty of Candour, but this had not helped to embed the terminology.

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- Critical care staff reviewed patient mortality and morbidity (M&M). There was a variable attendance of doctors/consultants at the M&M meetings, some with a higher number than others. There did appear, however, to be no members of the senior nursing team in attendance, although they were invited. There were good records of discussions held demonstrating reviews into patient deaths and any other concerns. Learning points from discussions of patient deaths were highlighted, although actions, and who was responsible for delivering them, were not written down. Alongside the meetings, which were held every two months, was a valuable summary report of important themes and learning points for a whole year produced by the consultant clinical lead. Staff also told us they discussed what they termed as 'good saves' at M&M meetings. These were patients whose lives were saved by the intervention of critical care doctors and nurses. The discussion of these was, however, intermittent, but seen as being a permanent feature of the M&M in the future, which would be an example of outstanding practice.

Safety thermometer

- Avoidable harm was low (good) within critical care. The trust reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered incidences of hospital-acquired (new) pressure ulcers; patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). The main points were:
 - In the most recent published data for August 2014 to July 2015, critical care reported 100% harm-free care in 10 of these 12 months.
 - When removing the category of 'all pressure ulcers' from the data (as these could be acquired elsewhere), the unit would have delivered 100% harm-free care in all but two months. The two months where an incidence of avoidable harm was reported were August 2014 and May 2015 where there was one patient in each month with a venous thromboembolism.
 - There were no falls with harm and no catheter urinary tract infections.
- The display of avoidable patient harm data was not meaningful for patients. The unit used the crude data (a group of green or red crosses showing any harm

occurring on each day of just the current month) to show how many days had passed with or without avoidable harm to patients. This covered pressure ulcers, falls, urinary catheter infections, and deep-vein thrombosis. What the data did not show was how the service had performed over time, or how long the unit had continued without avoidable harm to patients.

Cleanliness, infection control and hygiene

- Overall, rates for unit-acquired infections were relatively low. There had been very few incidences of unit-acquired *Clostridium difficile*. There had been slightly higher than average incidences of unit-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) in the past five years, although these were not infections in the bloodstream. There had been no MRSA infections in blood in the past five years. Data reported by the unit to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for all intensive care units in England, Wales and Northern Ireland) supported this evidence. During this time most rates of infection had been below (better than) the national average, but there were some single or multiple incidences of *Clostridium difficile*. Looking at more recent data on infections:
 - There were three unit-acquired MRSA infections (not infections in the bloodstream) in the year from April 2014 to March 2015 and one reported in the most recently available date for the first half of 2015/16 (April to September 2015: the latest data produced by ICNARC). These incidences overall were above (worse than) the national average of around two patients per year.
 - There were no incidences of unit-acquired *Clostridium difficile* in the same period in 2014/15 or the first half of 2015/16. The most recent incidence had been in 2012.
 - There had been 10 unit-acquired bacteraemia infections (not MRSA) in the year to March 2015 and three in the first half of 2015/16. This was more (worse than) than the national average of around four per year.
- There was not always full screening of patients for MRSA. Audits were required to be completed and reported on each quarter, but data provided showed this did not always happen. Results for screening of non-elective patients (those who came into the unit in an emergency) were reported for October 2013, March

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2014, September 2014 and June 2015. There were therefore some significant gaps in the audits being performed. Critical care had achieved 100% in one of these four quarters, 67% in two and 89% in the other. The senior sister on the ward had not been made aware of these audits.

- The visible quality of the cleaning in some areas of the unit during our visit did not meet acceptable standards. There were some areas of the unit not being systematically cleaned, although others were done well. The beds, including the frames and mechanisms and equipment around the beds, were cleaned well. The areas where there were problems were mainly as follows:
 - The main store for clinical consumables had a number of items that had been dropped on the floor and the floor had not been cleaned for some time, with dust and boxes on the floor. There was a problem with available space for storage in the unit, and there were boxes stored on the floor, which made the floor space hard to keep clean. The floor of the sluice was also not free of debris and dust.
 - There was a significant amount of dust on a computer AC adaptor socket and around the screens on a desk in the clinical area. The cleaner did not approach or clean this area during our inspection. We asked two staff about the area, and neither were sure whose responsibility it was to clean it.
 - There were a number of sticky areas on the staff workstations in the middle of the unit. This had been caused by the removal of notices that had been, it seemed, recently stuck to the desk areas with sticky tape. The residue of the tape had not been removed.
 - There were dressing tapes and wrappings on the floor in a number of places in the patient area. Some of these, we presumed, were from staff attempting to throw items into the bin, but them not reaching it and landing on the floor. Some were also around the patient bed spaces. We observed these items being swept during the day but they were left at the foot of the waste bin at one point for around 30 minutes before being removed.
 - There were fluids on the unit in boxes sat upon a delivery trolley, resembling a sack truck. The trolley was old and had not been specifically cleaned. It was the type for moving boxes or equipment throughout the hospital and not for storing equipment on the unit.
- Although it was not a clinical area, the resource room just across the main corridor was used frequently by staff for meetings and training. There was a lot of dust and debris on the floor of this room that appeared to have not been cleaned thoroughly for some time.
- There were notices taped to the wall with sticky tape in the patient bathroom within the unit. Sticky tape should not be used in clinical areas as it can become detached from the wall and attract dirt and dust. There was paint missing in the bathroom where sticky tape had been removed before.
- We observed one of the cleaning staff sweeping around a patient trolley and not moving it to clean underneath it.
- Despite our concerns, the hospital's audits of the cleaning reported high standards on the unit. Audits were carried out weekly. In the period from 4 January 2015 to 10 January 2016, almost all audits were above the 98% target level and the majority scored 100%. There was just one poor result of 78% in June 2015, but subsequent audits to this had results of predominantly 100%.
- Most cleaning audits for the commodes on the unit were compliant. However, there were times when the labels used to highlight that cleaning had been completed were missing. There were two occasions in the period July 2015 to early January 2016 where one commode was not clean. Those we checked on our inspection were clean and labelled.
- There was good compliance with the management of peripheral venous cannulas to help to reduce the chance of infection. The unit was audited monthly, unless there were issues identified when the audit would be escalated to weekly. In the period from April 2015 to January 2016, the unit was 100% compliant, except for two periods in November 2015. The unit was re-audited following these two weeks and had returned to full compliance since then. The results meant patients did not have their cannula for longer than required.
- Equipment was stored and sealed to prevent cross-contamination. All disposable equipment was in sealed plastic bags and placed in drawers or cupboards where possible to prevent damage to the packaging. Equipment at the patient's bedside, such as oxygen or

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other tubes, were plastic-wrapped when not in use to protect them from cross-contamination. Labels and a visual check showed there was regular cleaning of any large equipment stored in cupboards.

- The unit scored well with hand hygiene audits. In the 11 months from January to November 2015, the unit dropped below the 95% target to 94% on just one month. The other months were all above 95% with four at 100%.
- Staff followed hand sanitising and personal protective equipment rules on the unit. This met guidance around safe hand washing from the National Institute for Health and Care Excellence (NICE) statement QS61 Statement 3. We observed a good standard of practice from doctors, nursing and all other staff. They were following policy by washing their hands between patient interactions and using anti-bacterial gel. The bed spaces had red lines around them to remind staff to put on and remove gloves and aprons when coming into contact with the patient or equipment surrounding them. We observed staff wore disposable gloves and aprons at the bedside when carrying out patient care or, for example, disposing of fluids or waste products. Staff used hand gel when entering and leaving the unit or moving between clinical and non-clinical areas. All staff were bare below the elbow, and wearing no watches or inappropriate jewellery when they were within the unit.
- Visitors were required to follow infection control protocols, although the unit was not designed to provide any visibility of visitors using hand gel. There was no reception area in the unit and visitors were admitted to the clinical area without staff being able to supervise use of hand gels unless they met them at the door to the clinical area. The ward clerk met many visitors when they came into the unit and we observed visitors asked to use hand gel before coming into the unit. We also saw regular visitors using the hand gel each time they came into and left the clinical area. Staff told us they would increase their infection control procedures for visitors by providing them with personal protective equipment (gloves and aprons) when circumstances dictated this was the correct thing to do.

Environment and equipment

- The regular servicing and maintenance of equipment was not made clear from the records provided, although staff thought it was regularly undertaken. We met an engineer who was carrying out routine maintenance

during our visit. The maintenance schedule for critical care equipment contained just less than 450 different pieces of equipment. In the column indicating the next planned maintenance date, 123 of these pieces of equipment had no date alongside them. Some of this equipment was relatively new (2015), but a couple of items (laryngoscopes) had been supplied in the 1990s and had no date for planned maintenance. Some of the items (26) had planned maintenance dates in 2013, 2014 and 2015, but these had not been recorded as complete. This included two ventilators dated October 2015. The unit's blood gas analyser was not working during part of our inspection, and staff told us this was frequently breaking down. We saw a number of incident reports about regular failure of this machine used to measure alkalinity (pH) and partial pressures of oxygen and carbon dioxide.

- The unit had appropriate equipment for use in an emergency, although resuscitation trolleys were not tamper-evident. The unit carried resuscitation drugs and equipment including grab bags, defibrillators and a difficult airway intubation trolley. Staff said the resuscitation trolley was of a different type to those used elsewhere in the hospital, where the more typical large, red, locked trolleys were used. Critical care used plastic trolleys for the resuscitation kit that were the same as other general trolleys used for equipment. They did not have drawers to make their contents fully secure or to prevent or indicate tampering with the medicines or other equipment between checks. Some of the medicines were in a plastic box with a band around it to indicate the box had not been opened, but there was adrenaline, amiodarone, atropine and glucose in the open top drawer of the unit. The box with medicines was also easy to remove.
- Resuscitation equipment was checked most days, but not all. There was a requirement to check resuscitation equipment each day. The resuscitation trolley had a few gaps in the checklists from November 2015 to March 2016 (up until 16th) with 13 checks missing. There was no apparent responsibility among the staff for reporting when they found gaps in checking. We found one of the laryngeal airway masks in the paediatric equipment was past its expiry date of 21 November 2015.
- There was limited storage on the unit and no specified bays or places to keep certain essential equipment. Some was stored in a part of the unit converted to a storage room. The emergency equipment 'grab bags'

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were stored on the floor of the unit next to one of the staff work stations. These bags were not in a secure location. They were also not moved during our visit and prevented some thorough cleaning of the floor.

- There were hazardous substances in an unlocked sluice room. The sluice for the unit was in the main corridor of critical care, and not the clinical area. The door was not locked and there were flammable and irritant products stored in an unlocked cupboard, which presented a possible risk to visitors to the unit. This was brought to the attention of the senior sister.
- The unit had reasonable security and staff were aware of the shortcomings of not having a reception area, and endeavoured to meet or direct visitors. The main entrance doors were locked and visitors were checked before they were admitted. We found the relatively new intercom at the entrance to the unit was not easy to hear in the unit when the visitor was announcing who they were. If the ward clerk, or whoever admitted the visitor, could not hear what the visitor said, they would meet the visitor at the main entrance and either admit them to the clinical area or ask them to wait in the adjacent waiting room.
- As an older unit, the facilities met some but not all of the 2013 Department of Health guidelines for critical care facilities (Health Building Note 04-02). There was an entry on the unit's risk register about areas where the unit did not meet this guidance, but this had limited detail. Some of the ways the unit performed against the guidelines were:
 - The main operating theatre complex was located above the critical care department for accessing emergency support from colleagues.
 - There were separate buttons for patient call bells and emergency calls. The bed spaces had a suitable flat screen displaying multi-parameter patient monitoring. There was no computer at the bedside, but the unit had portable computers available on the unit.
 - Bed spaces did not meet the recommended size in terms of their area. Bed spaces should be sufficient for up to five staff to work safely with a patient in an emergency. This meant they needed to be around 25m². The spaces in the unit were smaller than the recommended size and we estimated they were around 16m². Staff admitted it was not always easy to move around the bed. Equipment was not up on pendants and cables trailed across the floor in places, particularly around the head of the bed.
- Patients in the main area and two of the four side rooms were visible from the central workstation. The other two side rooms were not particularly obstructed, but they were some distance from the workstation so needed close monitoring by staff (which they were receiving during our visit).
- Some provision of services was below recommended levels. As recommended for safety at the bedside, critical care units should have a minimum of three oxygen outlets in each bed space, but there were only two. There should be two air outlets and two medical vacuum outlets as a minimum, but bed spaces only had one of each. The Department of Health recommended each bed space should have a minimum of 28 'un-switched' single sockets (with no on/off switch – just a socket). The bed spaces were not all the same in terms of provision, but we saw between 12 and 22 sockets at most bed spaces. These sockets were also switched, which gave rise to a risk of inadvertently switching off equipment still plugged in. Staff said there were times when the number of sockets had proved not to be enough and they would need to use multi-blocks to provide enough places to plug in all required equipment.
- There was a reasonable level of mobile equipment available including haemodialysis/ haemofiltration machines, a monitor to generate an electrocardiography reading, and a bedside echocardiography machine. There was an ultrasound machine, a defibrillator, non-invasive respiratory equipment (CPAP and BIPAP), patient warming equipment, and bronchoscopes. There were also cardiac output monitors at each patient bedside.
- There were four patient isolation rooms, but these did not have changing lobbies or air-change facilities to minimise infection cross-contamination. However, each room was fitted with a hand-wash sink.
- Not all beds in the main unit had clinical hand basins. Individual hand basins were recommended to provide reduced risks of cross-infection. Sinks on the unit were shared between a number of beds.
- The unit was not using recommended disposable curtains around patient beds. Some of the curtains did not pull across the areas they were designed to

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reach, and a number were ill fitting in the side rooms. We asked staff to show us when the curtains were removed for cleaning, and a search for a record to show this could not be located.

- There was safe management of clinical waste. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. There was a full range of disposable equipment in order to avoid the need to sterilise equipment and significantly reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times. None of the waste bins or containers we saw for disposal of clinical waste or sharp items were unacceptably full, although one did have drops of what appeared to be blood on the lid area.

Medicines

- Most, but not all, non-emergency medicines were stored appropriately to prevent tampering or unauthorised removal. There was a visit twice a week by a pharmacy technician to check stocks and reorder medicines as needed. Medicines were stored as required in locked cupboards with access given only to authorised staff. Those fluids stored on the unit were in a lockable room, but this room was not locked on a number of occasions when we visited the unit, and the door was propped open on one occasion. There were renal replacement fluids stored in boxes on a trolley close to a patient's bedside where they were being used with the patient over a number of days. There was no security for these fluids. Neither of the medicine refrigerators were lockable. One was in the clinical area of the unit with the other non-emergency medicines and there was therefore no security for the contents of the refrigerator. The other was in a storage room, which was not locked on occasions during our visit.
- The temperature of the medicines refrigerators were expected to be checked each day, but this was not always the case. We saw the temperature checklists for February and March 2016 for the refrigerator in the clinical area and the one in the clinical store. These had not been checked on two days in March 2016, and on 12 days in February 2016. In February, there was one period where the checks had not been recorded for four consecutive days. We found those medicines requiring refrigeration were kept at the correct temperature on the days when the temperature was checked and recorded. As with the resuscitation trolley checks, there was no apparent responsibility among the staff for reporting when they found gaps in checking.
- The unit had performed well in an October 2015 audit of antibiotic stewardship, although with a relatively small sample size. The main findings were:
 - Of 11 prescriptions reviewed, all had a stop or review date documented.
 - For patients with intravenous antibiotics, all 10 prescriptions had a review documented at 48 hours.
 - The prescriber was clearly identifiable in 90.9% of prescriptions reviewed in critical care.
 - We reviewed four prescription charts and although none of the antibiotics had a stop date, they all had review dates.
- Controlled drugs were managed in line with legislation and NHS regulations. There were clear recordings in the controlled drugs register of medicines booked into stock, administered to a patient, and any destruction or return to pharmacy. We checked controlled drugs in tablet (all boxed) and liquid form and stocks of liquid potassium chloride 15% W/V. All were stored and secured appropriately as a controlled drug. Stocks were accurate against the records in all those drugs we checked at random. We cross-referenced one of the drugs with a patient drug chart and found the drug documented as administered on the occasions and at the dosage stated in the controlled drug register. One minor problem was identified. As the controlled drug register had become almost full with entries, staff had delayed starting a new book. Some entries had been made on half a page already started for another drug. This was an incorrect use of the book, as recognised by the senior sisters, as it led to a risk of incorrect record keeping and possible confusion.
- There was some audit of the controlled drugs, but the absence of the lead pharmacist for a time meant the required quarterly check had not been done in the previous three months. The critical care staff had carried out their own regular checks of the stocks and these were marked in the book in red pen (to differentiate from the other entries) and checked by two members of staff.
- All patients' medicine records were checked each day by a member of the pharmacist team, and specifically upon admission and discharge of a patient.

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- Patient prescription records were clear, although there was one record where a missed dose was not explained. We reviewed in detail three prescription cards on the unit. The prescribing doctor had signed and dated all the entries. Patient allergies (if any) were noted, and there was an indication to say if the patient did not have known allergies. Antibiotics and use of preventative measures (called prophylaxis) to manage identified risks from a blood clot (venous thromboembolism) were clearly recorded. There was one record from the three we looked at where a patient had been prescribed an antipsychotic medicine, which had not been given to the patient on one occasion. There can be good reasons for an omission, but this was not documented on this occasion.

Records

- Most patient records were held confidentially, and nursing records and prescription charts were held at the patient bedside. Storage at bedside was not ideal as some of these records were not supervised at all times, but this was a low risk on a busy unit. There were, however, two sets of nursing notes left unsupervised on one central workstation on two separate occasions. These records were less secure and could have been removed or tampered with. There was also a folder of 'ITU referral forms' on a work station that was often unoccupied during the day. This folder had confidential patient information including patients' names, home addresses, medical history, and some information on their current health.
- Patient records were mostly well completed. We reviewed six sets of notes in detail and two patient observation charts. The patient notes recorded the name and role of the person completing the record. We were able to determine from records that a consultant reviewed patients within 12 hours of their admission, as is best practice. There were two of the six records where the time of decision to admit the patient to critical care was not recorded. This therefore did not enable staff to know if the patient was admitted within four hours, which is the recommended safe standard to meet. There was clear written diagnosis of the patient's condition and a comprehensive management plan. Records contained evidence of consultant-led ward rounds, input from the multidisciplinary team, care plans and risk assessments. In the two patient observation charts we saw there was no pain or

sedation score for the first patient for one day (21 hours) following the patient's operation. On the second patient's chart there was also no sedation score for a shift and no pain score for eight hours. Other observations, including the one-hourly comfort reviews were, however, all complete. There was no audit carried out of the patient observation charts.

- Documentation audits showed a high rate of completion of nursing records, although a couple of areas had fallen below a high standard and there were some gaps not explained. Each record was audited against 24 different factors.
 - Over the seven months from April to December 2015, critical care had scored between an average each month of 83% and 100%.
 - In the most recent audit, 16 elements scored 100%, but there was a score of only 20% for two areas relating to a falls assessment and mobility assessment being undertaken.
 - There were blanks in a number of areas including the nutrition support record and communication assessment.
 - There had been a number of areas in June 2014 not meeting compliance, but there had been a noticeable improvement in the following month.
- There were good discharge arrangements for patients moving out of critical care to the wards. The presence of a structured critical care discharge summary providing essential information to ensure continuity of care after critical care discharge was a key requirement specified within NICE Guidance 50. There was a policy to support a safe and appropriate discharge. Patients were getting a safe handover from staff on critical care to the wards. Other safety measures included all patients discharged to the ward being followed-up by the outreach nurses the following day, and beyond if judged necessary.

Safeguarding

- Staff were trained to recognise and appropriately respond to concerns in order to safeguard a vulnerable person, and almost all had updated their knowledge by the trust's deadline. Safeguarding training covered vulnerable adults and children, so gave staff direction to safeguard any adults, children or young people admitted onto the unit. It also gave staff guidance to safeguard children of any age associated with a patient

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or visitor. Updating training was mandatory with an expectation of all staff completing it. The results at the end of December 2015 for the nursing/support staff were:

- Adult-related training was 97% at level one, and 94% at level two.
- Child-related training was 99% at level one, and 96% at level two.

We did not have this information for the critical care medical staff separately, but for the medical staff in the anaesthetics division (where critical care doctors reported), statistics were as follows:

- Adult-related training was 90% at level one, and 79% at level two.
- Child-related training was 90% at level one, although only 45% at level two.
- There were policies, systems and processes for reporting and recording abuse. The safeguarding adults' policy had been implemented in accordance with national guidelines. The policy had been updated in 2016 to take account of the statutory requirements of the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The policy referenced the local authorities' policies to ensure approved and recognised local safeguarding systems and processes were recognised. There were listed definitions of forms of abuse and people who might be at risk. This linked with the provisions of the Mental Capacity Act 2005 in relation to deciding if a person was vulnerable due to their lack of mental capacity to make their own decisions. The policies (including the policy for child safeguarding) clearly described the responsibilities for staff in reporting concerns for both adults and children, whom, as required, were subject to different procedures. There were checklists and flowcharts for staff to follow to capture relevant information and inform appropriate people.
- Staff were aware of their responsibilities to report abuse, and how to find any information they needed to make a referral. We spoke with a range of staff who described those things they would see or hear to prompt them to suspect abuse of the patient or another vulnerable person (such as a child in the care of the patient or a visitor). This included some of the obvious signs such as bruising or broken bones. It extended to the less obvious markers including the patient or another

vulnerable person being withdrawn, scared or uncertain. Staff recognised how abuse could be physical, but also emotional, financial or neglectful. Staff were aware of their statutory duty to report their concerns and said there were no barriers to making referrals. There was a patient admitted to the unit during our visit where there were safeguarding concerns. The staff had involved a multidisciplinary team within the hospital to ensure all the right people were aware of the concerns and they were escalated. There was good documentation in the patient's notes of conversations and observations around safeguarding.

Mandatory training

- There was a mostly a good performance from staff in meeting the trust target for getting up-to-date with the latest mandatory training refresher courses. However, the medical staff were not as up-to-date as the nursing team. Compliance with the mandatory training requirements at the end of January 2016 for the nursing/support staff was 95%. Medical staff statistics were not provided just for critical care, but the results for the anaesthetics division (where critical care doctors reported) showed 79% had updated their training. Staff were trained at induction in a wide range of statutory and mandatory subjects. Staff were expected to update this training at certain intervals set by the trust. The training included a wide range of topics such as equality and diversity awareness, conflict resolution, infection control, Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, life support, and health and safety topics. In terms of subject matter, some results should be highlighted:
 - Of nursing/support staff, almost all had updated their health and safety, infection control, blood transfusion, and moving and handling training.
 - Of nursing/support staff, the only topic where staff had not achieved the 90% target was conflict resolution – and this was just below the 90% target. Of the 73 eligible staff, 65 (89%) had updated their training.
 - Of the medical staff, the 90% target had been met for health and safety, infection control (level one), and moving and handling update training.

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- Of the medical staff, there was a reduced performance in updating training for fire safety (40%), information governance (60%) and medical gas safety (60%). Infection control (level two) had only been updated by 77% of medical staff.

Assessing and responding to patient risk

- Critical care staff were using systems for monitoring acutely ill patients, although consistent compliance with use of the tool needed to improve. The trust had implemented and the National Early Warning Score (NEWS) system for the monitoring of adult patients on wards in August 2014, and had been using it since. Audits of the use of NEWS were undertaken on all wards each month. Two measures were taken – one was the percentage of NEWS recorded and the other measured the accuracy of the score. The nurses in critical care were required to capture and document the NEWS for patients who were approaching discharge to a ward (as they otherwise recorded other patient observations at regular intervals). The unit had been audited for its completion of NEWS from June to December 2015. The unit had been fully compliant with recording a NEWS score on two of these seven months, but was between 54% and 76% in four of the months. There had been an improvement to 94% by December 2015. The unit had not been compliant with accurate scoring of NEWS on any of these seven months. One month had been as low as 39% and the highest result was 86%.
- Critical care staff responded well to patient risk through regular assessments and reviews. Ward rounds in critical care took place in the morning and evening and were led by the consultants on duty. The ward round tended to be split into two groups, with the two consultants on duty reviewing a group of patients independently of each other. There was input to the ward rounds from unit-based staff including the junior doctors, and the nurses caring for the patient. However, neither a pharmacist nor physiotherapist was present throughout the ward round we observed, which, if they were present, would be good multidisciplinary practice. The nurse-in-charge did not attend the full ward round as there were two rounds at the same time. We observed pressure on the nurse-in-charge to help with many other things at the same time as the ward rounds. The trust told us there was a strategy to ensure the nurse in charge was kept informed of all developments from the ward rounds. The ward rounds we observed and listened to were thorough, detailed, not rushed, and everybody was required, and encouraged, to contribute.
- The hospital did not fully meet recommended practice with the provision of outreach services, and some unplanned or planned staff absence could not be covered by the number of nurses in the outreach team. Outreach services supported acutely and critically ill patients, including early identification of deteriorating patients and timely admissions to critical care. The hospital had 12-hour daytime, but not 24-hour, cover from the critical care outreach team. Experienced and skilled nurses provided the outreach service from 8am to 8pm, 365 days a year. The Guidelines for the Provision of Intensive Care Services (Faculty of Intensive Care Medicine, Intensive Care Society, and others, 2015) recommended outreach services or their equivalent be provided 24 hours a day. It stated the hospital should “ensure an appropriate response always occurs and is available 24/7.” At night, deteriorating patients were the responsibility of the hospital-at-night team. The hospital-at-night team were skilled practitioners, although the trust recognised in a review of National Institute of Health and Care Excellence (NICE) guidance CG50 (responding to acutely ill patients) the night sisters had “varying levels of skills and have been identified as requiring additional training.” The night team also had a multiple focus across the whole site. There was therefore a risk to patients of care or transfer not being timely or met with the right skills, particularly when there were competing priorities for the hospital-at-night team.
- The critical care outreach team were not staffed sufficiently to meet holiday or sickness absence. To provide a full service, the team needed 3.5 whole-time-equivalent (WTE) nurses. The service had 2.7 WTE. This meant staff sickness or some holidays were not covered. When this happened, the nursing team would let the ward coordinators know when they would not be available and make sure the medical registrars were also informed.
- There was some use of both physical and pharmacological restraint (use of medicines to sedate or reduce anxiety) for patients assessed at being at risk to themselves or others. Patients were assessed for use of restraint and this became part of their care plan if it was

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determined to be the safe and most appropriate course of action. If it was used in either physical or pharmacological form, it was explained to and discussed with the patient's family.

- There was a lack of formal or procedural handover between the outreach team and the hospital-at-night team. There was a variable handover to and from the hospital-at-night team and this process had not been formally agreed. The outreach team said the night team had often left before they came on duty and they endeavoured to meet with one of them at the end each day, but it was not always possible as there was no agreed overlapping handover period.

Nursing staffing

- There were safe nursing staff levels in critical care in line with professional standards. However, due to unfilled vacancies, these were supplemented too often by bank staff and what should have been supernumerary senior nurses, nurses to take emergency admissions, or the clinical nurse educators. There were shortages in filling healthcare assistant shifts, although this had improved recently for daytime shifts. Nursing numbers were in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Therefore, patients assessed as needing intensive care (described as level three) were cared for by one nurse looking after that one patient at all times. High dependency patients, (described as level two), were cared for by one nurse looking after two patients. The nursing rotas demonstrated meeting this nursing ratio, although with the use of bank staff and supernumerary staff. Staffing levels over the period August to November 2015 were as follows:
 - For nurses, the fill rates in the daytime were between 89% and 98%. At night it was between 92% and 99%.
 - For healthcare assistants the fill rates were not as good. In the daytime they were between 71% and 83%, but at night between 42% and 65%.
- The critical care operating policy, relating to critical care nursing staff, was not being followed in practice. Staff were being moved from critical care to other wards when the other wards were short of staff. The policy stated at page 11 "when the wards are short staffed and the dependency of patients on the unit is at least two less than the number of nurses on shift, it may be possible, in exceptional circumstances, and where all other reasonable options have been exhausted, for

critical care nurses to assist with ward duties." Staff told us in practice the policy was not followed and staff were requested by the site team to move to work on wards if there was just one 'extra' nurse on shift, or a supernumerary member of the team could be used to provide direct patient care. This included the 'admission' nurse being counted in the numbers. The role of admission nurse otherwise was a protected role and was used for enabling the unit to admit an emergency patient (if a bed was available). Within the policy was a list of criteria relating to staff moves. Staff said these criteria, such as them not being involved or responsible for drug rounds (so they could be withdrawn urgently back to critical care), were not met.

- Nursing and healthcare staff being moved to other wards affected the managerial time and responsibilities of the senior staff. Data for the period April 2015 to March 2016 showed this was not a problem in some months, but there had been times where this was not acceptable. In May 2015, the shift coordinator had to provide direct patient care for 12% of shifts in May 2015, 14% in June, 5% in October, and 9% in February 2016. This would leave the unit with no shift coordinator. There were no figures available to show how many staff had been moved to other wards and the effect this had on safety on the unit.
- The supernumerary staff did not meet the recommended levels. The Faculty of Intensive Care Medicine Core Standard 1.2.5 stated the unit, with 13 beds, should have two supernumerary registered nursing staff. There was, however, only one supernumerary nurse in the establishment numbers. The clinical nurse educators were also counted in the establishment numbers for direct care. There was no provision for them to provide their supernumerary education support at all times, particularly when the unit was busy and they were required to provide direct patient care. They and the supernumerary unit managers (which included the sister leading the unit) were also required to cover shifts when the hospital site management team requested a critical care nurse or healthcare assistant to work elsewhere in the hospital.
- The staffing numbers for nurses working in critical care were recorded as over establishment, although other documents reported vacancies. We were told the numbers included the additional staff for the additional beds funded in 2015, which had not been factored into

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the original budget. There were, although it was not apparent, vacancies within critical care nursing staffing levels, but the numbers provided suggested the unit had more staff than required. For example:

- In January 2016, there were reported vacancies in critical care of 8.61 whole-time equivalent (WTE) nursing posts. (Note: the trust appointed to 5.3 WTE of these vacancies in February 2016)
- Against this, the establishment figures for January 2016 reported there were an extra 1.8 WTE staff in band 7/8 and an extra 4.2 WTE staff in band 5/6.
- Critical care endeavoured to limit the use of agency staff and most unfilled shifts were covered regular and unit-based bank staff, rather than agency. The FICM Core Standards recommended agency staff did not exceed 20% of the nursing staff cohort on any shifts. This was to ensure the unit was predominantly staffed by experienced nurses at all times. Reports from the trust showed there was one month in the data provided for April 2015 to January 2016 where the unit had over 20% bank/agency staff. However, the data did not differentiate between bank and agency staff. A number of different staff on the unit said in 2015 and 2016 this would have been predominantly bank staff.
- Although there was limited use of agency nurses, there was a high use of bank staff to fill shift vacancies. In the period from April 2015 to January 2016, there was an average of 12.1% of shifts filled by bank staff. This had improved from the year 2014/15 where there had been an average of 19.1% bank/agency staff.
- Sickness levels for nursing staff were variable. In the year 2015 there were average levels of staff sickness among the different grades as follows:
 - Band seven nurses – 3.5%
 - Band five and six nurses – 4.3%
 - Band two to four healthcare assistants – 6.7%

This was against an NHS average of around 4%. Within these averages were several months where there was no sickness (particularly among the senior staff) and some months where sickness was high.

- There was good handover on the unit between nurses and nursing teams. Nurses safely handed the patients over to the new shift following a set protocol working through the patients' risks and care planning. A daily shift-change safety briefing took place in the morning

before the ward round. This included discussion of staffing levels, acuity (patients' needs), checking of the resuscitation equipment, the risk of pressure ulcers, and organ donation.

Medical staffing

- Critical care leadership was provided by an experienced consultant clinical lead supported by a skilled team. The clinical lead was a consultant in intensive care medicine and a Fellow of the Faculty of Intensive Care Medicine (FICM). The 13 consultants working on the primary rota were consultant intensivists and anaesthetists and therefore highly experienced in delivering care to some of the most critically ill patients in the hospital.
- The experienced consultant presence in critical care followed the recommendations of the FICM Core Standards. This had been expanded to safely care for the additional patients now admitted following the increase in beds in October 2015. The standard was for a consultant to patient ratio of one consultant to a maximum of 14 patients. During the week there were usually two consultants on duty during the daytime. This delivered a ratio of one consultant to six or seven patients. Due to other commitments, there was only one on duty on a Monday afternoon and Friday afternoon, but this still met the recommended ratio. On weekends, there was one consultant on duty in the daytime, which continued to meet the recommended ratio of one to 14 at most, and took into account the reduced workload from patients not having planned operations, which took place during the week. One consultant was on call from 5pm to 8am and had no other commitments outside of critical care during that time.
- There was a good commitment of consultant time on the unit. The FICM Core Standards required consultants to have a minimum of 15 programmed-activities of consultant time committed to critical care each week. This was achieved on the unit, and generally far exceeded.
- The number of trainee/junior doctors on duty met the recommendation of the Core Standards. During the weekdays and weekends in daytime hours, the unit's arrangements met and well exceeded the recommendation for there to be at least one junior doctor for a maximum of eight patients. There were

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three or four doctors on duty during the day, supported by one or two consultants, so exceeding this standard. There were plans from later in 2016 to further expand the cover from the junior doctors.

- There was support to new doctors, but they were not included in the rota and did not hold unacceptable responsibilities. There were foundation year one doctors working on the unit to experience and learn critical care practices. As with the recommendations of the FICM Core Standards, these were not left as a sole resident doctor at any time.

Allied Health Professional staffing

- There was a good service from the pharmacist team, although it did not quite meet the recommendations of the Faculty of Intensive Care Medicine (FICM) Core Standards in terms of seniority of cover provided. The level of recommended cover was a consensus of critical care pharmacists, the UK Clinical Pharmacy Association, and the Royal Pharmaceutical Society. If the unit was full with 13 patients, and patients were at levels used for planning (seven level three and six level two patients), the FICM Core Standard 1.4.1 recommended there be one senior grade whole-time equivalent (WTE) pharmacist (band eight A or above) providing a full service to the unit. In practice, the unit had cover from one WTE band seven pharmacist, and 0.6 WTE band eight B pharmacists. This was more cover in terms of WTE staff than the standard recommended, but not quite to the right level of seniority. The band seven pharmacist did, however, have support available from the senior pharmacists during the week.
- The pharmacist team provided a routine on-call service to make sure advice was available and provided at all times. This extended to out-of-hours cover 24 hours a day.
- There was safe provision of physiotherapy for patients, although not enough therapy staff to meet the requirements of the FICM Core Standard 1.3.7 or National Institute of Health and Care Excellence (NICE) guidance. There was a team allocated to critical care, but this team also covered five other surgical wards. There was a business case to increase this service being developed to be presented in 2016.
- There had been no increase in staffing levels for allied health professionals to coincide with the increase in patients since the service increased from 11 to 13 beds

in October 2015. There had been no corresponding increase in the staffing levels of pharmacists (although this was sufficient now) or physiotherapists to meet the increased needs to patients.

- The support from speech and language therapists did not meet the recommended standard, and dietitians were only available for input on-call or a weekly ward round. There was no regular input from a speech and language therapist, and this did not meet the recommendation of the FICM Core Standard 1.3.2 which stated the unit should have access to a speech and language therapist. The unit had recognised this gap in therapy support in a review of the Core Standards, and stated it would reach “full compliance by June 2016” but not how this would be achieved. The dietitian came to the unit and assessed all patients once each week, and was then available for support on call. The recommendation of the FICM Core Standard 1.5.2 stated a dietitian should be part of the multidisciplinary team, and although the frequency of visits was not stated by the standard.

Major incident awareness and training

- The critical care unit had a copy of the trust major incident policy in a folder on the unit. This was, however, dated September 2005 and was not the trust's current policy. There was an emergency evacuation plan dated 2013.
- The hospital had the ability to increase its capacity temporarily to care for additional critically ill patients in a major incident, such as a pandemic flu crisis or serious public incident. This would involve primarily using the anaesthetic rooms and recovery area in the operating theatre suite. Anaesthetic and recovery staff were trained in caring for ventilated patients and would be supported by the critical care team. In addition, help, support and advice would be provided by the South West region Critical Care Network.
- Business continuity plans were described by senior staff as “under-developed”. There were no specific plans drawn up for failures of equipment or services for critical care, and the unit tended to respond to problems rather than anticipate them with continuity arrangements. For example, there was a power failure in 2015, which was managed well and without harm to patients. However, there was no contingency plan for this event and one had been produced after the event.

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Are critical care services effective?

Good



We rated effectiveness as good because:

- Patients had good outcomes as they received effective care and treatment to meet their needs. There was delivery of medical treatment and care in accordance with best practice and recognised national guidelines. There was good management of patients' needs in relation to pain, nutrition and hydration.
- There had been a programme of audit and research leading to reduced infection rates and improved outcomes for patients.
- There was a strong multidisciplinary approach to assessing and planning care and treatment for patients. Services required to meet patient needs were available across all seven days of the week.
- Data was submitted for critical care to the Intensive Care National Audit and Research Centre to reveal outcomes for patients and compare these with similar units and national outcomes.
- The mortality rates within the unit showed, over time, more people than would have been expected survived their illness due to effective care.
- Almost all staff working on the unit had been assessed for their performance.
- There was a dedicated and successful contribution to the national organ donation programme.
- There was good support to new nursing/healthcare staff and junior and trainee doctors.
- There was a good knowledge base of Deprivation of Liberty Safeguards

However:

- There were insufficient physiotherapists to meet best practice in terms of the rehabilitation needs of patients.
- There were some link roles among the staff, but this useful practice had not been well embedded.
- , but the trust policy did not meet the Code of Practice. The written clinical protocols, guidance and procedures relied upon in one of the folders within the unit were out-of-date for review, and some had not been updated for a number of years. There was no evidence to suggest the procedures were, however, unsafe or no longer the appropriate clinical practice.

Evidence-based care and treatment

- There were some areas of key clinical guidance recognised by the critical care team as not fully compliant. Some actions were identified, but not for all of those areas identified. The critical care service had looked at how it performed against the National Institute for Health and Care Excellence (NICE) standards particularly relevant for its patient group. One of the recommendations of NICE 50: Acutely ill patients in hospital (recommendation two) was around the response strategy for patients identified as being at risk of clinical deterioration. The hospital steering group charged with looking into compliance with NICE 50 (Deteriorating Patient Steering Group) recognised that while the daytime outreach team comprised of nurses trained in critical care, there were varying skills in the team of nurses that looked after the hospital at night. It had been recognised these nurses required additional training to ensure the hospital met recommendation two of NICE 50. There was no action plan associated with delivering the new training. The service had also looked at how it complied with the other key piece of NICE guidance: NICE 83: Rehabilitation after a critical illness. One of the areas that did not meet the recommendations related to physiotherapy provision, particularly over the weekend. A business case had been submitted to the trust to expand provision of physiotherapy to meet the rehabilitation needs of patients and a structured approach to ongoing care.
- There were insufficient levels of physiotherapists to meet best practice and the rehabilitation needs of patients. There was a team of physiotherapists attached to the unit, but they were also attached to the five surgical wards. The team wanted to deliver a strong focus towards rehabilitation, but they were restricted with time and therefore focussed upon respiratory therapy at the cost of physical/rehabilitation therapy. Where it was required, each patient received respiratory therapy each day, but physical/rehabilitation therapy was restricted to three times per week, excluding weekends. The Faculty of Intensive Care Medicine Core Standard 1.3.4 stated each patient should have a minimum of 45 minutes of each therapy required for a minimum of five days each week. This was also linked to the NICE quality standard for stroke patients. The

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physiotherapy staff said they would not be able to meet this recommendation with their current workload or staff availability. This was part of the business case put forward as mentioned above.

- The physiotherapist team had recently introduced the use of an assessment tool to assess a patient's improvement to respiratory and physical therapy. It was early days, but the staff were working with the recognised Chelsea Critical Care Assessment Tool. This was developed by the Chelsea and Westminster Hospital along NICE 83 guidelines, to look at improvements in how a patient was mobilising on the one hand (physical therapy related), to their ability to cough on the other (respiratory therapy related).
- Patients were assessed on admission to the unit and their care planned and organised to meet evidence-based standards of care. One of the recommendations of the Faculty of Intensive Care Medicine Core Standards (2.6) was for patients to be seen by a consultant within 12 hours of being admitted to the unit. Any patient newly admitted to the unit would take priority over routine patient review.
- Audit of current practice and a review of research and best practice in critical care provision had led to changes and improvements. Examples of improvement included the cases of ventilator-associated pneumonia, which, after identifying how rates should be reduced, led to the unit revising the care provided and providing training and education. This resulted in the infection rate reducing from 60 cases per 1,000 ventilator days (ventilator days being the standard for measuring these infection rates) to less than 10 cases. This also reduced the use and cost of antibiotics to treat the infection and improved the length of stay and outcome for patients. There had also been a change in ventilation strategy (called 'value the volume') which had led to improvements and was being audited on a regular basis. Added to this, the introduction of cost-effective disposable bronchoscopes had reduced the incidence of infection from using non-disposable equipment from around two cases each month to none.
- In line with the tracheostomy care recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), the unit was using a World Health Organisation (WHO) checklist in all tracheostomy insertions. This was a checklist to guide doctors each step of the way in preparing, carrying out, and completing tracheostomies, to ensure the process was

safe and each part of the process carried out as required. Each ventilated patient was monitored using capnography, which checks the concentration or partial pressure of carbon dioxide in respiratory gases. Equipment was available at each bed on the unit and used during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions. Appropriate positioning of the airway tube was made, again as recommended by NCEPOD, using airway endoscopy.

- The unit was using specialist equipment and techniques to safely ventilate patients who needed help with breathing. This included mechanical ventilation to assist or replace the patient's spontaneous breathing using tubes inserted through the mouth or nose into the trachea, or tracheostomies, which were tubes inserted through the windpipe in the trachea. The unit also used non-invasive ventilation to help patients with their breathing, usually using masks or similar devices. There was constant review of all ventilated patients through monitoring equipment connected to the patient's breathing equipment.
- Patients were monitored by their nurses through the use of care bundles. Care bundles are recognised techniques and plans for specific procedures, such as insertion and management of the lines that carry medicines. For each patient there was a set of care bundles completed and monitored each day. These included ongoing care for the prevention of ventilator-associated pneumonia, insertion and ongoing care of central venous catheter lines, venous thromboembolism risk assessments and prophylaxis (preventative measures), pressure ulcer management, and care of patients receiving renal dialysis.
- Critical care staff followed NHS guidance and best practice when monitoring sedated patients and followed recommended guidance to provide the right levels of sedation. Sedation is one of the most widespread procedures used in critical care. It is used to help deliver care and treatment safely and try to ease the patient through a distressing time. Maintaining light sedation in stable adult patients in critical care has been shown to improve outcomes (Faculty of Intensive Care Medicine). Improvements include reducing the patient's length of stay, better evaluation of neurological conditions, and reduced levels of delirium from not overusing sedative drugs. In critical care, there was daily

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assessment of each sedated patient according to the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. Sedation was then withdrawn, continued or adjusted dependent upon how the patient reacted.

- There was assessment of delirium for patients admitted to critical care, as is best practice and recommended by the Faculty of Intensive Care Medicine (FICM). This was introduced through a training and awareness programme in December 2015. Delirium is a state of confusion and altered brain activity that can cause delusions and hallucinations in critical care patients. It is recognised as a fairly common experience. The FICM Core Standard 1.3.3 recommended screening all patients for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM-ICU) and a multidisciplinary, multi-modal approach.
- Ad-hoc audit reviews had led to improvements in practice. The unit had looked at blood retrieval from patients with a view to reducing the amount taken unnecessarily. The unit now used smaller (paediatric) blood bottles to send for analysis. This had led to the reduction in blood taken by 34% over the course of a year, which amounted to 15.3 litres of blood.
- Critical care met best practice guidance by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. As is best practice, critical care led on organ-donation work for the trust. In the NHS, there are always a limited number of patients suitable for organ donation for a number of reasons. The vast majority of suitable donors will be those cared for in a critical care unit. The trust had appointed one of the experienced consultant intensivists as the clinical lead for organ donation. There was a specialist nurse for organ donation employed by NHS Blood and Transplant (NHSBT). They were part of the South West NHSBT team but spent their time at the Royal United Hospital Bath in the critical care unit to directly support the organ donation programme and work alongside the medical and nursing team. The organ donation team had also spent time with the community promoting the programme of organ donation.
- The hospital trust was part of the National Organ Donation programme. It followed NICE guideline CG135: Organ donation for transplantation and had policies and strict criteria for organ donation. We reviewed data about donations from the Royal United Hospital Bath

for the year from 1 April 2014 to 31 March 2015 and the most recent six-month report from April to September 2015. There had been 34 patients eligible for organ donation during this 18-month period. Of these, there was an approach to 18 families (53%) to discuss donation. This was slightly below the UK average of 59% for approaching families to discuss donation. The specialist nurse was involved with 13 of these families (72%), against a national average of 79%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. In the 18-month period, five patients went on to be organ donors and nine people became recipients of those organs.

- The standard operating procedures, protocols and guidance in one of the files on the unit (and being referenced by staff) were not sufficiently current. The unit had access through the trust intranet to up-to-date trust policies and procedures. However, the set of standard operating procedures and clinical guidance in this particular file contained documents which were all either due for review or significantly old. Some were significantly out-of-date, such as the nasogastric feeding protocol, which was dated May 2005, and the physical restraint protocol, which was dated October 2008. Other protocols and procedures, such as eye care, were more current, but still overdue for review. We raised this with one of the senior management team, who removed the documents for urgent review.

Pain relief

- Those patients we were able to talk with said their pain was being well managed. Patients said staff were regularly asking them if they had any pain, and giving pain relief when it was required. Patients also said they felt their pain was managed well overall, and they had been offered alternative control methods, such as intravenous pain relief they could manage themselves ('patient controlled analgesia' or PCA).
- There was access to a specialist acute pain team. This team visited the unit, along with the rest of the hospital, each day, seven days a week to review specific patients. This included patients who needed a specific pain review as requested by clinical staff, although this was not a regular request. The reason for the visits were predominantly to review patients who had epidural pain

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relief or were using a PCA machine. Out of hours, the intensivist consultants and/or the hospital anaesthetist team on duty could provide specialist pain advice and treatment.

- There was consideration for patients who were unable to communicate if they were in pain. The unit had a pain tool, which was the recognised Abbey Pain Scale, for use with patients with cognitive problems, or staff could refer to the specialist pain team for advice. The Abbey Pain Scale was designed for people who could not tell staff about any pain. It measured if the patient was indicating pain verbally, their facial expressions, body movements and any changes in their usual behaviour. Relatives of patients with dementia were asked if any of those things detected in the patient were usual behaviour so this could be taken into account. Other measures considered were physiological changes, like temperature and blood pressure, and any physical changes such as skin damage or bruising.

Nutrition and hydration

- There was effective assessment and response to patient nutrition and hydration needs. The patient records we reviewed were well completed, and safe protocols were followed to ensure patients had the right levels of nutrition and hydration. Fluid balance was calculated, recorded in the patients' records, and analysed for providing the appropriate balance. We saw appropriate adjustments and consequent improvements.
- There was assessment and management of the risks to patients from acquiring pressure ulcers from dehydration or malnutrition. The unit was using the Braden risk assessment tool (a recognised scoring tool for determining a patient's risk of skin damage). This evaluated the standard risks from a patient's sensory perception, moisture of the skin, activity, mobility, nutrition, and friction to the skin. All the scores appropriate to these tests were then added-up and the risks of dehydration, malnutrition and developing of pressure ulcers addressed through use of preventative therapies or treatments.
- Audit of pressure ulcer prevention showed an improving picture and some good results. There were monthly audits of the Braden risk assessment: an assessment of a patient's risk of developing a pressure ulcer to be carried out within six hours of admission. These showed between 79% and 92% of patients had a risk assessment completed between July and September

2015, but this had increased to 100% from October 2015 up until the most recent data for February 2016.

Reassessment for pressure ulcers taking place every 48 hours was more variable with five of the nine months scoring 100%. This had dropped to the low of the period of 82% for February 2016.

- Nutrition care plans were drawn-up for all patients to identify who needed further supplements. Energy drinks and food supplements were prescribed and administered for patients who needed them.
- Adults receiving intravenous (IV) fluid therapy in critical care were cared for by healthcare professionals competent in assessing fluid and electrolyte needs. Staff were prescribing and administering IV fluids and monitoring patient responses. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 Statement 2: intravenous therapy in hospital.
- Patients could take their own food and fluids if they were able. For patients who could help themselves, drinks and any meals were available on bedside tables and within reach of patients.

Patient outcomes

- There was routine monitoring of patient outcomes and these were compared against those achieved nationally. Critical care demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC) for at least the last five years. Data contribution therefore met the recommendations of the Faculty of Intensive Care Medicine Core Standards: a set of recognised guidelines for intensive care units to achieve for optimal care. This participation provided the service with data measured and compared against other units in the programme and those that were similar in size and patient type. Data returned to ICNARC was adjusted to take account of the health of the patient upon admission to allow the quality of the clinical care provided to come through the results. The service had been contributing a high standard of data, meaning the records submitted were mostly fully complete and could be evaluated and compared.
- Almost all critically ill patients were cared for at this hospital and not transferred to another unit elsewhere. Research has recognised how it is sub-optimal to move a patient to another hospital critical care unit without careful planning and management. According to ICNARC data, there had been three patients recently transferred

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to another unit for non-clinical reasons, and this was in the most recent data from March to September 2015. These were the first non-clinical transfers since early 2013. This was just above (worse than) the national average of transferring around one patient each quarter. Patients sometimes would be transferred for clinical reasons, as they needed more specialist care, or to be closer to home. Non-clinical transfers were usually due to a bed not being available. The unit otherwise had not transferred any patients since early 2013 but prior to that there had been a regular transfer of one or two patients each quarter, so this outcome had significantly improved.

- Mortality levels for patients admitted to critical care had, in recent years, been almost always below (better than) predicted levels. Since around the middle of 2012 mortality levels had consistently been below or at national average levels. The measure of the likelihood of a patient dying was provided by ICNARC data using a prediction model. This took physiology data from early in a patient's stay and used it to predict the probability that the patient would die before ultimate discharge from hospital. The latest ICNARC mortality prediction data showed the unit had fewer deaths than predicted. Any variations in the trend were downward due to better results than predictions made.
- Few patients were discharged before they were ready. Statistics from ICNARC highlighted a number of indicators:
 - In recent years, there were no early discharges from the unit. Early discharge is where clinicians recognised the patient would have ideally remained on the unit for a longer time, but were usually under pressure to provide a bed for a new patient admission.
 - One indicator of patients discharged too early was post-unit deaths, and in the last year these were below (better than) those of similar units and the national average. Post-unit deaths were patients who died before ultimate discharge from hospital, excluding those discharged for palliative care.
 - Early readmissions to the unit (those readmitted back for critical care within 48 hours of discharge to a ward) had been mostly below or the same as the national average. They had been below average since 2011, but had just slightly exceeded the average in July to September 2015. There were three in this quarter against a national average of two early

readmissions. Prior to that, for example, there were six early readmissions in the year from April 2014 to March 2015, against a national average of around eight.

- Late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) followed a similar pattern to early readmissions. There were 13 in the year April 2014 to March 2015, against a national average of around 16. There were nine in the six months from April to September 2015, against a national average of around seven. Previously, and for the last five years, there had been some quarters above the national average, but most late readmissions were below (better than) average.
- Early or late readmissions can indicate a patient was discharged too early. Due to the nature of critical care illness, it is recognised, however, that a number of these patients would return to the unit for conditions unrelated to their original admission.
- In terms of national audit, the unit/hospital had contributed to the 2014 National Confidential Enquiry for Patient Outcome and Death (NCEPOD) 'On the right Trach': A review of the care received by patients who underwent a tracheostomy (2014). The unit had self-assessed their tracheostomy care against a set of standards, looked for gaps, and produced an action plan to meet any non-compliance. The assessment had 25 recommendations and the unit had met 20 of these when it made the initial review. Of the others, four were partially met and one was not met. Of the four partially met, each had an action plan. They related primarily to the training and competence of staff caring for tracheostomy patients on the wards beyond critical care. There were plans to ensure all those staff who required specialist training were competent by December 2016 through a rolled-out education programme. The recommendation not met at the time of the review was involvement of a speech and language therapist to assist with more complex patients. The unit said it had responded to this by including a speech and language therapist in weekly tracheostomy ward rounds. However, this statement was contradictory to other information, which said there was almost no input from this therapy team.

Competent staff

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- Almost all of the nursing and support staff in critical care had been assessed each year for their competency, skills, and development. By January 2016, all six of the band seven nurses and 93.4% of the 57 band five and six nurses had been through their annual performance review. All of the six band two to four healthcare assistants had also been appraised. Of the two support staff, one appraisal was in date and the other had just fallen due. This good performance was an improvement over the last two years when the percentage for band five and six nurses having their appraisal was 78% in 2013/14 and 82% in 2014/15.
- There was evaluation of medical staff for their competence. Since 2014, there has been a requirement of a doctor's registration to have an annual appraisal as part of the 'revalidation' programme (General Medical Council, 2014). There were 13 consultants working in critical care and the trust provided us with information about 11 of these. All of these had been through their annual appraisal and the dates for their revalidation and next appraisal were recorded.
- There was a senior experienced pharmacist supporting critical care with support from a colleague who had recently joined the service. The new pharmacist was working through the critical care competency framework with support from their senior colleague and the hospital pharmacy service.
- There was an experienced nursing team in critical care, although just slightly below the recommendations of the Faculty of Intensive Medicine (FICM) Core Standard 1.2.8 in relation to post-registration training. The Core Standard recommends more than 50% of nursing staff should have a post-registration qualification in critical care nursing. At the time of our inspection, there were 49% of nurses in critical care with this qualification (31 from 63 registered nurses). Three staff were undertaking the training at the time of our inspection, which would raise the percentage to 56% once it had been completed.
- The unit had two clinical nurse educators (one band seven and the other a band six) who both worked half of their time in this role, so providing one whole-time-equivalent post. However, not all training and education in critical care was delivered as planned due to pressure on staff to provide direct care for patients. There was, nevertheless, commitment to training and education within critical care. The FICM Core Standard 1.2.6 recommended one dedicated nurse educator for around 75 staff. The unit employed close to this number of nursing staff, so the standard was achieved between the two nurses.
- There was a focus on education and improvements to care within the unit, although less opportunities for professional development beyond the service. There were educational projects run on the unit every two months. In December 2015, the unit ran an education programme on delirium screening for patients. The use of this process was introduced during that time and had become a daily practice. Some staff said they otherwise found limited opportunities for further professional development, although some charitable funds were available for some further development. The junior staff were, nevertheless, keen to develop and gain new skills and experience. There had also been leadership courses offered by the trust. One of the nursing team was on the highly rated advanced critical care practitioner training scheme. This was part of the Department of Health's national education and competency framework, and would train a nurse as a highly skilled practitioner.
- The unit had a resource room, which held various examples of kit and equipment used, and a mannequin and hospital bed for simulation training sessions.
- The critical care outreach team had three nurses. One was a band seven sister who was trained in critical care. The other two nurses were trained in emergency medicine. The service had set goals to develop these nurses with critical care competencies. The Guidelines for Provision of Intensive Care Services recommended all critical care outreach nurses had annual competency-based assessments of their core skills and specific additional competencies relating to first-line clinical assessments and intervention. This was not currently being delivered, and the service, as with other aspects of this critical care unit, was affected by the lack of a matron in oversight of the service for 15 months. The sister leading the critical care outreach team advised the service was in the process of getting a competency framework to work to from the local Operational Delivery Critical Care Network in the South West.
- There were some link roles among the staff, but this had not developed into a full programme where all grades of staff had lead topics. Lead roles gave staff a subject to specialise in and provided other staff with guidance and support, particularly where the subject may not arise in

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day-to-day practice. A group of junior nurses and healthcare assistants we met did not have patient-related lead roles among them, although some had discussed how to be involved or develop this idea further.

- There was a good induction programme for new staff starting on the unit. All non-experienced staff had a six-week induction period where they worked alongside other staff and completed induction training. Each new member of staff was provided with an induction pack and 'helpful hints' for working in critical care. New starters worked shorter shifts over five days in order to provide a good period of structured induction without overwhelming new staff. Each new starter had a preceptorship period of six weeks following their induction where they worked under the guidance of a mentor. After three months on the unit, new starters were given a performance review and asked to think about their strengths and weaknesses. Any areas where they felt unsure were given more time and learning.
- There were study days for the junior (band five) nursing staff on specific learning topics. These took place on four days each year, and all new staff were expected to complete them within their first year. An away day had been arranged for April 2016 for the band three healthcare assistants.
- Staff were trained on existing equipment and new equipment or techniques introduced to the unit. For example, the unit introduced a new renal replacement therapy in August 2015. Nursing and medical staff were trained in use of the new equipment. This was managed by the company providing the equipment and one of the band seven sisters responsible for overseeing the project. The unit had 10 'super-users' (higher-level training) among the staff team and overall 76% of the staff have been trained as either a 'super' or 'basic user'. The unit introduced new ventilators in November 2014. The unit had five 'super-user' trained staff and overall 74% of staff were currently trained in use of this equipment. Further sessions were planned to increase trained staff in this equipment and techniques.
- There was good support to junior and more senior trainee doctors. Those we met said they felt valued members of the team. The consultants were approachable (described by one junior doctor as "amazing" and by another as "awesome") and provided good supervision and support. The junior trainee doctors told us they had hands-on teaching and were

given the chance to increase their experience in skills around, for example, ventilator support, use of inotropes (cardiovascular medicines), tracheostomies, lines, ultrasound use, and renal replacement therapy. The junior doctors presented studies, research and audits and were involved with the mortality and morbidity meetings. There was a journal club every other month. This was an educational meeting where doctors were able to present and critically review recent academic articles in a relevant field of interest.

Multidisciplinary working

- There was good input into patient care from many different experienced staff, although there was no regular input from a speech and language therapist. The Faculty of Intensive Care Medicine Core Standard 1.3.2 recommended units have access to an adequately experienced and senior speech and language therapist to help or contribute to patients being weaned from ventilators. The unit otherwise had regular input into patient care and treatment from the pharmacist team, physiotherapists, dietitians, and other specialist consultants and doctors as required. Consultants and doctors from throughout the hospital specialities visited patients in the unit on a regular basis to liaise with the critical care team.
- There was a multi-disciplinary approach to weaning plans for complex and long-stay ventilated patients. Weaning is the gradual decrease in duration of mechanical ventilation with the goal of the patient breathing independently as quickly and safely as possible. The physiotherapist team had experienced staff able to contribute/construct a suitable weaning plan in collaboration with the multi-disciplinary team.
- There was support from a microbiologist ward round (a healthcare scientist concerned with the detection, isolation and identification of microorganisms that cause infections). The microbiologist visited the unit each day and reviewed all patients with the medical team. Staff, and specifically the pharmacist we met, commented upon the excellent help and support from the microbiologist, particularly in relation to the use of antibiotics.

Seven-day services

- A consultant intensivist was available in person or on-call across the whole week for the whole seven days. They led the two ward rounds every day. When they

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were not on duty in the unit, there was good cover from the consultant intensivist team. Consultants lived within a 30-minute journey of the unit when they were at home but on call. Trainee doctors said the consultants frequently took calls or attended the unit when needed.

- There were arrangements for pharmacist and microbiologist services across the whole week. On weekdays, the pharmacist team and microbiologist were available on site in the daytime. There were arrangements for the supply of medicines when the pharmacy closed. The pharmacist team worked to ensure those medicines used both regularly and infrequently, but needed for a complex patient, were available for supply out of hours. A pharmacist and the microbiologist were available on call in the evenings, at night and on weekends.
- Access to clinical investigation services was available across the whole week. This included X-rays, magnetic resonance imaging (MRI) scans, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for brain activity, endoscopy, and echocardiograms (ultrasound heart scans).
- Therapy staff were available in person or on call across the whole week, but seven-day services were limited. If therapy staff were off duty, there was access to certain staff out-of-hours through on-call rotas. Otherwise, therapy staff, including physiotherapists, the dietitian, certain occupational therapists, and speech and language therapists, were available on weekdays. Physiotherapists were also on duty on weekends, but providing only respiratory physiotherapy. Nursing staff were able to provide patients with non-specialist rehabilitation physiotherapy on the weekends.

Access to information

- Information needed to deliver effective care was available and accessible. The unit had a range of care plans and other patient documentation in labelled drawers and paperwork was easy to locate. There was a formal handover of information for a patient being transferred from critical care to a ward. The National Institute for Health and Care Excellence guidance (NICE 50) recommended a patient should have a formalised handover. The critical care service had established an electronic referral for transfer from the unit that accurately recorded the clock start time and completion time.

- Access to patients' diagnostic and screening tests was good, although as reported above, the blood gas analyser on the unit had broken down frequently. The medical teams said there was usually good and quick provision of test results and urgent results given the right priority.
- Patient paper notes and records were usually available in good time. Staff said records available at the hospital were provided relatively quickly in emergency admissions (all patient records were on paper for patients coming from other wards or new admissions). The notes were held in an electronic booking system, which tracked them when they moved around the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent when they were mentally and physically able to do so. Staff acted in accordance with legislation and guidance when treating an unconscious patient, or in an emergency. Staff said patients and their families 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.
- Staff had a good understanding and application of the Mental Capacity Act 2005. Staff acted in the best interests of patients who were not able to make their own decisions, due to a lack of mental capacity at the time. Staff correctly identified how capacity could fluctuate and could return in some patients and be lost with others, so assessments needed updating. There were arrangements within the hospital to provide an Independent Mental Capacity Advocate (IMCA) if a decision was needed in a patient's best interests and the patient had no family or friends to speak for them at the time. A patient admitted to the unit had been assessed as not having the capacity to make decisions at the time. The patient's records documented the discussions around acting in the best interests of the patient in good detail. There were multiple entries by the medical team with good detail of conversations with family members.
- Staff had a good understanding of the Deprivation of Liberty Safeguards (DoLS), although the trust policy had not accurately interpreted the Code of Practice for DoLS. The critical care service was monitoring developments within the legal system as they related to patients

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receiving intensive or high dependency care. However, the staff we met described a process where they would recognise if a deprivation of liberty was occurring or was likely to occur. In this situation, they would work with trust staff to apply to the local authority to authorise the deprivation, or exercise the trust's right to have a trust-appointed urgent authorisation (providing an application went to the local authority alongside this). Staff explained how any deprivation would be after other avenues to provide safe care had been explored. Any deprivation to protect or care for the vulnerable patient would be in their best interests. A vulnerable patient would be one who did not have the mental capacity at the time to make his or her own decisions. The trust policy (reference 7019), however, stated said an authorisation would not be considered if the patient's stay was not likely to be more than 72 hours, but it did not provide for flexibility in relation to the application of the 72-hour rule. The policy also did not yet reference the 2015 guidance from The Law Society for deprivation of liberty in hospital settings. The Code of Practice for Deprivation of Liberty of the Mental Capacity Act 2005 does not place any time limit on the patient's stay in hospital before an application should be made.

Are critical care services caring?

Good



We rated caring as good because:

- Staff cared about their patients, treated them with dignity and respect, and patients were involved as partners in their care.
- People said good things about the service. Comments we read and received had been positive. Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe.
- Patients, their family or friends were involved with decision-making. They were able to ask questions and raise anxieties and concerns and given answers and information they could understand.
- We observed staff treating patients with kindness and warmth.

However:

- There was some support for patients who stayed on the unit for a long time in order to keep them in touch with life going on around them. However, the unit did not actively use or promote a quality patient diary.

Compassionate care

- All the patients and relatives we met spoke highly of the care they received. Due to the nature of critical care units, we often cannot talk to as many patients as we might in other settings. However, patients we were able to speak with said staff were caring and compassionate. Patients said they felt safe and supported. Visitors we met said staff were "amazing from bottom to top" and "terrific, really first rate". Cards sent to staff on the unit included the following comments: "Your professionalism and kindness meant such a lot to us all", "thank you for your dedicated care...and the care and comfort to us as a family...", and "you are truly a wonderful team from the ward clerk, HCA, nurses, doctors and consultants, you all treated [the patient] with dignity and respect as well as supporting and including myself...in [the patient's] care and that has been appreciated and will never be forgotten."
- We observed good attention from all staff to privacy and confidentiality. There was less than the recommended space between patients' beds (more space helps to increase auditory privacy) but staff lowered their voices to avoid others overhearing confidential or private information as much as was possible or practical. Staff held confidential, sensitive or possibly difficult conversations with patients' relatives in private rooms, although there was limited provision of quiet spaces. All patients we spoke with said they were treated with dignity. They said staff drew curtains around them for intimate care or procedures and we saw this in practice.
- The nature of the critical care unit meant there were often limited opportunities to provide single-sex wards or areas. Staff therefore had limited opportunities to place patients by gender to increase privacy and dignity. There were four side rooms, and staff said they had been able to admit patients to these more private areas when possible or practical. Some areas of the unit were quieter than others and with less footfall from staff or visitors passing by. We observed a patient with a higher level of needs and anxiety who had been admitted into a bed in one of the busier sections of the ward. Although

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staff said they had considered where was the best and safest place for this patient, it did not take into consideration the disruption to other patients when the patient was most anxious.

- Staff made sure patients and relatives knew whom the staff were and what they did. All healthcare professionals involved with the patient's care introduced themselves to patients and relatives, explained their roles and responsibilities. Patients and visitors said all the staff they had met had told them who they were, and their role. One family said they had met three different doctors who had all explained who they were and talked about what they had learned about the patient from the handover from their colleagues. The family said how this was helpful to see continuity of care. They said they felt there was a high standard of compassion among all the nurses and doctors who recognised the anxieties the families had and tried to reassure them all the time. We witnessed staff introducing themselves in many of the patient interactions we observed, even if the patient was drowsy or confused.
- Visiting times could be flexible to meet the needs of the patient and their loved ones, but were otherwise at set times to prioritise the needs of the patient, while being supportive to relatives. There were set times for visiting hours (11am to 3pm and 5pm to 8pm). Visitors were encouraged not to visit before 11am due to ward rounds, physiotherapy and tests being carried out. Families were encouraged to telephone the unit outside of visiting times for updates, and we heard staff being helpful, reassuring and informative with people on the telephone. Staff said they would accommodate visitors as much as possible at all times taking account of visitors who might not be local, and the patient's health.
- Visitors we met said staff indicated when they needed to support the patient and visitors had been asked to step outside or to the waiting room for a short time. Visitors said the staff explained politely why this was necessary and staff returned to invite them back to the unit when they had completed the care or procedure.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken. Those patients who were able to talk

with us said they were informed as to how they were progressing. They said they were able to make their own decisions, but given good information about the options available to them. One patient said they had followed all the advice they were given by staff, but also felt staff would have supported them even if they wanted to make a decision staff might otherwise think unwise. Patients and visitors said staff encouraged them to talk about anything worrying them.

- Staff communicated with those close to the patient and kept them informed and involved. We met two families who had visited their relative on a number of occasions. Both families had been impressed with the information the staff had given them at all stages in the patient's stay. They had been able to ask questions and one told us they felt they had asked the same question over and over, but staff had recognised they were finding it hard to take in the responses. Staff had offered to write things down with the family or talk with them at any other time if that helped. One family commented on how staff knew "the little things that matter to us" and one of the younger members of the family said: "they know we are anxious and a bit scared for [the patient] and have been telling us everything without being too medical about it all. It's been really helpful."
- Staff made sure visitors were identified and only gave information to them that they were entitled to know. The ward clerk was an integral part of the team. They were aware of any confidential information and delicate or difficult situations with patients or their relatives in order to act appropriately and sensitively. Some families had passwords to use when they telephoned the unit. This was to make sure anyone not entitled to have information about the patient was not given this.

Emotional support

- Staff would recognise when patients or relatives needed emotional support, although there was limited professional support for psychological problems. The hospital psychologist had been on sick leave for a long time. There was some support available from the neurological psychologist, but not a full service. One of the patients we met who had undergone surgery told us of the kindness of one of the nurses. The nurse knew the patient was anxious about having surgery and had accompanied the patient to the operating theatre to give them support. A questionnaire had been sent to 119 patients discharged from critical care in 2015 to ask

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them about their mental health and experience of critical care. There was a response from 29 patients. A trainee clinical psychologist also interviewed staff at a focus group about emotional support for patients. There were plans to look for themes and recommendations from these questionnaires and interviews aimed at reducing psychological risks for patients. A report was due in 2016.

- There was some support to keep critical care patients in touch with what was going on around them or tell them about what they might have missed when they were on the road to recovery. Critical care staff had yet to introduce the use of the patient diary for longer-stay patients, although had introduced this for one patient as a trial. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Diaries can provide comfort to patients and their relatives both during the stay and after the patient goes home. They not only fill the memory gap, but can also be a caring intervention to promote holistic nursing. We spoke with one family of a long-stay patient to ask if this facility would have been something they would have used. We explained how it might have been used, such as to record everyday events in their lives to tell the patient about, or let them read when they were well enough. The family said this would have been something they would like to have contributed to, with some encouragement and advice on how to use it effectively. The trust staff told us long-stay patients were offered a Wi-Fi-enabled tablet, could be taken outside for fresh air or to the coffee shop (including patients with a ventilator in use), and had arranged visits home.
- There was a sensitive approach to relatives when a patient might be a possible eligible organ donor. We spoke with the specialist nurse for organ donation (who was part of the critical care team although employed through NHS Blood and Transplant). The critical care team also had a consultant intensivist appointed as the clinical lead for organ donation. The specialist nurse and the medical team were closely involved with families of a patient who had died or was at the end of their life. The specialist nurse was not part of the nursing staff team caring for patients on the unit, so was able to give unrestricted time and support to families and those close to patients who were at the end of their life and considering organ donation. Along with emotional

support from talking and spending time with the families, they had resources such as a kit for making hand or footprints and locks of hair for families to take if they wished.

- There was access to a team of five chaplains and lay volunteers for people of all faiths or none. The team was available in working hours and then on-call 24 hours a day all year round. There was a chapel/prayer room and ablution facilities. All facilities were also available 24 hours a day all year round. The trust described their services as “to support people of all faiths and maintain close contact with faith leaders in the community”. The trust also had a group of 50 volunteers from local churches who ran a weekly service for patients in the chapel on a Sunday evening.

Are critical care services responsive?

Requires improvement



We rated responsiveness as requires improvement because:

- Services did not always meet patients’ needs or best practice. There were bed pressures in the rest of the hospital and too many patients were delayed in their discharge from critical care to a ward. These delays were worse than the national average.
- Some patients were discharged onto wards at night as a bed had become available, when this was recognised as less than optimal for patient’s wellbeing and mortality.
- There was no follow-up clinic provided to patients. Despite research and guidance into the potential poor psychological outcomes for patients in or discharged from critical care, there was limited psychological support for patients or those close to them. A business case for this service was to be submitted to the trust board in 2016.
- The critical care unit facilities did not meet some of the recommendations for modern units, such as little natural light, no separate toilet facilities, no separate entrances for patients and visitors, limited facilities for visitors, including no toilets within the unit. There was a limited amount of printed or web-based information for patients and visitors.
- The unit had a higher level of noise at times.

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- Training in the new priorities of care policies in relation to end of life care had not been completed.

However:

- Critical care responded to, and received support from, the operating theatres' department, which was directly above the unit.
- There was a good timely response from consultants and nurses with new patient admissions. Rotas were organised so all patients should be seen by a consultant within 12 hours of admission.
- There were fewer urgent operations cancelled due to lack of a critical care bed than the national average. There was a much-reduced level of cancelled planned operations, specifically since the provision of two more beds on the unit.
- There was good support from trust staff for patients admitted to the unit with a learning disability or living with dementia.
- There was support for equalities and diversities. There was no discrimination in any aspect of care delivered, or in policies supporting care.

Service planning and delivery to meet the needs of local people

- The service provided by critical care had been located to meet people's needs. It was located to enable staff to respond to emergencies either within critical care or within the emergency operating theatres directly above the unit.
- The critical care was designed over 10 years ago and therefore not built to the current specifications. The unit met some of the recommendations of the Department of Health guidelines for modern critical care units as they related to meeting patient needs and those of their visitors. However, there were some areas where changes could be made to meet or work towards modern standards. Areas which met the recommendations included:
 - Dimmable artificial lights, but also having sufficient strength to enable surgical interventions and response to life-threatening situations at the bedside.
 - Intercom-controlled entry with CCTV in use. There was a secure entrance, which could be opened only by authorised hospital staff.
 - Enclosed storage at the bedside for consumables or medicines, or small amounts of patient property.

- Although they were not in as large an area as recommended, bed spaces were capable of giving reasonable visual and auditory privacy.
- There were some areas relating to the needs of patients and their visitors not meeting the guidelines. These included:
 - There were no gender-separate toilet or bathroom facilities. There was just one patient toilet/shower room located within the entrance door to the clinical area.
 - There was limited natural daylight for bed spaces. The unit was on the ground floor and windows were obscured to maintain privacy for patients, but at the detriment to natural light.
 - There were limited high-backed chairs with adjustable footrests for patients to sit in, and not, as suggested, one for each bed space. The bed spaces were also too small to be able to put a chair at each patient's bed on a permanent basis without obstructing staff.
 - There was only one entrance/exit from the unit. The Department of Health recommended patients and visitors should not share the same entrance and deceased patients should not be transported using the visitors' entrance. All patients, visitors, staff and supplies were using the same entrance.
 - The unit did not have a reception desk or visitor meeting point. There was no natural surveillance of the entrance by staff, although the ward clerk was based at the clinical entrance to the unit.
 - There were no toilet facilities for visitors to the unit, and visitors had to leave the unit to use these facilities.
- There was reasonable provision of facilities for visitors to critical care, although relatives had reported this did not meet their needs. There was a waiting room sited just within the entrance to the unit (outside of the clinical area) for visitors to wait or to enable them to step away if they wanted a break. There was a television, a vending machine and a water cooler, although the water cooler was old and stained with lime scale. We were told the vending machine broke down intermittently and the unit was expecting to receive a new one. There was a relatives' overnight room just beyond the entrance to the unit with sofa beds and a kitchen. When we visited the room, which we were told was used often, there were no relatives staying there that day, but the room was exceptionally cold. This was obviously not a clinical

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area, but the cleaning of the room had been poor. All the pictures and surfaces were much smeared with what looked like cleaning with a very damp cloth. Visitors we met said they thought the facilities were not great if they needed to visit the unit over the long term. One family said staff had found it hard to find somewhere to talk with them in private. We found the quiet meeting room, which was within the unit but away from the main waiting room, was occupied with a family's possessions when we visited and staff were not able to use it. A member of staff therefore had to talk with a visitor in the unit's staff resource room, and were interrupted, as a meeting had been booked for the room.

- There was, in our experience, sometimes a relatively high level of noise when there were many people on the unit and high activity. There were no noise-detecting monitors along the lines of those used in some units where noise had been an issue in the past. An area generally criticised by sedated patients in critical care settings was from noise perception. Research has showed how sedated patients can be affected by noise. The unit's equipment would be an unfamiliar noise, and although alarms could be clearly heard for safety, they were not silenced quickly in a number of cases we heard. One alarm on a pump sounded for just over 10 minutes before being silenced and another for more than five minutes. Loud noise from bin lids had been managed by bins that mostly, but not all, closed quietly. The unit was not helped by having low ceilings and patients' beds (in the main unit area) closer together than recommended distances. This meant staff were always close to other patients when giving care. A former patient of the unit we met said they had found the unit noisy at times, particularly from footfall. Another patient who had been recently admitted to the unit said they did not find they were able to get to sleep due to "alarms constantly going off" and they took a while to be silenced.
- Patients were able to see a clock from their bed to help with orientation. The Department of Health recommended all patients should be able to see a clock. This had been recognised and clocks had been put up around the walls in appropriate places.
- The unit had equipment to meet patients' health needs that could be unrelated to their critical illness or condition. This included, for example, haemodialysis machines to provide treatment for patients with kidney failure, which might be unrelated to their critical illness.

These machines were dual purpose in also providing haemofiltration. Patients therefore needing renal replacement therapy for acute kidney injury were treated on the unit, and not transferred elsewhere for this specialist therapy.

- Patients and visitors were given some, but limited, information about critical care. There was a short leaflet for relatives of patients admitted to the unit, and a folder with information in the waiting room, but nothing further than this for patients or relatives to take home. There was also limited and not entirely accurate information on the trust website page for critical care. The number of beds was updated when we asked for clarification, but the number of consultants, for example, stated six in post, when there were as many as 13. There was no specific information or resources for some situations, such as use of a ventilator, tracheostomy, going home from critical care, and associated possible physical and psychological hurdles the patient and relatives might face. The unit had recently started sending a card to bereaved relatives, but there was no specific bereavement advice or packs for relatives beyond a small booklet. The unit had booklets designed to give to children visiting a patient in critical care.
- Critical care was not providing patients with access to a follow-up clinic led by a consultant intensivist or senior nurse. This service was part of NICE guidance 83 recommendation 1.1.25, and the Faculty of Intensive Care Medicine (FICM) Core Standard 2.16. The FICM stated: "critically ill patients have been shown to have complex physical and psychological problems that can last for a long time. These patients benefit from the multi-modal approach that an ICU follow-up clinic can deliver." The unit had recognised this and placed the lack of this service on the unit's risk register. The action plan alongside the entry was to make a business case in 2016 to provide this service in the near future.

Access and flow

- There were too many patient discharges delayed due to a bed elsewhere in the hospital not being available. Similar to most critical care units in England, data from the Intensive Care National Audit and Research Centre (ICNARC) reported a high level of delayed discharges from critical care. In the last five years, around 70-80% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. That was

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always above (worse than) the national average of around 65%. The trend had, however, reduced of late from around 80% to closer to 70% each quarter. Transfer within four hours was the standard recommended by the Faculty of Intensive Care Medicine Core Standards. Although patients remained well cared for in critical care, when they were medically fit for discharge the unit was not the best place for them. It also could delay patients who needed to be admitted, or meant the unit was always at higher occupancy levels than recommended. The delays were, however, mostly less than 24 hours although some were longer. The rate of delayed discharges had been high for the last five years and at no point had been better than the national or similar-unit average in this period.

- The delayed discharges were reported in detail through the surgical division performance report. The report noted the delayed discharges on a monthly basis. The December 2015 report showed only 11% of patients in critical care had been discharged without delay. Patients delayed between four and six hours accounted for 13% of patients, and those between six and 24 hours accounted for 52%. The remaining 24% were delayed for more than 24 hours.
- The discharge of patients from critical care was not always achieved at the right time for the patient, and the unit was above (worse than) national averages for moving patients at night. 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. Data from ICNARC for April 2014 to September 2015 for discharges made out-of-hours (between 10pm and 7am) showed the unit had been two or three times the national average for night-time discharges for similar units. In the 2014/15 year, the out-of-hours discharges were around 12% of all discharges against a national average of around 6%. At the end of 2014, they had been 18% of all discharges. In the most recent data for July to September 2015, the out-of-hours discharges were around 15% of all discharges against a national average of around 5%. Rates had fluctuated in different quarters but had always been above the national average.
- The critical care unit had some higher occupancy levels compared with recommended levels and national averages. The high occupancy levels were due to a lack of a ward bed into which to move a discharged patient, and, as with the national picture, an increasing demand

for critical care beds. The Royal College of Anaesthetists recommended maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggested a unit was too small, and 80% or more was likely to result in non-clinical transfers that carried associated risks. Detailed occupancy figures for critical care for August 2015 to January 2016 (taken on the fourth Thursday of each month at midnight) showed the rate had been 100% in two of the six months. In the other four months, it did not fall below 80%. The average occupancy was 83.9% against an NHS average for the same six-month period of 82.8%.

- There were fewer operations than average cancelled due to the lack of an available bed in critical care and a much-reduced rate of cancelled planned operations. In data supplied to NHS England, the Royal United Hospital Bath cancelled on average two urgent operations per month due to no critical care bed being available in the six-month period from August 2015 to January 2016. This was against a national average, based on bed numbers, of 3.2 operations per month. None of these operations was cancelled for a second time in this period. There had been hard work to make the case for additional beds and in doing so, reducing the number of high-risk elective operations cancelled. High-risk operations were those where a bed in the critical care unit was needed after the operation. This had reduced from around 60% in 2014 to around 10% in 2016.
- The critical care unit had established what was called a 'hot' bed, although this plan was not working all the time. This 'hot' bed was planned as an emergency bed that was to be kept available and staffed at all times by what was termed an 'admission nurse' to admit an emergency patient. Staff told us the bed was available, in their view, around 50% of the time, but this availability was reduced by the bed not being staffed as either the 'admission nurse' was asked to work on another ward to cover shortages of staff, or needed to work directly with another patient on the unit.
- The hospital bed management/site coordination meetings were now taking into account the bed status within critical care. There were three meetings a day and the early morning meeting at 7:50am reviewed and considered the status of all patients in critical care. Plans for elective surgery were reviewed and either confirmed or changed, with critical care staff able to say if they were able to accept post-operative patients.

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- The hospital was caring for its own patients (as opposed to admitting them from other hospitals). In the ICNARC data for the five years to September 2015 there was just one unplanned patient transferred into the unit from another critical care unit at the end of 2014, and otherwise, before that time, just one in 2010. The rate of planned transfers from other units was mostly below the national average for similar units, although had been just above this in early 2015 and in the most recent period of July to September 2015.
- Patients were staying on the unit for a length of time similar to the national average. Research has found it is sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. The unit submitted data on patients' length of stay to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for intensive care patients). This provided national benchmarking against other units of a similar type and patient group. The length of stay had been below (better than) average in most of the past five years. The average length of stay for all admissions in the three months of July to September 2015 (the most recent ICNARC data) was 4.1 days, compared with the national average of around four days. Over the last five years, the average for the department was just under four days against a national average of just over four days.

Meeting people's individual needs

- There was provision of communication aids to help patients who could not use speech. Staff had pens and paper, low-resistance drawing pads, a laminated alphabet and words, computer tablets (recently introduced) and speech devices for patients with tracheostomies. The service was able to refer patients to a speech and language therapist for additional support.
- The unit was not currently capturing or reporting same-sex occupancy breaches. Due to issues with patient flow on the wards, critical care was rarely able to meet gender separation rules for patients who were fit for discharge, but still within the unit. A patient would strictly breach these rules when they were in a unit occupied by a patient(s) of the opposite gender and the first patient had been declared fit for discharge to a ward. Department of Health guidance recognised it was difficult to fulfil this criterion in units like critical care where emergency and complex care was required. Like many older intensive care units nationally, critical care in the Royal United Hospital Bath had no separate gender toilets or washing facilities. Although the unit had two relatively discrete sides, one that was smaller than the other, there was no protocol to endeavour to locate different genders at either end. This was usually, however, for practical reasons connected to patient acuity, staffing, and safety of the patient. ICNARC data showed there were around 70% to 80% of all patients delayed in their discharge from critical care to a ward bed by at least four hours. This meant the unit (technically) frequently breached the same-sex rules. The trust reported that the mixed-sex policy was under review and would be addressing how and when to report mixed-sex breaches when this review was completed.
- Although recognised among the consultant intensivists for its importance, there was limited support available to patients in critical care with psychological problems or anxieties. There is increasing evidence showing the psychological impact of a critical care admission can be severe. Patients can experience extreme stress and altered states of consciousness. Patients will be exposed to many stressors in critical care. Acute stress in critical care has been shown as one of the strongest risk factors for poor psychological outcomes after intensive care. The National Institute for Health and Care Excellence (NICE) guideline CG83 stated that patients should be assessed during their critical care stay for acute psychological symptoms. There is also evidence that the critical care experience is difficult for families and a critical care psychologist can play a big role in communicating and working with distressed families.
- The services reflected the needs of the local population. There were no apparent barriers to admission due to a patient's age or gender. The average age for patients admitted to critical care was 61 years, which was similar to the national average and had been much the same over the past five years. ICNARC data for the year from April 2014 to March 2015 showed a typical distribution of ages of patients admitted, and the unit, like other similar units, had treated patients in their late 80s and early 90s. Typically, the majority of patients admitted were male (around 53%).
- There was specialist advice requested for the new practices for end of life care although the critical care unit had not yet taken-up the training from the specialist team. They were not therefore fully updated in their

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training with the new priorities of care policies. The unit had a senior nurse in a link role for end of life care, but they had only been in this role for three months. Like most staff, patient care had taken priority and supernumerary time to spend on non-direct care roles had been limited or lost. However, staff referred to the specialist palliative care team when they required support for caring for a patient at the end of their life. Critical care staff also referred to the palliative care team when a patient at the end of their life was moved from critical care to a ward bed in the hospital. In the last year, the team had worked with a multidisciplinary team including the local hospice and the patient's GP, to bring a patient home from critical care. This enabled the patient to end their life in their preferred place of care.

- Staff recognised patients who were admitted to critical care with decisions around resuscitation already made and outlined in their notes. These decisions were observed by staff when the patient was admitted, and noted in ward rounds and nursing handover meetings. Otherwise, staff completed a form in discussion with the patient/family and the multidisciplinary team caring for the patient if this was appropriate.
- Patients were treated without discrimination through staff mandatory training, and policies assessed and approved for equality and diversity. We looked at a number of policies where assessment against equality and diversity was an important aspect to consider. These included safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, resuscitation, and consent. All of these had been ratified for their equality and diversity impact and found to have been drafted in such a way that they did not contain any discrimination on equality grounds. To complement this, almost all staff had completed their equality and diversity training.
- When needed, the hospital trust had facilities to provide translation services. The trust had engaged third-party services providing face-to-face, telephone, and written translation services. The trust also provided services for people who were vision and hearing impaired and used techniques such as Braille and British Sign Language. The trust had a policy for interpretation and translation, which guided staff in deciding whether an interpreter was needed, and how to access services. Staff we talked with said they knew how to access services and had found them easy to reach, timely, and helpful when they had used them with patients and carers.

- There were follow-up letters to the families and loved ones of patients who had gone on to be organ donors, whether the eventual donation had been transplanted or not. These were sent around 10 to 14 days after the donation. Where a transplant had been carried through, the families were given a description of the recipient of the organ. There were also adapted letters for children.
- Staff looked to reduce anxiety for patients and relatives by, as much as possible, doing what they promised to do. A patient and a number of relatives said the staff did those things they promised as much as they could. One example was where a patient said they needed a blood test. They said staff came directly to them and explained what they were going to do and why and “then they got on with it rather than tell me they would be coming over later to do this.” A family of a patient who was due to be discharged said they would not move the patient until there was an appropriate place for them to go. The family said staff had “not got our hopes up just for nothing then to happen.”
- Food and drinks were provided to patients at regular intervals. One patient who was well enough to talk with us said, “There is nothing wrong with the food and the porridge is fantastic.” The patient had some dietary restrictions and said staff had worked hard with the catering staff to find and try different foods to make sure the patient always had something they liked to eat.
- Staff helped to provide some entertainment for patients, although due to the nature of critical care, there were no systems at the patient bedsides to provide this. One patient said staff had brought a television to their bedside to enable them to watch programmes. This patient had been fit for discharge for a number of days and commented how the provision of a television had helped them relax and “feel more like normal life coming back.” The patient did also comment, however, that they were keen to move on to a ward so “there was more going on, and I might get to watch television when I feel like it.”
- There was access to the unit for all patients and visitors. The unit was located on the ground floor of the hospital and accessible by flat access at the main entrance. The doors into the unit, the waiting room and clinical area were wide enough to allow wheelchair access and remained open long enough for people to safely enter and leave the unit.
- There was support to the critical care team from experienced and trained staff when a patient with a

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learning disability was admitted to the unit. There was a hospital liaison team experienced and trained in supporting people with a learning disability. Staff would contact the lead nurses if a patient with a learning disability were admitted to critical care to provide guidance and support. Carers or care workers were also encouraged to stay with the patient when and where possible to provide support. Patients who came to the hospital from a community care setting were asked to bring or produce a 'hospital passport'. This was a recognised document used for people who live with a learning disability, so staff were able to know as much about them as possible. Staff told us about a patient who had been admitted to the unit recently with a learning disability. The family were able to stay with the patient around the clock, in shifts, to provide familiarity and comfort to the patient.

- There was support for patients living with dementia with use of link nurses and a trust lead for dementia care. The link nurse had a folder of information to help staff with strategies and guidance for supporting patients with this illness. Staff said they used the 'This is Me' document. This was a document designed for patients living with dementia, to describe how they normally behaved in certain situations. It was usually produced with the patient and their relatives. Patients could bring a completed document with them, possibly from their stay on a ward, or one produced on the unit. This enabled staff to more accurately know when something might be wrong, and the patient was not behaving as they usually would. This helped specifically, for example, with pain relief and nutrition and hydration management. At the time of our visit there were no patients living with dementia admitted to the unit so we could not review a version of the document in use. However, it was advertised on the staff notice board in the staff rest room.
- The unit had been conducting some research among relatives of patients admitted to the unit about meeting their physical and psychological needs. Questionnaires were collected over a period from September 2015 to January 2016. Twenty-four were returned to the unit, which was a 40% response rate. The preliminary results showed the following:
 - Feeling that the hospital personnel cared about the patient – reported as done “very well”.
 - Having questions answered honestly – reported as done “very well”.

- Being assured the best care possible is being given – reported as done “very well”.
- Need to see the patient frequently – reported as “not at all”.
- Facilities of the department – reported as “not satisfactory”.

Learning from complaints and concerns

- There was active learning from any complaints or concerns. As with many critical care services, there had been very infrequent complaints. No complaints had been received by this unit for more than a year. There was some feedback from a patient that was unclear as to the origin, but was around a perceived lack of confidentiality by the patient. Even though this feedback could have related to another unit, the staff were made aware of the comment and reminded to consider patient confidentiality. Although there had not been complaints to the unit, this was an item at the unit's governance meeting, so any complaints or comments would be brought to that meeting if received, and discussed with the senior team.
- There were leaflets for the hospital's Patient Advice and Liaison Service (PALS) in the visitors' waiting room.

Are critical care services well-led?

Requires improvement



We rated well-led as requires improvement because:

- There had been no matron in post in the unit for 15 months. There had been active recruitment, but no candidate had been appointed in this time. Although there was support, strength and guidance from the clinical lead, the senior sister, and the senior manager providing temporary oversight of the service, the unit was not performing as it should without the guidance of its most senior nursing post.
- There was sometimes a lack of sharing and inclusion both with, and by, the critical care unit and the wider hospital. The unit was not always benefitting from the wider expertise and skills of trust-wide teams and sometimes not inviting these skills into the unit and patient care.
- There was no clear long-term vision and strategy for critical care. There were no actions describing how to achieve performance improvement objectives.

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- There was limited effective use of the risk register. It was not a standing agenda item at governance meetings and not used as a tool to deliver improvement and change.
- There was a poor relationship with the bed management/site team that had not improved despite efforts to resolve internal problems and finding a balance between the unique needs of critical care and other pressures in the hospital.
- There was a disappointing lack of direct general feedback requested and gathered from patients and visitors to use to improve practice.

However:

- There had been noticeable improvement in safety and quality measurement, and governance arrangements, although still areas that could be improved, including the unit's inclusion in the wider directorate. The leadership promoted the delivery of safe patient care. The senior staff in critical care were committed to their patients, their staff and their unit.
- There was good evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC). Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance.
- There had been measureable and valuable innovation and change within the unit following audit, research and investigations into best practice.

Vision and strategy for this service

- There was no written long-term strategy for the unit. We were provided with a business plan on a trust template document, which was to cover the period 2015/16 to 2019/20. This covered only the current strategic plans and therefore focussed predominantly on the increase in bed numbers in 2015/16 and the benefits of this plan. The business plan had gone on to describe what performance and quality indicators it would be working towards. This included objectives around audits, targets for patient discharge (so none out-of-hours and all patients discharged within four hours), bed occupancy targets (so less than 90%), and attendance at governance-related meetings and sessions. There were, however, no strategic plans for how the unit was going to achieve those objectives it currently did not meet.

There were no long-term plans in the document. Although it was a trust-wide template, it did not have sections for any longer-term visions or goals. The document had no indication to say it had been approved at board level and this section was blank.

Governance, risk management and quality measurement

- The unit held multidisciplinary clinical governance meetings every two months, increased in 2015 having previously been quarterly. There was good attendance from the consultants, pharmacists, nursing staff, the outreach nurse, and allied health professionals. However, their roles had not been shown on the attendance list, which would have been best practice. We know from our previous inspection of critical care at the RUH in 2014, there had been a good improvement in the arrangements for governance. Senior staff recognised, however, there were still other areas that should be included, and some room for improvement. There was now a structured format and standard agenda, although this did not follow all activities in a clinical governance framework. The risk register and a review of audits were not standing agenda items, for example. There were, nevertheless, wide-ranging discussions about areas of concern. This included, for example, staffing updates, operational activity and patient flow, safety, serious incidents and infection control. The Intensive Care National Audit and Research Centre (ICNARC) report was on the agenda, but there was no meaningful discussion of this major report in the three sets of minutes we saw from June to December 2015. There was no review of documentation, standard operating procedures, or protocols, which might have picked up how there was a range of these being used within the unit that were significantly out of date.
- There was senior staff input into governance although not yet protected time. There was a consultant intensivist with responsibilities for governance, although they had recently been appointed to this post. The clinical lead for the service had been responsible for governance up until the recent handover, and was able to meet with us to examine and talk through the governance arrangements. There was currently no member of the nursing team responsible for governance arrangements and this was currently the role of the senior sister on the unit who, without a matron in post, was managing many competing priorities.

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- There was sharing of governance with the wider directorate in which critical care sat, but this had only recently been established. The consultant clinical lead for critical care had recently attended the governance meeting for the surgical directorate for the first time, having otherwise not been included within that framework. Critical care had therefore not had a voice within the divisional governance framework from an experienced individual. The lead consultant now planned to attend this meeting on a regular basis in future and represent the issues and risks for the critical care unit. This would also provide an opportunity to share areas of good practice and concerns, as well as new ideas and innovation. We were told the minutes of the critical care governance meeting were otherwise shared with the surgical directorate.
- There was limited effective use of the critical care risk register. The use of the risk register had improved as some recent entries had been added, which addressed some of the issues the unit faced. Discussions with the senior staff and a review of governance meeting minutes confirmed the unit did not have a review of the risk register at the clinical governance meetings. This meant the entries had not been considered by the multidisciplinary team and there had been no input to the content and actions associated with the risks identified.
- Critical care participated in a national database for adult critical care as recommended by the Faculty of Intensive Care Medicine (FICM) Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported the data supplied was well completed and of good quality.
- There was participation in the local Critical Care Operational Delivery Network. As with recommendations from the NHS Commissioning Board, critical care was an active member of the South West Critical Care Network. The FICM Core Standard 2.14 recommended a critical care unit participate in “regular peer review”. There had been some informal visits from the Network to the unit, but as yet, no peer review.
- There had been good work with audits against published standards and recommendations, although not a detailed escalation to the unit’s risk register. Critical care staff had assessed their service against the Guidelines for the Provision of Intensive Care Service in

some detail. The unit had also been assessed against the Department of Health guidance for modern critical care units (Heath Building Note 04-02, 2013). Audit against these guidelines was a recommendation of the FICM Core Standard 3.1 and any non-compliance (of which there was some for the unit) should be included on the risk register. The Core Standard recommended any non-compliance be identified and reported along with an indication of when facilities might comply with HBN 04-02. The unit had reported gaps in the recommendations of HBN 04-02, but only as they related to infection prevention and control. The unit did not escalate the other areas around the physical environment to the risk register or consider how and when facilities might comply with the recommended building standards.

Leadership of service

- There was a significant gap in the unit’s leadership from the lack of a critical care matron, a post that had been vacant for the last 15 months. There had been active recruitment although no candidate had been appointed in this time. One of the team of senior sisters was now managing the unit and the outreach team, but without the support, guidance and mentoring from a critical care trained and experienced matron. The senior sister had not been provided with support or mentoring from one of the other matrons in the hospital to give advice and guidance. The hospital had, however, more recently appointed one of the senior nurse managers to oversee critical care while recruitment to the matron’s post was ongoing. They had relocated their office to the critical care unit to be more available to staff. This senior nurse manager had provided strong and capable support to the critical care team, but openly acknowledged this was not their area of clinical expertise and it was not a role to replace the matron post. The senior manager was also continuing with their other fulltime role at the same time, and although had strong support from their managers, had too many responsibilities and pressures.
- The leadership of critical care by the clinical lead consultant intensivist and the team of experienced medical staff was strong and dedicated. There was a commitment to delivering a safe service and saving lives. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the

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allied health professionals, and commented on how they worked as cohesive and collaborative teams. This was something we witnessed and observed throughout our visit.

- Although depleted both in terms of morale and practically by the long-term absence of a matron, the senior nurse and their team were committed to their staff, their patients and each another. The consultants we spoke with had a high regard and respect for the nursing team, and the allied health professionals. There was clear mutual respect for each other's roles, challenges and talents.

Culture within the service

- There was sometimes a lack of sharing and inclusion both with, and by, the critical care department, that was not helped by the vacant matron's post. None of the critical care staff were invited to attend the infection control meetings, for example. Some of the audits undertaken, such as around screening of MRSA, had not been shared with the senior sister. Other teams, such as the pain team, appeared to give limited input to critical care, as they were not often directly requested to provide support. The pain team came on their own regular ward rounds, rather than being part of a multi-professional approach. There was limited regular input from the speech and language therapy service and limited input from a dietitian. The unit gave an impression of endeavouring to self-manage and although it had highly skilled and experienced staff, it was not benefitting from input of some teams with particular expertise.
- There were facilities for staff to work and rest, although these were limited. In accordance with Department of Health guidance, there were staff offices and changing rooms. Senior nursing staff shared office space but they said they were able to find somewhere for private conversations. There was, however, no doctors' office area and limited areas for the doctors to work in a quiet space. There was a small staff rest room with a kitchen area for staff with access to hot and cold drinks and food storage/preparation areas. Staff facilities were far enough away for them to withdraw into some peace and quiet away from the unit, although they were able to return quickly in case of emergency.
- The culture within the unit and the hospital trust encouraged candour, openness and honesty. It was centred on the patient and delivering the best care.

Those staff we met said they felt supported within the unit to raise concerns or anxieties, although they were disappointed at not getting feedback from reporting incidents. Staff said they would support one another and help their colleagues to raise concerns if needed. All those areas of concern for the leadership of critical care related to delivering safe and quality care. The primary area of concern with all the senior leadership was with staffing levels and how the lack of senior nursing management, and supernumerary and supervisory support, was harming the morale and goodwill of the small but committed nursing staff team.

- The staff on the unit felt well supported and a group of the junior staff we met (both nurses and healthcare assistants) all told us they felt part of a team and strong culture.
- There was a continuing poor relationship between senior staff in critical care and the bed management/site team that, despite efforts, had not been resolved. The trust between the teams was described by the critical care staff as "broken" and there was a "lack of understanding" of critical care pressures by the site team. The critical care staff said they understood the pressures on the site team to provide safe staffing levels, but the discussions between staff about releasing critical care staff to work elsewhere had been unfriendly and fractured. There were a number of incidents reported along these lines. The teams had an away day in early 2015 to try to develop an empathy and understanding of each other's position, but this had not shown real improvements.

Public engagement

- There was a disappointing lack of direct general feedback requested from patients and their families, although the unit had invited feedback from patients and relatives on specific subjects. A more systematic way of learning people's views, opinions or experiences had not been established. People's views were otherwise gathered through compliments, cards and letters to the services. Staff were confident that should any complaints or negative comments be received (which were rare), these would be discussed and, where possible, learning and actions taken.
- There was some information for visitors in the waiting room of the unit, although information about the unit was limited to a leaflet and brochure from a support group for intensive care.

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- The specialist nurses for organ donation had participated in promotion of this important area of medicine in the wider community. There were meetings with local Women's Institute groups, presentations to GP practices, work with local black, Asian, and minority ethnic (BAME) groups, promotion with hospital staff, and there was work underway to establish a permanent piece of artwork at the hospital celebrating organ donation.

Staff engagement







- There was good use of a message board in the staff room. The board included the 'message of the month' (which was related to the education theme of the current month) and 'message of the week' (which was related to documents for patients who had died on the unit, and also confidential waste disposal). There was information about Duty of Candour, the hospital safeguarding team and a further noticeboard with more detailed information. This included a reminder for staff about professional revalidation, pressure ulcer key messages, study days, and information about caring for people with a learning disability or living with dementia.
- The absence of a matron, coupled with staffing and bed pressures, had limited the time for regular team meetings on the unit, but these were now happening more frequently. We saw minutes from a meeting of the senior staff team in September 2015, which included the senior and junior sisters and staff in the critical care outreach service. There was a unit meeting in September and November 2015 with a wider group of staff.
- There was a newsletter produced and provided quarterly for critical care staff. We had one example of this from October 2015, but it was a detailed and wide-ranging document produced by the medical and nursing lead and the senior manager. Topics included changes to staff, and welcoming new staff to the team. There was an update on the introduction of a new renal replacement therapy, and learning points from the rollout of the new procedure. There were updates on other new equipment and procedures, outcome data, and administrative matters.

- There had been some great titles devised for training and education programmes on the unit to engage and remind staff of the various programmes. This included 'Delirium December' (about the introduction of delirium screening), 'Zap the VAP' (about improvement to ventilator-associated pneumonia), 'Value the Volume' (about a change in ventilator strategy), and 'Tracheosto-May' (training in management of tracheostomy emergencies).

Innovation, improvement and sustainability

- There was research, innovation and change within the service. This included:
 - Critical care had converted to a new renal replacement therapy protocol in line with international recommendations. This meant patients with upper gastro-intestinal and post-operative bleeding could now be treated safely on the unit. The new system had a prolonged filter life and this reduced patient blood loss in filter sets and reduced patient bleeding.
 - The unit had also introduced the use of nasal high-flow cannula, which avoided ventilation for a number of patients and improved respiratory care for those who had been taken off ventilation.
 - There had been introduction of a process for management of atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). This included guidance for the use of anticoagulation following discovery of an appreciable stroke risk in this condition. This was the first process of its kind in use in the South West and followed a review of literature and journal club discussions (a review by doctors of specific articles and research).
 - The critical care unit was one of the only units in the South West to use cerebral bispectral index monitors routinely in patients undergoing neuromuscular blockades. This was a method for determining the risk of accidental awareness of patients under anaesthesia. This had been introduced prior to a national report supporting this process, and highlighting how this condition was a high risk for patients in critical care.

Maternity and gynaecology

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

Information about the service

The Royal United Hospitals NHS trust maternity services provided a range of antenatal, intrapartum and postnatal care in the Royal United Hospital and within local community settings in Bath, Wiltshire and Somerset. The provision of maternity and gynaecology services were managed within the women and children's division of the trust.

At the Royal United Hospital, consultant led care was provided for women assessed as having low and high risk needs, on the Princess Anne wing. Midwifery led care, for those women assessed as having low risk was provided in the hospital and at five units located in Trowbridge, Chippenham, Paulton, Frome and Shepton Mallet. A separate report has been written for these services. Women assessed as low risk also had the option of a home birth.

On the central delivery suite in the Princess Anne wing, there were nine delivery rooms all of which has en suite facilities and two birth pools. There were three operating theatres on the unit specifically for maternity and gynaecology patients, with an anaesthetic room and a recovery area. At the time of our inspection, only two of the theatres were in use, the third required maintenance works.

There was a maternity day assessment area, early pregnancy service, emergency gynaecology unit and fetal medicine unit all with consultation and assessment rooms and ultrasound services. These enabled prompt

gynaecology investigations and pregnancies to be monitored, screening tests to be completed and potential problems diagnosed. These services were accessed on an outpatient basis.

There was a 40 bed combined antenatal/postnatal ward (Mary) for patients who required ongoing monitoring, treatment and support. This had eight single rooms, six with en suite facilities, a day room and kitchenette area for patients and relatives to access hot and cold drinks and snacks. There were eight, four bedded bays with shared bathroom facilities. The ward allocated 10 beds to antenatal patients and 30 to postnatal patients.

Between June 2014 and March 2015 there had been 3,110 births at the Princess Anne wing. Between April 2015 to February 2016 there had been 3,512 births. This rate of births per month during this period ranged between 290 and 357.

The gynaecology services included: general, specialist and emergency gynaecology, urogynaecology (pelvic floor disorders), fertility, menopause, endometriosis, colposcopy, and gynaecological oncology. The majority of patients undergoing elective gynaecological procedures had these completed during outpatient clinics or as a day case. Women requiring inpatient care for gynaecological or early pregnancy care were admitted to Charlotte Ward, a 22 bedded female only unit. On the ward ten of the beds were allocated specifically for gynaecology inpatients and the remainder for general medical patients. Charlotte ward had a communal day room, six single rooms, two of which were en suite. There were four, four-bedded bays which shared bathroom facilities.

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A termination of pregnancy service was provided. Medical terminations were undertaken up to nine weeks of pregnancy and surgical terminations were provided between nine and 12 weeks of pregnancy. Terminations required beyond these gestation dates were referred to an alternative specialist service.

During our inspection we spoke with nine patients, two relatives and 37 staff working throughout the gynaecology and maternity services at the Royal United Hospital. These included the clinical and management leads for the women and children's directorate, consultant obstetricians, gynaecologists and anaesthetists, registrars, senior house officers, sonographers, the senior matron for midwifery, lead nurses and midwives for gynaecology and maternity inpatients, specialist nurses for gynaecology, physiotherapy staff, lead midwives for screening, safeguarding and risk management, labour ward managers, midwives, nurses, health care support workers, maternity support workers, and ward clerks. We held a number of focus groups and meetings, which were attended by a total of 15 midwives.

We observed a multidisciplinary staff handover for the maternity and gynaecology services. We reviewed 12 sets of patient records. Before, during, and after our inspection we reviewed the trust's performance information.

Summary of findings

Overall, we rated the service as good because:

- There were effective safeguarding processes in place. Staff were knowledgeable about safeguarding, understood their responsibilities and had access to support.
- There were effective incident reporting processes, which staff understood and confirmed they received feedback for learning.
- Staff cared for pregnant women before, during and after birth with kindness, compassion, dignity and respect.
- Patients told us they felt involved with their care, had their wishes respected and understood.
- Systems were in place to support access and flow around the maternity services.
- There was evidence of personalised care provided to gynaecology and maternity patients and their relatives. This included gynaecology patients with memory loss conditions who had additional care and support needs.
- There were thorough risk management and governance structures and processes in place. These linked risk and governance meetings at both departmental and trust level. This produced an effective flow of information from ward to board and vice versa.
- The gynaecology and maternity services had an annual audit programme and evidence of learning and improving practice as a result of audits.
- Gynaecology cancer patients received appropriate care, which followed national standards and guidance.
- There was evidence of good clinical outcomes for maternity and gynaecology patients.
- There was evidence to show risk and quality measures were interrogated for service improvements and responsive actions were taken.
- There were systems to share information and learning.
- A positive and proactive culture was evident.

However, some improvements were needed:

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- There were staff trained to provide specialist bereavement care for maternity and gynaecology patients experiencing loss, and to advise other staff who required specialist support in this sensitive area. However, not all staff were familiar with these roles
- The two designated areas identified to care for bereaved women and their families lacked privacy, space and facilities.
- Improvements were required in records to demonstrate decisions relating to maternity care being midwifery or consultant led.
- Improvements were required in records to demonstrate that one to one care was provided to women in established labour 100% of the time.
- Improvements were required on the standards of cleaning in the maternity services. Improved documentation was required to identify what areas of equipment had been cleaned, by whom and when deep cleans were required

Are maternity and gynaecology services safe?

Requires improvement



Overall, we have judged safety as requires improvement because:

- Improvements were required in the standards of cleaning to prevent the risks and spread of infections in the maternity services. There were a lack of consistent records which identified what areas and equipment had been cleaned, by whom or when a deep clean was required.
- Evidence was not available to show all equipment on the delivery suite had been reviewed, serviced and checked as required.
- Written evidence in records was required to identify if maternity care should be midwife or consultant lead.
- Improvements were required in records to demonstrate that one to one care was provided to women in established labour 100% of the time.

However:

- There were effective incident reporting processes, which staff understood and confirmed they received feedback for learning.
- There was evidence Duty of Candour regulations were understood and followed.
- There was a low rate of avoidable patient harms on the maternity and gynaecology wards.
- Women had individual risks assessed and these were regularly reviewed during any consultations with staff.
- There were effective safeguarding processes in place. Staff were knowledgeable about safeguarding, understood their responsibilities and had access to support.
- There were systems in place to assess and support patients with perinatal mental health issues.

Incidents

- The maternity and gynaecology services maintained a joint incident database. Each entry provided a detailed summary of the incident and immediate actions taken to minimise risks to patients. This included the number of near misses which were events which may have

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caused patient harm if issues had not been averted by staff. Improvement actions were identified and recorded following the completion of investigations. These included how learning from incidents took place, and any required policy updates. Records dated November and December 2015 showed how this information was to be shared with relevant staff, such as through other meetings and newsletters.

- There was a consistent level of incident reporting by staff with the majority assessed as causing no harm or low patient harm. Between February 2015 to January 2016, 1,480 incidents had been reported of which 90% related to maternity and 10% to gynaecology. Analysis of incidents revealed the majority of the maternity incidents occurred during labour when care was least predictable. The majority, 98% (1,450) were assessed as having low impact or no patient harm. The remaining 2% (30) were assessed as causing moderate harm.
- All the maternity clinical staff we spoke with demonstrated a clear understanding of the types of issues that should be recorded as incidents. This included possible problems associated with birth such as shoulder dystocia, post-partum haemorrhage and perineal tears.
- All the gynaecology clinical staff we spoke with understood the processes to follow to report incidents and gave examples of types of incidents they would report. These included medication errors, slips, trips and falls and delayed or failed treatments or procedures. Senior staff told us they were aware reporting within the gynaecology services was not being completed as proactively compared to the maternity service. This had been specifically identified with regard to near misses. This was being addressed through various meetings, safety updates and staff newsletters.
- All staff we spoke with confirmed they were actively encouraged to report incidents and received feedback for incidents they had reported if they caused moderate harm or impact or above. Feedback was provided on a one to one basis and through service wide emails and meetings. We looked at a selection of meeting minutes. These reported incidents as standing agenda items. This included the rates and types of incidents, changes to policy and specific learning. Themes and learning from incidents were also reported at each staff shift handover.
- Records showed serious incidents had been reviewed following a root cause analysis (RCA) process. Between

February 2015 and January 2016 there had been four gynaecology and six maternity serious incidents. In addition, since January 2015 the maternity service contributed to the national quality improvement programme 'Each Baby Counts' (2015) Royal College of Obstetricians and Gynaecologists. All serious obstetric incidents were submitted to the national programme for review.

- We reviewed the investigation report (RCA) for two serious incidents, one for gynaecology and one for the maternity services. The incidents had been fully reviewed and investigated. The RCA reports included other contributing factors, care and service delivery issues and potential causes of the incidents. Action plans were put in place to reduce recurrence of similar incidents and further patient harm. The results of the investigations were shared with the staff, as a means of learning from events. We reviewed other records and meeting minutes, including governance and senior staff meeting minutes and saw serious incident information and actions were discussed.
- Perinatal mortality and morbidity (M&M) meetings were held every month. Complex patient cases or those which had resulted in a serious incident were reviewed for learning and improvements to practice. We reviewed the meeting minutes dated September, October and November 2015. The attendance list for these meetings showed a range of staff were present. For example, obstetric, paediatric and gynaecology consultants and registrars, midwives, the divisional patient safety manager, clinical governance coordinator and midwife lead for research.
- Minutes recorded summaries of each patient's history including clinical observations and test results. Detailed discussions were recorded which showed incidents were reviewed for future patient safety and clinical improvements and staff learning. There were systems to escalate mortality and morbidity information to the board and other relevant clinicians. We saw in other meeting minutes that mortality and morbidity summaries, actions and learning were discussed.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation which was introduced during November 2014. This regulation requires the trust to notify the

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relevant person that an unintended or unexpected incident has occurred. The trust should provide reasonable support to the relevant person in relation to the incident and offer an apology.

- Staff we met in maternity and gynaecology services demonstrated an understanding of duty of candour. All staff were clear regarding their roles and responsibilities when patient treatment or care had gone wrong or had not been satisfactory. One senior midwife we spoke with explained the trust approach to the duty of candour and gave examples of the processes they had followed when an incident had occurred. Posters were seen in staff areas explaining the duty of Candour responsibilities.
- We saw evidence of duty of candour requirements documented in mortality and morbidity meeting minutes. For example, in the minutes dated October 2015 a patient identified as living with a long term health condition should have received six hourly monitoring. This had not been consistently achieved which may have contributed to an obstetric complication. The meeting minutes documented a follow up appointment was provided for the patient. During this a consultant shared this information in full with the patient who was also offered an apology.
- There was evidence systems had been put in place to promote compliance with duty of candour regulations within the maternity and gynaecology services. The divisional governance meeting minutes dated December 2015 documented a presentation by the trusts leads for duty of candour and for risk and assurance. The regulations and responsibilities had been reviewed and discussed within the multidisciplinary meeting. Serious incidents had been reviewed for compliance with the duty of candour regulations. These processes established appropriate actions had been taken but were not always documented. Actions were put in place to improve this. This included allocating a lead person to be responsible for the duty of candour regulations for each serious incident.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care and involves a monthly snapshot audit. Patients staying on Mary (maternity) or Charlotte (gynaecology) wards had a low risk of experiencing an avoidable harm or contracting an infection. Both wards

collected patient safety information through the incident reporting system. This included: falls, venous thromboembolism (VTE), hospital acquired infections including urinary tract infections with a catheter and pressure sores. From February 2015 to February 2016 Mary ward reported no harms under these categories. Charlotte ward reported a low rate of avoidable harm affecting 6% of patients (17 out of 278).

- Other specific maternity safety thermometer information was recorded on a monthly maternity review (dashboard) in line with national recommendations (RCOG, 2014). This included rates of unexpected neonatal admissions to the neonatal intensive care unit and complications occurring during birth and surgery (summarised in Effective/Patient outcomes).

Cleanliness, infection control and hygiene

- Most of the ward and clinical areas in the maternity and gynaecology services appeared visibly clean. However, this was inconsistent on the delivery suite and Mary Ward. We spoke with staff who told us rooms were cleaned immediately after a patient left in order to be ready for the next admission. Cleaning schedules were not routinely documented to identify what areas and equipment had been cleaned, by whom or when a deep clean was required. We saw stickers on some equipment such as blood pressure (BP) monitors and cardiotocographs (equipment used for monitoring the fetal heart rate) to indicate they were clean and ready for use. However, we observed a BP monitor which was dusty and another which had a sticker on one side dated 11 January 2016 and a sticker on the front dated 16 March 2016. Some stickers were not renewed during our inspection showing that equipment which should have been cleaned after every patient use had not been decontaminated since the first day of the inspection. Some bins did not have lids and others had rusted insides, a bathroom light pull cord was dirty (room 9) and not all curtains had the replacement dates recorded. There were areas of floor and skirting board that were chipped, some of which were covered with tape. On damaged and exposed surfaces, debris and dirt collected and rusted equipment could not be cleaned effectively.
- The trust provided data recording weekly and monthly cleaning audits for the maternity and gynaecology services. It was not clear from these

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records which equipment or areas had been included in the audits. We reviewed this information dated May 2015 to December 2015. The monthly audits had been completed on Charlotte and Mary wards and the antenatal area. Weekly cleaning audits had been completed for most weeks on the delivery suite (no audit information available for four occasions) In all areas the trusts cleaning compliance target was 95%. On Mary Ward this was achieved on six out of ten months (not achieved rates ranged between 85% and 94%). On Charlotte ward the cleaning target was not met on seven of the 11 audits completed (not achieved rates ranged between 84% and 94%). In the antenatal area, the cleaning target was not achieved for eight of the ten audits (not achieved rates ranged between 89% and 94%). On the delivery suite, the weekly cleaning compliance target was 98%. Whilst this was not achieved for 20 of the 28 cleaning audits, most of the audits were scored slightly below, between 96% and 97%. Action plans included increased audit to improve standards.

- There was a low (small) risk of patients contracting a hospital acquired infection on the gynaecology (Charlotte) and ante/postnatal (Mary) ward. We reviewed information from January 2015 to 03 January 2016. During this time there had been two incidents of *Clostridium difficile* (Cdiff) and one of *E.coli*. There had been no incidents of methicillin-resistant *Staphylococcus aureus* (MRSA) or methicillin-susceptible *Staphylococcus aureus* (MSSA).
- Staff hand hygiene audits were completed every month on Charlotte (gynaecology) and Mary (ante/postnatal) wards, the antenatal clinic areas and delivery suite. Between January 2015 and November 2015, hand hygiene was recorded as between 96% and 100% compliant. There was one episode when hand hygiene standards dipped to 91% on Charlotte ward. Staff were reminded and prompted and audits increased to weekly until compliance levels increased. This was recorded as 100% achieved in the following weeks.
- Antibacterial hand cleaner was available in clinical areas. We saw staff were bare below the elbow in order to completed effective hand washing. We observed visitors were prompted to use hand sanitiser when entering clinical areas.

Environment and equipment

- The delivery suite environment was well organised, with equipment stored appropriately. All areas on the delivery suite were appropriate for use.
- The maternity day assessment area was cramped and cluttered with some resources and equipment stored on the floor. One area was used by midwives for the initial patient maternity booking. This area lacked privacy.
- Improvements were required on the delivery suite to maintain the safety of patients. The delivery suite and ante/postnatal ward (Mary) were either locked or accessible with a swipe card for staff or controlled by a remote system for admitting patients and visitors. In these areas, CCTV was used by ward clerks, clinical and security staff to monitor unauthorised access to the delivery suite and wards. Baby alarm tags were not used but staff were familiar with the trusts abduction policy. However, we saw visitors were able to freely exit the delivery suite without the need to speak with staff.
- The central delivery suite, ante and postnatal wards and the obstetric theatres all had adult and baby emergency resuscitation equipment. These were accessible and appropriately stocked. Records showed that the equipment was regularly checked in accordance with trust policy.
- The trust told us they had enough equipment on the delivery suite. There were six cardiotocograph machines shared between nine delivery rooms and there were four sonicaids. Both of these forms of equipment were used to monitor the fetal heart rate. Staff told us there had been an agreement by the trust to purchase a further 10 sonicaids. Since our inspection, the trust confirmed the additional sonicaids had been received.
- Appropriate processes were followed to ensure the ultrasound machines were safe and working effectively. The standards for the provision of an ultrasound service (p11, the Royal College of Radiologists) states equipment should be reviewed between 4-6 years of age. The review should also include whether the machines remain up to date with the latest technology. Based on these findings a decision should be made to either continue with the equipment or replace. Risk assessments had been completed and two ultrasound machines had been replaced with new during April 2016..
- One of the three dedicated maternity/gynaecology theatres had been decommissioned due to maintenance works required on the air flow system. The

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two theatres were used for planned (elective) and emergency surgery. At the time of our inspection we were told funding for this work had just been approved and was due to start during August 2016.

- There were two rooms on labour ward with birthing pools. In the event of an emergency, a net would be used to evacuate the patient from the pool. We were informed staff had been trained to use the net. However, those staff we spoke with were not clear about this procedure.
- In one of the rooms with a birthing pool there was insufficient space to put a bed beside the pool to move the patient onto. The patient would have to be placed onto the floor. This presented a potential risk as it would be difficult for staff to provide effective care, and uncomfortable and undignified for the patient.
- Records were available which showed of a range of equipment checks were in date and completed. This included: a neonatal trolley and resuscitaires, temperature monitors and infusion pumps (to deliver fluids and medicines). However, in two of the delivery rooms (eight and nine) the nitrous oxide (Entonox), oxygen and suction systems were dated as last checked during 2014. Staff told us all equipment in the delivery rooms was checked every day but there was no written evidence to confirm this.

Medicines

- Medicines and controlled drugs were stored safely. In the maternity theatres and other clinical areas on the delivery suite, we observed medicines in appropriately locked cupboards, and secured within the resuscitation trolleys.
- Midwives and nurses told us they had adequate stocks of medicines and no issues with the pharmacy services.
- Oxygen and nitrous oxide (used for pain relief) was piped into delivery rooms. Records showed the maintenance of these gases was reviewed and monitored. Stronger analgesia was available if patients required it.
- Medicines that required storage at low temperatures were kept in dedicated fridges in locked rooms accessible only by staff. Records were available to show controlled medicines had been appropriately checked. Records showed fridge temperatures had been checked most days.

Records

- Gynaecology and midwifery medical records and other confidential patient information were stored safely in lockable record trolleys in most areas. On Charlotte (gynaecology) ward we observed three record trolleys along the main corridor, outside patient bays were left unlocked. Whilst staff freely moved around the ward and corridor area, so did patients and visitors. Therefore, there was a risk data protection may have been compromised.
- When maternity medical records were not required, they were stored in a central office, which was locked when not staffed. Otherwise, the trolleys and office were accessible to all authorised staff who required access to them. Staff told us this ensured they had medical records in a timely way for clinical interactions with patients.
- We reviewed 12 maternity and gynaecology patient records and the maternity safeguarding files. Documentation showed referrals to other professions or services had been made where necessary and information shared appropriately.
- The way patient records were used and organised enabled clinicians to access relevant information to review care. Pregnant women had hand held records (a file of all the information related to their pregnancy) which was started at their initial booking of ante-natal care. These were maintained by maternity staff through to completion of post-natal care. We saw individual risk assessments were completed and regularly reviewed. Risks were recorded as having been discussed with patients.
- There were systems ensuring the legal requirements relating to a termination of pregnancy were documented in records. Processes were followed which ensured records were properly completed and information forwarded as required to the Department of Health in a timely way.

Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. Staff demonstrated an understanding of what kind of issues might alert them to consider possible safeguarding issues, and what they could do to respond to the patient in a safe and supportive manner. We looked at patient assessments in records which included prompt questions related to potential patient

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vulnerabilities. Where concerns had been identified, appropriate referrals had been made and these were fully documented. The lead midwife for safeguarding was responsible for updating information as required.

- Systems were in place to assess and provide appropriate support for mental health issues as part of antenatal, perinatal and post-natal care. There was a lead midwife for mental health needs, and all the midwives working in the boundaries of Wiltshire had completed specialist perinatal mental health training. The benefits of the Wiltshire perinatal pathway were being reviewed with a view to being adopted in the Bath and North East Somerset locality.
- There was good compliance with mandatory safeguarding training. Staff attended one of three levels of mandatory safeguarding children and vulnerable adults training, dependent upon their role. All midwives were trained to level three and the midwifery support workers to level two. Compliance with training was 92% for these staff groups. Other records provided by the trust showed the overall compliance within the division for in date safeguarding children and vulnerable adults training was 87%. This included medical and gynaecology staff. This was slightly below the trusts target of 90%.
- Systems were in place to effectively support staff with safeguarding issues and concerns. The lead midwife for safeguarding was trained to an advanced level four. This person had a link role with the other key agencies such as the local authority and police and provided advice to others when required. In addition, 11 midwives had been trained by the local clinical commissioning group (CCG) to provide safeguarding supervision and support to staff.
- Systems were in place to learn from and share good practice related to safeguarding issues. A maternity safeguarding committee met on a monthly basis. This was chaired by the senior matron and attended by all band seven midwives from the community, ward (Mary) and delivery suite. The lead midwife for safeguarding also attended a professional network meeting chaired by the designated lead nurse for the local clinical commissioning group (CCG). The purpose of these meetings was to review and discuss new policies and serious case reviews and share best practice and learning.

Mandatory training

- There was variable compliance to a range of staff mandatory training, which included annual updates. This included conflict resolution, infection control, fire safety, equity and diversity, information governance, manual handling, the Mental Capacity Act and Deprivation of Liberty Safeguards. Records dated February 2016 showed compliance ranged from 78% to 99%, against the trusts target of 90%. Senior staff said mandatory training was being promoted through meetings and newsletters.
- Maternity staff attended additional mandatory skills and drills 'PROMPT' training (practical obstetric multi-professional training). This was multidisciplinary and included the use of a simulation model used to recreate emergency scenarios. Records showed 76% of midwives, 68% of midwifery support workers, and 58% of obstetric doctors had in date training. This was below the expected 90% compliance rate.
- Midwives completed annual updates of the UK Resuscitation Council Neonatal Advanced Life Support training. Records showed 82% of midwives had in date training.
- We spoke with senior staff regarding the compliance levels of the additional maternity mandatory training. We were told during the year a number of senior midwifery posts needed to be covered due to retirements, this was compounded further by sickness. Doctors and midwives had been booked to attend update training sessions but then called off as clinical care and emergencies had been prioritised. Staff were confident as vacancies were filled, mandatory training compliance levels would increase.

Assessing and responding to patient risk

- The delivery suite was consultant led and able to support women with high risk pregnancies and/or complex health. Appropriate experienced and skilled staff were available at all times to respond to acute, severe and unpredictable obstetric emergencies. Anaesthetic and obstetric medical staff were available 24 hours a day, seven days per week. Midwives who cared for women assessed as having low risks, referred to consultants immediately if a patients was assessed as giving any cause for concern.
- All pregnant women had comprehensive risk assessments that started at their first appointment. This included screening for pre-eclampsia, gestational diabetes, venous thromboembolism, and other medical

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conditions. Other risk factors were assessed and discussed with women including: previous obstetric history, family medical history, social issues, and screening for domestic abuse and mental health. Risk assessments and action plans were reviewed with every subsequent contact with a doctor or midwife.

- There was a lack of documentation within maternity records to clearly identify if patients required midwifery or consultant led care. Six of the 12 records we reviewed were maternity records; patient hand held records and the trusts IT system (Millenium). These showed each patient had individual risk assessments completed and action plans put in place. However, there was no clear evidence to identify if care should be midwifery or consultant led. Staff we spoke with said the process was confusing and reliant upon repeat checking of information; with the patient, colleagues, assessments and records.
- There were various emergency 'grab boxes' available on the delivery suite. These contained essential equipment and medicines to treat and manage specific obstetric conditions. For example, for pre-eclampsia and post-partum haemorrhage. There was adult and baby resuscitation equipment on the delivery suite and on the ante/postnatal ward. Records showed this equipment was regularly checked.
- We observed 'fresh eyes' stickers had been signed to confirm cardiocotograph (equipment used for fetal heart monitoring) recordings and findings had been double checked by a second midwife. These actions ensured any additional concerns or actions required could be promptly responded to.
- There were systems to ensure clinical information on patients was updated. The delivery suite coordinators maintained regular review of the complexity of patients on the delivery suite and linked this with appropriate staffing levels. This enabled staff to have oversight of changeable patient risks and priorities.
- There were processes in place to keep staff informed about safety issues. Daily staff safety briefings were conducted on the gynaecology ward (Charlotte), delivery suite and ante/postnatal ward (Mary). This ensured staff were aware of potential or emerging risks. We looked at records which showed a range of issues were reviewed and actions taken. For example, patient acuity (level of need), equipment, security issues, safeguarding issues and theatre activity and cover.
- The maternity staff were routinely notified of any risk issues requiring immediate attention through a 'Risk Management Newsflash' which was emailed to all staff and put on staff notice boards. In addition a quarterly newsletter was sent to all staff summarising all recent safety issues. We reviewed the most recent editions dated winter 2016. This discussed safety information relating to incidents, records and communication.
- All the maternity staff practiced emergency skills training which was often based on previous clinical experiences and issues. Staff were familiar with guidelines for the management of conditions such as cord prolapse and post-partum haemorrhage.
- Patients with high care needs or unpredictable risks were given a room close to the staff reception area. This was where the anaesthetists were based when not providing clinical care and also where the emergency equipment was stored.
- There were processes and equipment for safe care or transfer of newborn babies requiring additional or specialist support. A paediatric registrar was based on the ante/postnatal ward (Mary) from 8.30am to 5pm, on Monday to Friday. Out of hours this person was based on the neonatal intensive care unit (NICU), and was contactable by bleep. The NICU was situated close to the delivery suite. Maternity staff confirmed paediatric staff were available within minutes if required.
- There were processes to treat and admit emergency patients. There was a maternity day assessment unit, and early pregnancy and emergency gynaecology service which was used to assess patient risks. If required, emergency maternity or gynaecology patients were admitted directly wards. Gynaecology patients who attended the trust's emergency department were also transferred to Charlotte ward where possible.
- Systems were in place to monitor the use of, and accuracy of recording, of patient early warning (deterioration) assessments. Maternity patients admitted to Mary ward had Maternity Early Warning (MEOW) assessments completed. Gynaecology patients admitted to Charlotte ward had National Early Warning Score (NEWS) assessments completed. A retrospective audit of 50 maternity patient records and the use of MEOWs was completed during January 2016. This showed 90% compliance with these risk assessments. The frequency and accuracy of use of NEWS was monitored every month. We reviewed records dated July 2015 to December 2015. These showed the

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completion of NEWS ranged from 77% to 97%. Of these, between 81% and 98% had been completed accurately. Records showed a staff training programme had been implemented to improve the compliance and accuracy.

- We observed how maternity staff responded to a potential emergency situation in response to a patient collapse. It was quickly established the patient had fainted. However, we observed an immediate multidisciplinary staff response to the emergency call. Dignity curtains were placed around the patient, and emergency equipment was on hand. All staff acted with calm and purpose.

Midwifery staffing

- There was sufficient midwifery and other staffing to support the safe care of maternity patients at the Royal United Hospital and within community settings. There were 143.4 whole time equivalent (WTE) midwifery posts. The trust followed the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. This recommended a midwife to patient ratio of 1:28 for safe capacity to achieve one-to-one care in labour. The ratio at the Royal United Hospital was slightly higher than this. Between April 2015 and February 2016, ratio was between 1:35 and 1:29. The higher ratio had been due to a combination of sickness and retirements. Recruitment was ongoing to fill vacancies.
- Shortfalls in midwifery staffing were covered from part time substantive midwives temporarily increasing their hours. If staffing issues were not resolved this way, the maternity escalation policy was followed. This required the community and ward midwives, and if required, the specialist midwives to be redeployed to fill any staffing gaps. No maternity agency staff had been used.
- Improvements were required to capture evidence that one to one care was provided to women in established labour 100% of the time. The data recording system used did not distinguish between antenatal, intrapartum or antenatal care. This made it difficult to establish ratios during established labour and required cross checking with other records. It was the responsibility of midwives to record any lack of one to one care as an incident. A review of incident Information dated November 2015 to March 2016 showed one to one

care in labour had been provided between 90% and 97% of the time. A review of the midwifery management files suggested this was in part as a result of reporting errors as opposed to lack of midwives.

Medical staffing

- There were 7.5 WTE obstetric consultant staff who provided 45 hours of cover per week. This did not comply with Royal College of Obstetricians and Gynaecologists (Towards Safer Childbirth, 2007) recommendations on staffing for a unit of this size. Between June 2014 and March 2015 there had been 3,110 births at the Princess Anne wing, at the Royal United Hospital. Between April 2015 and February 2016 there had been 3,512 births. The rate of births per month during this period ranged between 290 and 349. However, the trust confirmed that the consultant obstetrician hours were to be increased to 60 hours per week from August 2016.
- There were sufficient anaesthetic and gynaecology medical staff to provide surgical and clinical support to the maternity and gynaecology services at all times. This was managed through a dedicated on call rota. The midwifery and junior medical staff confirmed the obstetric consultants were consistently supportive and responsive the needs of patients, attending the delivery suite during out of hours whenever required. Consultants lived within half an hour or 10 mile radius of the hospital.

Other staffing

- Senior staff said there were sufficient staff employed in roles which supported the midwifery and gynaecology services. These included sonographers (employed by the radiology department), ward clerks, and care assistants and maternity support workers. There were 46 WTE support workers working trust wide ranging from band two to band four.
- There was sufficient numbers of gynaecology staff and skill mix on the gynaecology ward (Charlotte). There were 11.8 WTE support workers and 24.7 WTE qualified staff to support patients in the 10 allocated gynaecology beds.
- Senior staff on Charlotte ward confirmed the physiotherapy team (managed elsewhere) provided a responsive service to gynaecology patients.
- Other specialist staff were available to provide direct patient care and support for colleagues. Medical

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patients were regularly placed on the gynaecology ward (Charlotte). A medical consultant did a ward round twice per week. In addition, two doctors were based on Charlotte ward between 8am and 5pm, Monday to Friday. Out of hours support for medical patients was provided through the medical on call system.

- Dedicated theatre staff from the surgical division was available to the maternity services at all times.
- The antenatal/postnatal ward (Mary) also had access to a number of volunteers, who supported staff. Some of the volunteers had been specifically trained to offer breast feeding support. In addition the ward facilitated learning placements for trainee nannies who were completing degree courses. We spoke to senior staff who told us they had been providing a rolling programme of placements for approximately 10 years. The nannies assisted maternity staff with the provision of care and support.

Major incident awareness and training

- Senior staff demonstrated awareness of the trust's major incident plan and how to access this, but had not taken part in any training or drills.

Are maternity and gynaecology services effective?

Good



We judged effective in the maternity and gynaecology services as good because:

- The gynaecology and maternity services had an annual audit programme and evidence of learning and improving practice as a result of audits.
- Gynaecology cancer patients received appropriate care, which followed national standards and guidance.
- There was evidence of good clinical outcomes for maternity patients.
- The maternity services had full accreditation (level 3) with the UNICEF UK Baby Friendly Initiative.
- There were a number of specialist skilled and trained maternity and gynaecology staff who provided clinical updates, audit information, advice and support to other staff.

However, there were some areas which required improvement:

- There was a lack of maternity birthing equipment to assist with pain and discomfort during labour and birth.
- Post-operative infection rates following a caesarean section were not routinely monitored for themes and learning.
- There was a lack of evidence of audit, evaluation and full compliance with national guidance and recommendations regarding the termination of pregnancy service.

Evidence-based care and treatment

- We observed policies and guidelines in the maternity and gynaecology services had been developed in line with national policy. These included a range of National Institute for Health and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologist; Safer Childbirth (RCOG, 2007), The Care of Women Requesting Induced Abortion (RCOG, 2011) and the Termination of Pregnancy for Fetal Abnormality (DH, 2010) guidance. Patients received care in line with NICE quality standards 22 (for routine antenatal care), 32 (for caesarean section) and 37 (for postnatal care).
- The gynaecology and maternity services had an annual audit programme. This included local clinical audits and participation in national clinical audit. These enabled services to evaluate if treatment and care was being provided in line with national standards and to identify improvement actions. There were a range of audits at various stages of progress, planning and completion. There were 16 audits currently being completed for gynaecology and 10 for the maternity services. We saw one page audit summaries were completed and shared with staff.
- There was evidence of learning and improving practice as a result of audits. We reviewed one recent audit which aimed to reduce the risk of retained vaginal swabs. A baseline observational study had been completed, which identified areas for improvement. These included; changing the maternity packs, developing a birth safely checklist, standardising procedures for counting, and training staff on findings and revised processes. Records showed 206 staff had received this training including; midwives, obstetricians,

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anaesthetists, theatre staff and maternity care assistants. Senior staff told us swab counting was being added to the maternity emergency skills and drills mandatory training to further embed into practice.

- All gynaecology cancer patients received appropriate care, which followed national standards and guidance. The gynae-oncology consultants had systems in place to link with a regional gynaecology cancer network. Once a week a multi-disciplinary meeting took place via video conferencing. This enabled clinical treatment plans at the Royal United Hospital to be discussed and reviewed by the specialists at the regional cancer centre, and good practice to be shared. This ensured standards and clinical care were coordinated and consistent across the region. This included NICE improvement outcomes guidance, 2003 (for ovarian cancer) and 2004 (for gynaecology cancer), and The Cancer Reform Strategy, 2007.
- The obstetric anaesthetic services had been audited and reviewed against national standards (Royal College of Anaesthetists, Obstetric Anaesthesia Services, 2013, 2015). This included; staffing levels, pain management, consent and management of complications. Where deficits were identified, action plans had been identified to make quality improvements to the care and treatment of patients. For example; clinical responsibilities were reviewed and reorganised and two additional anaesthetists were employed to ensure adequate consultant cover at all times.
- The termination of pregnancy service was provided in line with most of the Royal College of Obstetrician and Gynaecology (RCOG, 2011) evidence-based clinical guidance and standards. These included pathways of assessment, treatment and support before, during and after procedures. There were two patient pathways; one for those having a medical procedure (use of medicines) and one for a surgical procedure. However, there was a lack of evidence to show all significant risks were discussed with patients. We reviewed two sets of patient notes relating to termination of pregnancy and spoke with staff working in this service. Risks related to the surgical procedure followed RCOG guidelines and were evidenced as discussed with patients. Risks related to the medical procedure were brief and did not include the risk of bleeding. This was a significant risk for the medical procedure (RCOG).

- There was no evidence of venous thromboembolism assessments and prevention (VTE) in the termination of pregnancy patient records. This was recommended for patients admitted for day case and inpatient procedures (NICE quality standard).
- There was no evidence of regular audit and evaluation of the termination of pregnancy service to evidence compliance with national standards, and improve clinical practice and patient experience.
- The trust participated in the National Neonatal Audit programme (NNAP). The most recent evaluation was dated 2013 (published October 2014). This showed the standard had not been met for women who should have received steroids for babies born prematurely. Steroids were provided to 78% of pregnant women which was below (worse than) the national standard of 85%.

Pain relief

- All the patients we spoke with told us they regularly had their pain assessed by staff and were given medicines promptly. We looked at patient care records and saw pain and comfort needs had been assessed.
- A range of pain relief was provided on demand in the delivery unit. Each room had an electronic delivery bed which could be adjusted to support different positions and ease pain. Nitrous oxide gas (Entonox) and oxygen were piped into each delivery room. Epidurals and other pain relieving medicines were available for women in labour 24 hours a day, seven days a week. Midwives confirmed anaesthetists responded promptly to requests for support with pain relief.
- On the delivery suite (apart from the birthing pools, limited to patients with low risks) there was no additional equipment or resources available to support and assist with pain relief and promote a natural birth. For example, there was no provision of birth balls, slings, mats, stools and aromatherapy oils. Staff told us this was due to infection control concerns and as a result of one patient who had sustained an injury using a birthing ball. However, most delivery suites provide additional equipment and services as standard with no negative impacts. We were told patients were able to bring in and use their own equipment.

Nutrition and hydration

- The maternity services had full accreditation (level 3) with the UNICEF UK Baby Friendly Initiative. This meant

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staff had fully implemented breast feeding standards which had been externally assessed. This involved interviewing mothers about the care they had received and reviewing policies, guidance and internal audits.

- There was an infant feeding coordinator midwife who provided advice and support to patients and staff with all aspects of baby feeding.
- On the ante/postnatal ward (Mary) there was a dedicated baby feed fridge. We observed ample stocks of breast pumps which were available for use by patients if required.
- Patients were complimentary about the hospital food and told us they were offered plenty of hot and cold drinks. We observed water jugs were frequently refreshed.
- Between set meal times, snacks and drinks were available to purchase 24 hours a day. On the ante/postnatal ward there was a kitchenette area where patients and their partners could access hot and cold drinks and snacks.

Patient outcomes

- Women were encouraged to breastfeed following best practice guidance and the uptake was better than the national average. Records showed between September 2015 and February 2016 the uptake of breastfeeding by women supported by the maternity services ranged between 73.5% and 86%. The National average of women starting breastfeeding was 74% (NHS England, July 2015).
- The maternity services maintained a dashboard with clinical outcomes rated as red, amber or green (RAG). This related to birth figures and complications during perinatal care. The parameters of this were checked against Royal College of Obstetricians and Gynaecologists (RCOG) recommendations or against local targets if these were of a higher standard than national benchmarks. We reviewed the clinical dashboards for the period September 2015 to February 2016:
 - The percentage of planned community or home births resulting in transfer to the delivery suite on the Princess Anne wing was between 16% and 24%. Senior staff told us all unplanned transfers were scrutinised for potential service improvements. The majority of transfers were due to unpredictable issues such as failure to progress during the second stage of labour and requests for an epidural.
 - The rate of elective and emergency caesarean sections was between 20% and 25% which was below (better than) the national average of 26%.
 - The rates of third degree tears at the Royal United hospital were below (better than) the recommended rate. The monthly rate of third degree tears ranged between 1% and 2%. There were two fourth degree tears recorded between September 2015 and February 2016. RCOG guidance stated tears should occur in fewer than 5% of deliveries.
 - Postpartum haemorrhage rates were analysed for practice improvement implications. A rate of between 500mls and 1000mls is common (RCOG, Green-top guidance no 52, 2011). No trends had been identified other than an increase in patients body mass index (BMI), a known risk factor for postpartum haemorrhage. Between September 2015 and February 2016, the postpartum haemorrhage rate above 1500mls for vaginal and caesarean births was between 2% and 3.5%. This was within the recommended rate of between 1% and 5% of all births (RCOG).
- The maternity service participated in the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE). We reviewed the most recent report dated November 2015, containing data from 2013. The Royal United Hospital had a 10% lower rate of perinatal mortality compared to other similar-sized trusts. The rate of stillbirths was recorded as 10% higher compared to similar sized trusts. All stillbirths were subject to a thorough multidisciplinary review and analysis for learning and improving care. No themes had been identified.
- All unexpected admissions to the neonatal intensive care unit (NICU) were reviewed for recurrent themes or issues. Senior maternity staff were aware of an increased rate of neonatal admissions to NICU, this included babies born at term. Between September 2015 and February 2016 the number of unexpected neonatal transfers to NICU was within the expected range for just two out of the six months. The anticipated transfers rate was between six and 11 babies, calculated on the number of births. During the other four months the number of babies transferred to NICU was between 11 and 17. The number of babies born at term requiring admissions to NICU ranged between 39 and 54 admissions. The directorate patient safety manager explained a process of retrospectively reviewing and

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scrutinising medical records was underway. Whilst this work had not been fully completed, the patient safety manager was aware of two emerging themes. These had highlighted potential areas for redesigning processes to more effectively support patients and develop the skills of clinicians.

- The percentage of women transferred from home to hospital from April 2015 to February 2016 ranged from 16% to 24%. There were no national standards to benchmark transfer rates but each case was reviewed for potential learning. Themes recently identified had included the management of blood pressure and infection. The midwifery patient safety lead had joined a network group with other safety leads from other trusts in the south west region. We were told that the group intended to focus on reviewing unplanned maternal and neonatal readmissions.
- There was a low rate of gynaecology patients acquiring a post-operative infection. Between December 2014 and November 2015 there were a total of 846 gynaecology operations/procedures. Of these, 20 (2%) acquired an infection. Of these 12 patients required to be admitted for further treatment and eight were treated on an outpatient basis.
- Post-operative infection rates following a caesarean section had not been routinely monitored. Staff said during the past six months they were aware of three post caesarean section wound infections which had been reported as incidents. Staff told us these had undergone multidisciplinary review, with no themes identified.
- Perinatal mental health clinics were facilitated by midwives jointly with the mental health liaison team based at the Royal United Hospital. This enabled more detailed mental health assessments to be completed and action plans put in place. Patients' consent was sought to make referrals and share information with other professionals involved with their care.

Competent staff

- There was evidence midwifery practice was reviewed and appropriately challenged to maintain clinical standards. The Local Supervising Authority completed and annual assessment of the role and effectiveness of the trusts supervisors of midwives. The most recent report was dated 26 March 2015. Between April 2014 and March 2015 there had been four supervisory

investigations. This demonstrated the supervisors were challenging poor practice. In each case, appropriate actions were put in place to ensure each of the four midwives remained competent to practice.

- Not all staff were supported to have an annual appraisal. We reviewed divisional operational report dated December 2015. This showed 84% of gynaecology staff had in date appraisals. Other records showed between September 2015 and February 2016 the appraisal rate for maternity staff was between 66% and 76%. This was below the trust's target of 90%. An appraisal action plan had been implemented with managers to prioritise booking appraisals and raise the compliance levels.
- The ratio of supervisors to midwives met recommended guidelines. The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SoM). By law midwives must have a named SoM with whom they meet once a year to consider their practice. The recommended ratio of SoM to midwives was 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). The ratio at the Royal United Hospitals trust was one to 13.
- There were experienced specialist midwives who had completed additional training and had enhanced skills. This included midwives for: safeguarding children and vulnerable women, mental health, infant feeding, audit, practice development and risk management. These midwives had lead roles for their specialties, providing clinical updates, audit information, advice and support.
- There were a number of specialist gynaecology nurses who had specialist skills and knowledge and were available to provide clinical support and advice to junior staff. This included nurse specialists for: colposcopy, gynaecology oncology and family planning. These nurses took lead roles for their specialties, providing clinical updates, audit information, advice and support.
- There were processes to maintain the skills of midwives. On the delivery suite, ante/ postnatal wards and community, there was a combination of core and rotational posts. Core midwives worked permanently in specific clinical areas. Rotational midwives moved every four to six months between the three clinical areas. This combination ensured midwives had the necessary skills to provide care in both a consistent and flexible way. We spoke with one midwife who had been based in the community for a number of years and had recently

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joined the team on the delivery suite. This midwife told us she was initially anxious but had been welcomed and supported to adapt to the different environment and was thoroughly enjoying the different types of challenge and pace. This midwife told us she felt her confidence and competence were increasing as a consequence.

- The induction process was designed to ensure new maternity staff were able to work in all clinical areas. The induction for new staff took place over a six week period. New staff were allocated time in all the maternity clinical areas, with the neonatal intensive care team and community birth centres.
- There were systems to ensure junior midwives had the required skills for practice. Newly qualified band five midwives completed a preceptorship programme during the first year in post. This was to enhance confidence and competence in order to provide safe, effective care to patients. The programme included two to three months based within obstetric theatres and on the neonatal intensive care unit. Once competencies had been fully reviewed and approved, these midwives progressed to band six posts with increased independent working and responsibilities. This practice followed the recommendations in the Preceptorship Framework (Department of Health, 2010). We spoke with some preceptee midwives who told us they felt well supported by all staff.
- We spoke to staff new to the trust and were told the induction programme had been both thorough and enjoyable.

Multidisciplinary working

- All staff we spoke with told us there was a good and established culture of multidisciplinary working. This ranged across all the maternity services within the hospital, with the community midwifery led teams and with the neonatal unit and paediatric staff. Maternity staff told us there was a good level of professional challenge and debate regarding the care and treatment of patients.
- A paediatrician attended the staff handover on the labour suite. This enabled potential admissions to the neonatal intensive care unit to be highlighted and planned for in advance.
- A multidisciplinary handover meeting took place every morning and evening on the central delivery suite. This ensured all staff were aware of the treatment and care plans of women requiring obstetric care. We observed a

morning meeting, attended by obstetricians and anaesthetists, paediatric staff, midwives and theatre staff. During the meeting the clinical needs of all patients were reviewed. The day's theatre list and neonatal units capacity was discussed. There was a safety briefing which included discussion and reminders of recent safety and policy updates. Staff were allocated roles and responsibilities. All staff engaged and contributed to discussions, which were productive and well managed.

- The obstetric consultants told us other specialty doctors worked in partnership with the obstetric team, providing support for patients with complex health needs. For example, cardiac consultants provided advice and support to the obstetric team.
- Information was shared appropriately with other professionals and services for the benefit of patient care. Some of the records we reviewed showed clear and detailed communication with other external services. For example, with patients GPs and with the local authority through the safeguarding procedures.

Seven-day services

- All the midwifery and junior medical staff we spoke with told us the consultants were supportive and responsive, attending the delivery suite at all times when required, including out of hours. All the consultants lived within a 30 minute or 10 mile radius of the hospital.
- There was sufficient anaesthetic cover for the maternity and emergency gynaecology services. Consultant cover was available on the delivery suite and for gynaecology emergencies Monday to Friday 8am to 5pm. Out of hours, the on call anaesthetic consultant was available.
- The central delivery suite was staffed 24 hours a day, seven days a week. The maternity service had never closed to patient admissions. We were told this was to always be able to respond to the needs of the local population.
- The maternity day assessment and ultrasound unit were open during weekdays. Medical staff had access to ultrasound equipment out of hours for maternity of gynaecology patients. The hospital's main imaging department also provided imaging out of normal working hours.

Access to information

- Medical records were accessible and available for both gynaecology and maternity clinics. Reception staff told

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us previous medical records were requested and were available to be checked before clinics. This ensured staff had access to patient's medical history information, which assisted with care planning.

- Pregnant women looked after their own records (hand-held records). These were provided and started during the initial booking appointment. These were used by all clinicians involved with care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for post-natal care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the correct processes to gain consent. The patients we spoke with confirmed that staff had asked for permission before proceeding with any care or treatment.
- Procedures to gain consent were documented. The 12 care records we reviewed clearly documented discussions regarding consent before carrying out any examination or procedure.
- Not all staff were in date with the trust's mandatory training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Records dated February 2016 showed compliance ranged from 78% to 99%, against the trusts target of 90%. Senior staff said plans were in place to increase the level of mandatory training for staff.

Are maternity and gynaecology services caring?

Good



We judged caring in the maternity and gynaecology services as good because:

- Staff cared for pregnant women before, during and after birth with kindness, compassion, dignity and respect.
- Patients told us they felt involved with their care, understood their choices and had their wishes respected and understood treatment and care plans.
- Feedback from patients and relatives regarding the care, treatment and support received was mostly positive.

However, there were some areas which required improvement:

- Improvements were required to increase the number of patients participating in feedback of experience surveys.
- Improvements were required to identify the quantity of patient feedback in the maternity services.

Compassionate care

- We spoke with nine patients and two relatives on the gynaecology ward (Charlotte), ante/postnatal ward (Mary) and delivery suite. One patient and their relative using the maternity services told us they had been "overwhelmed by the kindness of staff". Other patients told us they had received compassionate and sensitive treatment and care by staff.
- We were told of one negative patient experience following a pregnancy scan. This patient said following the scan when it was clear there were issues of concern, they had been taken to a waiting area with their partner. They told us another patient and partner, who were distressed, joined them in the waiting area. During this time the patient said they felt shocked and bewildered and felt the area lacked privacy and dignity for all people in the room.
- Limited information was available regarding feedback from patients who participated in the NHS Friends and Family test. The maternity service recorded the percentage of patients who recommended the maternity service on their monthly performance dashboard. From April 2015 to February 2016 this ranged between 96% and 100%. However, there was no information to show how many patients had provided this feedback each month.
- The Friends and Family test results for the gynaecology service were poor. Information dated 1 July 2015 to 31 December 2015 gave feedback from two patients staying on the Charlotte ward and five who used the gynaecology outpatient's service. From this limited sample, between 64% and 79% would recommend the service.
- The maternity service participated in a national survey. A questionnaire was sent to all women who gave birth during February 2015. Patients were asked about their care and treatment during labour and birth, the attitudes of staff and care provided following birth. There were 159 responses. The maternity services scored about the same for the majority of questions

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compared to other trusts. The service scored better on two questions. These related to having confidence and trust in staff during labour and birth and being treated with dignity and respect.

Understanding and involvement of patients and those close to them

- The patients we spoke with told us staff were respectful of personal choices regarding treatment and care. Patients said they felt staff had read records and plans as they understood patients' preferences for the delivery of care and frequently checked there were no changes to choices.
- Patients told us doctors explained what treatment needed to be carried out and why. This included risks and potential complications or side effects. Patients said they felt they had time to consider options before making a decision.
- We spoke with two partners of women who said they felt included and had been given explanations of care as it was occurring which they had found helpful and reassuring.
- We looked at 12 sets of records and saw discussions and treatment plans documented as discussed with patients and, where appropriate, with those close to them.
- Compliments were made regarding all levels of staff within the maternity and gynaecology services. Ward and clinical areas were relaxed and we observed staff had friendly but respectful interactions with both patients and relatives.
- Tours of the maternity unit and facilities were available twice weekly. Pregnant women and their partners or family were able to view all areas of the maternity service. Staff told us this enabled women to interact with maternity staff and gain a greater understanding of how the hospital maternity services functioned. We observed a tour taking place during our inspection. We observed visitors were encouraged to ask questions and were provided with explanations and information leaflets regarding maternity care and services.

Emotional support

- One patient told us they felt their midwife had invested time to get to know them and their partner. This understanding was invaluable when difficult decisions

had to be made. The patient said throughout, they felt they were fully involved and completely supported. This person said all staff had been incredibly kind and care had been dignified and respectful.

- One to one counselling was available for women diagnosed with gynaecology cancer and/or their relatives. This was a free service provided at the Royal United Hospital by a charitable organisation. The counselling staff were accredited to the British Association of Counselling and Psychotherapy (BACP) or an alternative professional body.
- Staff spoke with us regarding how they provided sensitive care to families who had experienced the loss of a baby, including those patients undergoing a termination of pregnancy for fetal anomaly. Staff provided personalised memory boxes, containing mementoes for bereaved parents. These had been developed in conjunction with the Stillbirth and Neonatal Death charity (SANDS). There were no identified specialist bereavement midwives. Staff told us patients were offered additional support through the chaplaincy service, which provided denomination specific and non-religious based support.
- One of the consultants provided a weekly clinic, available for maternity patients who required additional emotional support with any aspect of their care or treatment.
- One patient explained how anxious they had been prior to attending the hospital. This patient said all staff had been kind, caring and considerate and they felt reassured and well looked after.
- Staff said women who attended for termination of pregnancy for fetal abnormalities were allocated a side room to increase privacy. Partners were supported and able to stay for extended visiting and overnight.
- We observed emotional support provided to patients. We heard midwives supporting women on the telephone and in clinical areas. Individual concerns were promptly identified and responded to in reassuring and positive ways. Patients were spoken with in an unhurried manner, midwives checked if information was understood. When speaking on the telephone, women were encouraged to call back at any time if they continued to have concerns, however minor they perceived them to be.

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Are maternity and gynaecology services responsive?

Good



We judged responsiveness of the maternity and gynaecology services as good because:

- Systems were in place to support access and flow around the maternity services.
- There was evidence of personalised care provided to gynaecology and maternity patients and their relatives. This included gynaecology patients with memory loss conditions who had additional care and support needs.
- There were systems to evaluate complaints in order to learn and make service improvements.

However, there were some areas which required improvement:

- There were staff trained to provide specialist bereavement care for maternity and gynaecology patients and their families experiencing loss, and to advise and support other staff. However, not all staff were aware of these specialist roles.
- The two designated areas identified to care for bereaved women and their families lacked privacy, space and facilities.
- Access and flow through the gynaecology services was affected by trust wide and service specific pressures. This resulted in treatment and care being cancelled or provided within an inappropriate environment.

Service planning and delivery to meet the needs of local people

- There were processes to gather feedback from patients and local communities. The Maternity Services Liaison Committee (MSLC) gathered patient and public feedback on experiences and views on the maternity services. Membership was open to service users, health professionals, voluntary, and health and community services. Royal United Hospital maternity staff had attended meetings and information was shared with the local Clinical Commissioning Group. We looked at meeting minutes dated October 2015. Information discussed included proposals for amended and new

clinical pathway plans and discussions of national investigations (Morecombe Bay, Kirkup report). We saw action plans had been developed, including how to share findings widely.

Access and flow

- Systems were in place to support access and flow for non-urgent gynaecology patients. Individual needs were assessed and potential issues identified and managed through a dedicated clinic prior to the patient's admission date.
- Trust wide service pressures had affected access and flow through the gynaecology inpatient service on Charlotte ward. This ward had 10 gynaecology and 12 medical beds. However, gynaecology patients regularly had to be admitted elsewhere in the hospital due to the high number of medical and surgical patients on Charlotte ward. We reviewed information provided by the trust. From September 2015 to February 2016 between 10 and 27 gynaecology patients per month were admitted to other wards. This meant there were instances when gynaecology patients were not cared for by specialist gynaecology nurses. The referral to treatment time standard for admitted gynaecology was 50.7% in March 2016. In addition, planned gynaecology surgeries were regularly cancelled. From 1 September 2015 to 16 March 2016 there had been 50 operations cancelled on the day surgery was planned, and a further seven cancelled in advance of planned surgery. This delayed patients' treatment.
- The ante/postnatal ward (Mary) had effective discharge processes. Information was provided individually if requested. Alternatively, patients attended a group discharge meeting in the large communal day area which was large and comfortable. Staff said this released beds to accommodate other patients.
- Maternity screening clinics were held three evenings per week and on Saturdays. This gave patients a range of options for attendance.
- Systems were in place to support access and flow around the maternity services. An antenatal triage was available 24 hours a day, seven days per week. There was an early pregnancy clinic every week day between 8am and 9am during which patients were able to have a scan and be reviewed by a clinician. There was a

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maternity day assessment unit open from 7.30am to 7.30pm. If women required ongoing monitoring, treatment or care out of hours they were admitted to the ante/postnatal ward (Mary) or the delivery suite.

- Systems were in place to provide responsive emergency access for gynaecology patients. The gynaecology senior house officer (doctor) carried a mobile phone. Local GPs were able to call and discuss potential emergency referrals. An emergency gynaecology clinic was available every week day from 12.30 to 1.30pm. If required medical staff were able to access and use scanning equipment out of hours or refer patients to the diagnostics department.

Meeting people's individual needs

- There was an option for pregnant women to pay for a detailed 4D scan between 26 and 30 weeks of pregnancy. Staff said patients found these scans to be a positive and reassuring experience.
- New parents were able to register their baby's birth at the hospital. A full time registrar was available between 9am and 4pm, Monday to Friday.
- There were processes to support gynaecology patients who had other conditions associated with memory loss. On the gynaecology ward (Charlotte), senior staff confirmed all staff had completed dementia training. In addition, there was identified link staff who provided ongoing updates and information.
- The maternity services had specialist trained bereavement midwifery posts to act as a lead for maternity and gynaecology patient care and other staff providing; specialist education, support and advice. However, staff told us that when required, they relied on colleagues for additional support and were not aware of the specialist roles. Senior staff told us they tried not to allocate inexperienced midwives to patients facing grief and loss but this was not always possible to achieve.
- The areas identified for caring for bereaved women and their families lacked space, privacy and comfort. There were two designated bereavement rooms, one on the delivery suite and one on the ante/postnatal ward (Mary). Both of these rooms were close to other rooms where women laboured or stayed with their newborn babies. None of the rooms were soundproofed. The trust had plans in place to provide a private entrance/exit to the bereavement room on the delivery suite. It was anticipated works would be completed during August 2016. However, both bereavement rooms did not

include facilities other similar sized services provided. For example, private kitchenette and lounge areas, which could accommodate extended family in comfort and privacy. The en suite room identified within the delivery suite had never been used as it had been affected by maintenance works pending in the theatre area. The bereavement room on Mary ward had some soft furnishings but limited space.

- There were sufficient facilities to enable partners of women to stay overnight to provide emotional support. There were sufficient lie back chairs, designated bathrooms and drinks and snacks for purchase 24 hours a day. Depending on the capacity of the Mary ward, en suite rooms were available to reserve. This incurred a payable amenity charge.
- Midwives explained how they supported women with complex or specific needs at all stages of the maternity pathway. For example, patients who had complex family dynamics, mental health problems or were supported by other health or social care services. We observed on Mary ward (ante/postnatal) there were small pictures on the front of the kitchen units depicting the contents. Staff said this supported some patients who had learning disabilities and others for whom English was not their first language. Gynaecology staff explained how they had recently supported a patient with physical and learning disabilities to access the ward. Staff told us they had worked with the patient and their carers to understand and learn how needs were to be best met.
- There was an extensive range of maternity and gynaecology information available in clinical areas. This included information leaflets on specific conditions and clinical process. For example we saw: information relating to postnatal care of stitches, preventing infections in babies, breast feeding, miscarriage and stillbirth, pelvic floor repairs and gynaecology cancer. On the trust website we saw 23 maternity leaflets, including a 24 page document on labour and birth. Staff told us information could be provided in alternative languages.
- The midwives were familiar with, and used, a telephone translation service which was prompt and effective.

Learning from complaints and concerns

- There were systems for patients to register complaints and concerns. Patients told us they understood how to raise issues if they had concerns. Most patients told us they would raise issues directly with staff. There was

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clear guidance on how to raise concerns in information leaflets and on the trust's website. The contact details of the senior matron were available on take-away cards around the maternity service. Staff said this enabled patients to have any issues or concerns (or compliments) raised and addressed promptly.

- We asked four patients specifically if they knew how to make a complaint and all confirmed they understood the process. One gynaecology patient told us they had been unhappy with communication from the admissions/booking team and would raise a formal complaint when fully recovered. Other patients told us they had been satisfied with their treatment and care.
- There were systems to evaluate complaints in order to learn and make service improvements. The maternity service logged the number of complaints received each month. Between April 2015 and February 2016 there had been 27 formal complaints made about the maternity service. The number of new and ongoing complaints for both the gynaecology and maternity service was reviewed every month by senior staff and governance leads. Complaints were investigated and actions recorded. We observed learning from complaints was disseminated through meetings and newsletters.

Are maternity and gynaecology services well-led?

Good



We judged well-led as good for the maternity and gynaecology services because:

- There were thorough risk management and governance structures and processes. These linked risk and governance meetings and both departmental and trust level. This produced an effective flow of information from ward to board and vice versa.
- There was evidence to show risk and quality measures were interrogated for service improvements and responsive actions were taken.
- There were systems to share information and learning.
- A positive and proactive culture was evident.
- Despite senior midwifery vacancies, there was evidence of good leadership and support.

However, there were some areas which required improvements:

- Some governance and quality information gathered was not freely accessible to staff. This hindered oversight of the quality of treatment and care provided to gynaecology patients.

Vision and strategy for this service

- The obstetrics services had a five year plan, which had been developed by senior staff. Throughout the services, staff demonstrated a broad understanding of the vision and strategy and of the trust's core values. All the staff we spoke with stated their goal was to provide high quality, person centred care.

Governance, risk management and quality measurement

- There were governance and risk management processes including audit trails to track any required actions. We looked at a range of departmental meeting minutes and information. These included monthly risk management and clinical governance meetings and obstetrics and gynaecology directorate meetings. Governance, risk management, and quality information was recorded and appropriate actions taken. For example, through analysis of audit and incident reporting, an increased trend in unplanned maternal and neonatal readmissions to the hospital had been noted. These increased admission rates had also been a feature of the previous maternity provider (a different trust). Whilst the service handover processes had not picked up previous action plans, we were assured new action plans were being put in place. This included in depth case reviews and analysis of information to improve (reduce) readmission rates.
- All the senior staff we spoke with demonstrated an understanding of current risks and clinical pressures. However, in some areas senior staff were only able to demonstrate a broad overview of issues. For example; senior staff on the gynaecology ward and for the directorate could not say how many medical or surgical patients were placed on Charlotte ward above the agreed levels. Nor were they able to confirm how many gynaecology patients had to be placed on other wards in the hospital. This information was collated by the business intelligence unit and available if requested. However, senior staff were not able to provide an analysis of recent trends or impacts on gynaecology patients.

Maternity and gynaecology

- A monthly maternity and gynaecology operational report was produced by the women and children's divisional management team. These provided quality and risk assurance information to the trusts operational and quality leads. We reviewed the reports dated January and February 2016. Incidents were categorised and detailed according to the level of impact on patient care. Serious incidents were summarised, including what stage investigations were at and anticipated completion dates. The number of open risks was identified by specialty and significance. For example; the operational report dated February 2016 showed 58 open risks. Risks assessed as being significant had detailed updates by each summary. These included what actions were required to mitigate risks, anticipated completion dates for actions and what staff had responsibility for actions.
- Processes were in place to categorise and rate risks based on actual or potential impacts on patient treatment and care. Each day the lead midwife for risks reviewed the reported incidents. An obstetrician, the divisional and lead midwives for risk met when required to agree the significance and level of risks reported. Any risks identified as potentially of moderate harm or above were reviewed within 72 hours and also discussed with the trusts lead for risk and quality assurance. Each week actions, timescales and allocated responsible persons were added to a data base. The divisional lead for risk management maintained oversight of this database, using automated staff reminders to ensure actions were completed.
- There was evidence risk and quality measures were evaluated for improvements and learning. Each month incidents and issues were scrutinised for emerging themes which were benchmarked against a regional quality data base. The divisional lead for risk management explained how this surveillance had led to improved clinical outcomes. An elevation in complications with shoulder dystocia was noted. Other regional risk management leads were contacted, and 20 sets of patient notes were reviewed. This concluded slight differences between two trainers who provided the emergency skills and drills training. Whilst the same clinical advice had been given, the specifics of how to follow through on one emergency action had been inconsistent. The training was revised. At the time of our inspection it was too early to re-audit.

- Senior maternity staff told us they had learnt from national enquiries regarding the risks of staff working solely in one place (Morecambe Bay). This has led to the development of rotational posts (between clinical areas) and the employment of new maternity staff to work within the service rather than a specified area.

Leadership of service

- The consultants provided good leadership and support to junior medical staff. We spoke with junior doctors who said they had excellent support and working relationships with the consultants. The doctors told us they got the right balance of training opportunities and responsibility and they felt encouraged and nurtured by senior staff. One junior doctor said they were approaching the end of their extended training time and remained reluctant to leave. This person said they would highly recommend the training and support received to other medical students.
- Midwives and gynaecology staff gave positive feedback regarding the leadership of senior staff who we were told were approachable and supportive. On the days of our inspection, senior staff were visible and present in clinical areas and demonstrated an understanding of current clinical activity and priorities. Senior divisional staff told us an intrinsic part of their management roles was to encourage and support the good ideas forthcoming from staff in a positive manner.
- In the absence of a head of midwifery (advert out for recruitment), the senior matron was provided with support by the divisional manager and clinical lead for the women and children's division, and the director of nursing and midwifery. In addition, mentoring was being planned for the senior matron with an experienced head of midwifery from a different trust.
- Senior maternity staff told us they had access to and felt well supported by the divisional leads and director of nursing and midwifery.
- Senior maternity and gynaecology staff said they felt there was a good and open communication with the board and the division felt well supported. Staff were familiar with their non-executive link and the chief executive, both of whom visited clinical areas to talk with staff and patients. Senior staff also had good links with the director of nursing and midwifery, who facilitated monthly meetings and professional forums.

Culture within the service

Maternity and gynaecology

- Maternity staff were overwhelmingly positive regarding the permanent commissioning of services from within the Royal United Hospitals trust which commenced during 2014. Staff reported they felt a sense of belonging and were excited by the prospects of being able to make long term plans for the service. Enthusiasm and optimism for the service was evident from all the staff we spoke with.
- Throughout the maternity and gynaecology service staff told us they were proud of the care they provided and enjoyed working with their colleagues. Staff at all levels demonstrated a keenness for continued learning and improvement for the benefit of patient care.
- All the staff we spoke with displayed a passion and commitment to providing high quality care for patients. Medical staff spoke highly of the midwives and vice versa. The maternity support worker we spoke positively about the culture stating; “this (service) is the best place in the world to work”.

Public engagement

- A social media page had been set up by midwives as another method to promote patient involvement and gather feedback on services. We reviewed this (March 2016) and saw feedback was sought related to patient experience, service improvements and inclusion in local and national surveys. For example, feedback was sought on patient preference for the induction of labour and there was a link to a survey looking at the impact of creative groups and postnatal wellbeing. The social media page was monitored three times a day by one of three supervisors of midwives. We observed 817 people had positively rated the social media page.
- There was a specific forum for maternity patients to discuss their personal experiences and for this information to be shared more widely. The midwives provided a monthly listening clinic service. This provided patients with an opportunity to discuss a previous or current pregnancy if care was not provided according to birth plans. The services received a consistently high level of feedback and staff were looking at ways to expand the service to meet the increase in demand. The service provided a summary newsletter for staff. These included positive feedback on care provided and suggestions of ways to improve communication and care. A local university had invited the midwives to share their experiences of facilitating this service with student midwives.

- We observed patients being provided with feedback questionnaires and being requested to complete these.

Staff engagement

- Staff were kept updated and encouraged to provide ideas. Information relating to trust or gynaecology and maternity service updates were distributed through various newsletters, service wide emails and staff meetings. We reviewed a selection of newsletters, including the weekly maternity services newsletter. This was developed by three of the band seven midwives and was emailed to all staff, including all obstetricians and the director of nursing and midwifery.
- Senior staff told us they planned to undertake a full service review of the maternity service. As well as sharing information through meetings, emails and newsletters, senior staff said they planned to provide boxes for staff to be able to provide anonymous feedback on potential new plans.
- Senior midwives met with birth supporters (doulas) every three months to share information. We looked at the meeting minutes dated October 2015 and January 2016. Issues discussed included new clinical pathways and research developments.
- Systems were in place to support maternity staff following traumatic birth events. Trauma Risk Management (TRiM) provided an evidence-based post-incident management process for staff. Staff said the TRiM team were supportive and had been used as part of team debrief sessions.

Innovation, improvement and sustainability

- A number of senior midwifery posts were vacant due to planned retirements. This included five senior midwives, two matrons and the Head of Midwifery. Another three senior midwives were due to retire. Staff told us it had been difficult to make long term sustainability and succession plans due to the number of organisational changes in the service in recent years. Interim posts had been created and most of the vacancies had been advertised
- Maternity staff sickness levels were high. Between September 2015 and February 2016 this was between 5% and 9%. Senior staff told us they felt this related to a combination of factors including: long term sickness,

Maternity and gynaecology

performance issues and increased pressure on staff due to the number of vacancies. Plans were being made to more formally review the health and wellbeing of staff, including systems of support.

- There was evidence of innovation and sustainability. The maternity services won an award during 2015 from the West of England Academic Science Network. This was the most innovative team of the year award for the prevention of cerebral palsy in preterm babies project(PreCEPT). The maternity services had provided treatment to 88% of eligible patients compared to the national average of 12%.
- The maternity services had successfully applied for funding for additional equipment and projects through the trusts pop up innovation panels and quarterly trust improvement panels. For example; one midwife successfully bid for two mobile baby resuscitaires to enable delayed cord clamping for more complex births. This midwife had also presented the research, evaluation and patient outcomes for the use of this

equipment at the Royal College of Midwives annual conference during 2015. Other successful funding bids had been used for computer equipment. This enabled mothers on the ante/postnatal ward (Mary) who had a baby being cared for on the neonatal unit to see and communicate with them. This had been found to be beneficial for women who were unable to visit their baby, by reducing stress and anxiety.

- The maternity services had made a successful bid for additional NHS funding to purchase and develop clinical skills related to reducing stillbirths. The service had been awarded £21,000. Senior staff said this money would be used to purchase new specialised simulation models and a staff training package.
- One of the midwives had an article published in The Practising Midwife journal (October 2015). This was about the benefits of providing the listening service. The article had led to enquiries from other maternity services who were interested in setting up a similar service.

Services for children and young people

Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

Services for children and young people at the Royal United Hospital Bath NHS Foundation Trust are part of the Women and Children's Division and are located in the Children's Centre and the Dyson Centre for Neonatal Care.

The Children's Centre is situated on the ground floor and includes a Paediatric Assessment Unit (PAU) with waiting area plus an examination and assessment cubicle. There are 33 inpatient beds which cover medicine and surgical patients, day case work and an outpatients department. The patient assessment centre offers integrated therapy including physiotherapy and occupational therapy. Children are cared for up to their 18th birthday although any children over the age of 16 years have the choice of being treated on an adult ward. The unit is divided into three areas: one for babies, one for children and the other for young people.

Paediatric surgical services are provided for the following specialties: ENT, ophthalmology, oral surgery, urology, general surgery and orthopaedics. These services are managed within the surgical division. However, children who require inpatient care will be admitted to the Children's Centre. This is with the exception of children over the age of 16 years requiring day surgery, who are offered the choice of the adult day surgery unit or the children's ward.

In the Children's Centre there is a large playroom and play specialists who also provide activities at the bedside. There is a young people's chill out room and a quiet room

available to parents and staff. A school service, run by Bath & North East Somerset Council, is available in the school room within the Children's Centre during term time for all children in hospital for three days or more.

The Dyson Centre for Neonatal Care is located on the ground floor of the Princess Anne wing of the hospital. There are 21 cots providing intensive care, high dependency care, special care and transitional care. The majority of admissions to the unit are via the labour suite although some are transferred from elsewhere in the South West Neonatal Network, of which the Dyson Unit is a member.

During our inspection we spoke with 17 parents and nine children and young people. We also spoke with over 50 members of staff, including nurses, consultants, doctors, therapists, administration staff, support staff and housekeeping and cleaning staff. We visited all the areas within the Children's Centre and the Dyson Centre for Neonatal Care. We observed how babies, children and young people were being cared for, handover meetings between staff teams, outpatient consultations, and looked at care and treatment records, and other documents provided by the trust.

Services for children and young people

Summary of findings

We rated the services for children and young people as good because:

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff. Staff adhered to infection prevention and control policies and protocols.
- The units were clean and well organised and suitable for children and young people.
- Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service and with other agencies.
- Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the high quality of care were encouraged and acknowledged. Children, young people and their families were respected and valued as individuals. Feedback from those who used the service had been exceptionally positive. Staff went above and beyond their usual duties to ensure children and young people received compassionate care.
- Care was delivered in a compassionate manner. Parents spoke highly of the approach and commitment of the staff who provided a service to their children.
- Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families.
- Staff understood the individual needs of children, young people and their families and designed and delivered services to meet them.
- There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to children, young people and their families and to their colleagues. There were

high levels of staff satisfaction with staff saying they were proud of the units as a place to work. They spoke highly of the culture and levels of engagement from managers.

- There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

However:

- As the outpatient area was not subject to the same environmental audit as other areas used for children there were no checks in place to identify risks and to ensure the area was safe.
- There was a lack of security of some confidential information if left unattended on the children's ward.
- Although safeguarding supervision was embedding across the division it remained a challenge and required continued improvement.
- Completion of appraisals was below trust target and required improvement.
- Some other areas used by children in the hospital were not child friendly, particularly theatre recovery rooms.
- There were ongoing concerns about the sustainability of safe provision of high dependency beds on the children's ward with the current workforce establishment.
- The performance for discharge summary completion required improvement.
- There were concerns about the impact of the ongoing tendering processes for inpatient therapy provision for children and young people.

Services for children and young people

Are services for children and young people safe?

Good



We have rated the safety of children and young people's services as good because:

- There were systems in place for recording and learning lessons from incidents and staff told us they were encouraged to report incidents.
- Nursing and medical records had been completed appropriately and in line with each individual child's needs.
- Staff we spoke with were knowledgeable about the trust safeguarding process and were clear about their responsibilities. Mandatory training was monitored each month and most staff were compliant with their training.
- The units were clean and well organised. Staff adhered to infection prevention and control policies and protocols.
- Systems were in place for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs.

However:

- As the outpatient area was not subject to the same environmental audit as other areas used for children, there were no checks in place to identify risks and to ensure the area was safe.
- Safeguarding supervision remained a challenge and required continued improvement.
- There was a lack of security of some confidential information if left unattended on the unit.

Incidents

- Staff were open, transparent and honest about reporting incidents. There were systems to make sure incidents were reported and investigated appropriately. All staff said they would have no hesitation in reporting incidents and were clear on how they would report them. All staff received training on incident reporting and risk management. This was part of their induction through the education centre training team and through periodic updates, staff briefings and communications.

Further role specific learning, such as training for managers who were investigating incidents was provided by the risk management team in conjunction with the education centre training team.

- Staff were able to show us the incident reporting policy which contained a reporting flow chart, incident classification and actions for managers. There was serious incident criteria and guidance on the level of investigation.
- All incidents were reported directly onto the incident reporting database which was available from all networked computers within the trust. Any person directly employed by the trust or who was working on a temporary, locum, or agency basis, including placement students, were able to complete an incident form. The appropriate manager was automatically notified of the incident by email and required to carry out an investigation. Once reported, incidents were reviewed by the appropriate clinical manager and where necessary investigated. Staff said they were able to get feedback on incidents they reported.
- There were procedures for the identification and follow-up of all serious patient safety incidents and non-clinical incidents. These procedures defined the roles and responsibilities of those involved in a comprehensive root cause analysis investigation.
- Incident reporting activity was reviewed and discussed at management and governance meetings. We saw evidence that learning was discussed through action plan review meetings. The hospital's head of risk and assurance was responsible for collating all documentation and reports arising from the investigation of incidents. Regular quarterly and annual reports on the analysis of the data were presented to the operational governance committee and the divisional governance meetings.
- There was one serious incident reported by children's services under the Strategic Executive Information System (STEIS) for the period February 2015 to January 2016. There had been a full investigation and the report was being presented for review to the operational governance committee shortly after our visit.
- The incident reporting policy set out the processes for reporting and managing incidents. The serious incident reporting policy and procedure set out how the trust reported, investigated and managed any serious incident. The key features included which incidents would be graded as serious incidents, and application

Services for children and young people

of the Duty of Candour for incidents which caused severe harm or death. The policy described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

- From the report of the National Reporting and Learning System (NRLS) of incidents from February 2015 to January 2016 there had been 39 incidents relating to the children and young people's service. The majority of incidents reported (79.5%) resulted in no harm and the remainder (20.5%) resulted in low harm which required extra observation or minor treatment. The most commonly reported incident category was 'other' which accounted for 28.2% (11) followed jointly by medication incidents (12.8%) and incidents related to consent, communication or confidentiality (12.8%). The fourth most prevalent category related to treatments or procedures 10.3% (4).
- The timeliness of incident reporting to the NRLS had improved over the reporting period. Between October and December 2015 incidents had been reported within 14 days which represented an improvement in performance in previous months where no incidents had been reported in less than 15 days.
- The children's services held paediatric mortality and morbidity meetings and minutes showed that cases were discussed and learning points and actions taken were documented. Any exception in the trust mortality and morbidity would be reported to the governance committee via safety & risk reporting.

Duty of Candour

- Staff demonstrated an understanding of Duty of Candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.
- To ensure compliance, the trust had created a Duty of Candour policy to guide staff. This was being reviewed and updated in response to the feedback provided by staff. Clinicians were being asked to become Duty of Candour champions to assist with the dissemination of knowledge.
- Duty of Candour had been incorporated into the electronic reporting system. Moderate, severe and catastrophic patient safety incidents would automatically populate the system's Duty of Candour

fields. These had to be completed by the incident reporter, and would automatically notify other relevant individuals of actions to undertake. Failing to complete the actions in a timely manner resulted in reminder emails being sent to staff.

- The electronic reporting system enabled the risk management team to generate reports and perform audits. On a monthly basis, incidents deemed to have triggered Duty of Candour were selected at random and assessed against the requirements of the regulation to ensure there was evidence that the correct procedure had been followed. A review was performed on a quarterly basis of those incidents where the reporter had indicated that Duty of Candour was not applicable. A rationale for not applying the Duty of Candour was required and this was scrutinised against the regulation. If it was discovered that Duty of Candour should have been applied, the reporter of the incident was contacted to explain why the previous decision had been overturned.

Safety thermometer

- The service participated in the national safety thermometer performance and achieved consistently positive results. The trust reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered incidences of hospital-acquired (new) pressure ulcers; patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). From September 2014 to September 2015 harm free care was consistently maintained across the service. There were no falls with harm, no catheter associated urinary tract infections or reportable pressure ulcers.

Cleanliness, infection control and hygiene

- The units and clinical areas were seen to be visibly clean, well-organised and tidy.
- Bed and cot spaces were visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Notices and posters were laminated and stuck to walls or noticeboards with pins or reusable adhesive. We saw completed cleaning schedules and environmental audit scores which showed an average of 99% for the period September 2014 to August 2015.

Services for children and young people

- Both units had a dedicated team of cleaners who ensured the areas were clean and tidy. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. The cleaning staff were fully integrated with the clinical teams and one member of staff said there was “a real family feel” and “I take pride in my work.” The children’s ward also had two part-time housekeepers who carried out additional duties such as cleaning drug trolleys, fridges and weighing scales. They tidied the linen cupboards, ordered pathology supplies, found new supplies such as the beds for parents, and helped with breakfasts.
- Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.
- We observed all clinical staff, including doctors, nursing staff and therapists washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Non-clinical staff including reception and administrative staff and cleaning staff were also observed to be following the guidelines. Children and their parents were asked to wash their hands and use alcohol gel when arriving on the units and this was freely available and clearly visible. All staff, as required, were bare below the elbow when working on the units.
- The children’s ward was well equipped with hand wash basins with good access to liquid soap and paper towels for staff to use. There were wash hand basins at the entrance to the neonatal unit and visitors, including CQC staff, were asked to wash their hands before entering the unit.
- Infection control status was presented on a laminate sign outside of each room.
- There were regular monthly environment surveys undertaken by the matron and sisters for both units looking at the general environment. This included the visible cleanliness of walls, windows, ceilings and floors, hand basins being equipped with liquid soap and paper towels, and availability and replenishment of alcohol gel bottles. Furnishings and fittings were examined to check they were in a good state of repair. Clinical rooms, bathrooms, toilets, and the sluice room were checked. From the data available, overall results ranged from 79.4% to 86.8% for the children’s ward and from 94.3% to 96.8% for the neonatal unit against a target of 85%.
- Hand hygiene audits were carried out at least monthly. Where performance fell below 95%, audits were required to be carried out weekly until performance improved. During the period from January 2015 to January 2016 the children’s ward and the neonatal unit consistently exceeded the target.
- Commode audits were undertaken by the infection control team three times a week and the results disseminated to the ward sisters, heads of nursing and director of nursing weekly. Most cleaning audits for the commodes on the children’s ward were compliant although there was one occasion in the period September 2015 to January 2016 when a label to highlight the cleaning having been completed was missing.
- A monthly audit was completed of the management of peripheral venous cannula (small tubes inserted to the veins usually to carry medicines, fluids or blood products). Audit results were included in a healthcare associated infection report which was given to all wards and departments weekly. Results were also included on the ward dashboard, accessible to all wards and part of the assessment for ward and outpatient accreditation. Performance was discussed at the Infection Control Committee meetings.
- There were no unit-acquired methicillin resistant *Staphylococcus aureus* (MRSA) infections or incidences of unit-acquired *Clostridium difficile* during the past four years. The units participated in screening audits and as part of the Saving Lives audits, the units completed High Impact Intervention 7 (a care bundle to reduce the risk of *Clostridium difficile* infection) if and when they had a patient with this infection. Results were stored in a central database in the trust that all wards had access to.

Environment and equipment

- Areas were suitable for children and young people. The units were bright, welcoming and suitable for children and young people. Photographs of staff working on the units were positioned on the notice board to inform parents who was on duty. Play areas with a wide range of toys and activities were available in all areas. There were a plethora of art work and notice boards in the main ward areas.
- There was a soft play room, physiotherapy gym, occupational therapy (OT) gym, therapy garden, therapy rooms, and orthotics plaster room. The therapy areas

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were undergoing redevelopment and rooms had been cleared ready for work to begin in the near future. There were plans to have a new sensory room and chill out room for teenagers.

- The trust undertook a self-assessment in January 2016 against the national minimum standards for healthcare facilities for children. The assessment was rated using a RAG (red, amber and green) rating. Out of a total of 14 standards, 11 were green, including the provision of toys and /or books suitable to the child's age; children under the age of 12 were supervised at all times either by hospital staff or their parents; on admission children were weighed to allow for accurate calculation of drug dosage. Two amber ratings related to children being seen in a separate outpatient area, although there were dedicated outpatient areas for children with the exception of a fracture clinic, ophthalmology and oral surgery. Outpatient staff endeavoured to see children at the beginning or end of clinics and oral surgery had a dedicated children's clinic. The other amber rating related to a segregated area for the reception of children and young people into theatre and for recovery, to screen the children and adolescents from adult patients; the segregated areas containing all necessary equipment for the care of children. The main theatres had two paediatric dedicated bays with specialist equipment designed for children, including for resuscitation. Curtains provided privacy for children. Day surgery theatre undertook dedicated children's lists and had four bays for children with paediatric equipment. Separation for children was achieved with curtains dividing bays. The one red rated risk related to the outpatient area being subject to the same environmental audit as any other area used for children to ensure the area was safe, with any identified risks to children controlled.
- There were security systems to ensure the safety of babies on the neonatal unit and children and young people on the children's ward. To gain access to the neonatal unit, parents and visitors needed to identify themselves at the entrance door and reception desk using an intercom / buzzer system. This meant that access to the unit was as secure as reasonably possible. Effective use of CCTV coverage had enhanced safety arrangements. We observed parents being met and providing identification, and the CQC team were asked to provide identification on arrival to the unit.
- The doors to the children's ward were always closed and locked and entry was gained by using the intercom system. The CQC team were asked to provide identification on arrival at the ward. If a parent was concerned about leaving their child, a member of staff would sit with the child until the parent returned.
- There was resuscitation equipment available in all areas appropriate for babies, children and young people. The trolleys carrying the equipment and medicines had been checked daily for completeness and full working order and this was documented. An annual rolling programme of audit of resuscitation trolleys was undertaken by the hospital's resuscitation department. Results were reviewed and documented by the resuscitation committee and key areas of risk were highlighted.
- A neutropenic sepsis box contained all things required to administer treatment for febrile neutropenia within 30 minutes (this was being audited at present).
- We saw a range of equipment was readily available and staff said they had access to the equipment they needed for the care and treatment of babies, children and young people. However, some staff said there was a lack of blood pressure monitors and scales monitors.
- The trust medical equipment management service (MEMS), which helped the hospital in all phases of the lifecycle of medical equipment, carried out monthly checks of all equipment. Faulty equipment was labelled and left in designated areas and the fault reported. We saw repair equipment lists which included apnoea alarms, humidifiers, breast pumps and oxygen monitors. We also saw details of an electrical test equipment list for the ward, outpatients and the neonatal unit which included integrated scopes, power distribution stands and inspection lamps.
- There were linen stores on both units and washing machines were situated on the neonatal unit to enable linen and baby clothes to be washed at high temperatures. An expressing room was available for mothers, and milk was stored in a specific kitchen where there was a fridge and freezer. On the neonatal unit there was a corridor for removing used equipment and housing other maintenance and cleaning services.
- Filters for humidifiers were changed every three months and breast pump kits were sent for a medical fast clean as required. Freezers were defrosted every month.

Medicines

Services for children and young people

- Staff had access to the trust medicines management policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.
- We looked at the medicines storage audits, incidents and complaints, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring cool storage, were stored appropriately. During our inspection we found all medicines stored securely, and were only accessible to authorised staff. All cupboards were locked and the stocks well organised. Contents of the emergency drug cupboards were electronically recorded.
- Controlled drugs were stored in separate double locked cupboards. They were checked daily and the check recorded by two registered children's nurses and the paediatric pharmacist. The record book was up-to-date and completed correctly. There was a separate book to check and record patients' own controlled drugs. This was also up-to-date. Where medicines needed to be stored in a fridge, the temperature of the fridge was checked consistently.
- Nursing and medical staff had access to paediatric pharmacists. All pharmacy services were available on Monday to Friday between 8.15am and 6pm and between 9am and 5pm at weekends. The on-call pharmacist was available out-of-hours via the main hospital switchboard. A specialist neonatal pharmacist was available for the neonatal unit. Doctors could access various online resources to aid prescribing and administration. There was access to the latest information about medicines through the British National Formulary (BNF) online facility, an intravenous (IV) drug database and the neonatal network formulary. All new doctors received a one-hour training session from the ward pharmacist as part of their induction.
- The medicines management policy required processing of prescription orders within an hour. There was evidence that this was achieved in most cases, however, there were examples of two hour processing which led to delays in delivery.
- There was an online system for recording drugs requested with a paper copy for ordering patient medicines to take home. A new process enabled prescription forms for antibiotics, anti-spasmodic and pain relief to be issued to parents for collection from the pharmacy shop in the hospital. A porter had been assigned to deliver medications for patients to take home around the hospital. Discharge packs were available on the ward and included pain killers and laxatives. These were provided to patients when they had been approved by a doctor and nurse prescriber.
- Triple checks of all chemotherapy prescriptions were made by the pharmacist, the consultant or staff grade doctor. We saw details of these checks following an intrathecal route of drug delivery.
- Pharmacists carried out medicine reconciliation. They also attended regional pharmacy meetings at a specialist children's hospital in the region where changes in practice were discussed.
- Medication incidents were reported via the trust electronic reporting system. All medication incident investigations had pharmacy input. There had been several errors where the pharmacist had reviewed the record and advised staff accordingly.
- We saw from records on the neonatal unit that prescriptions were signed and dated. Antibiotics were prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines. Writing was legible and, as required, the weight of the baby was recorded. We also saw from records on the children's ward that documentation was complete and legible. It was signed and dated, with children's weights and allergies recorded.

Records

- Most medical notes for inpatients were locked in a secure room to ensure confidentiality and security. However, the risk register showed there had been instances in the past where notes had been left at the reception area on the children's ward. There was therefore a risk of a breach of security of records when the desk was unattended. A quote for improvement works to reduce the risk by adding doors to the reception area had been obtained and further discussions were underway to discuss the options. Records for oncology patients were kept in a secure office and were well organised in individual labelled drawers.
- Patient records were well completed and reflected the needs of children and young people. We reviewed eight sets of notes on the paediatric ward and four on the

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neonatal unit. We checked a range of information including the diagnosis and management plan, observations, and input from the multidisciplinary team. Also recorded were discussions with the family, consent, allergies, and the signature and date with the name and grade of the doctor or nurse reviewing the patient.

- On the neonatal unit information was clear and concise with details of what was happening now, the long term goals, how they would be achieved, and clear review dates. Care plans were reviewed and updated regularly in conjunction with the baby's family. All paediatric early warning scores were completed and accurately recorded to reflect the routine observations undertaken to determine where intervention might be required.
- Information was similarly complete and concise on the children's ward. Care plans were up-to-date and there was evidence of discussions with the child or young person's parents. Consent forms for sharing information and consent for procedures or operations were completed. All paediatric early warning scores were completed and scored.
- We saw a monthly audit of key documentation for the period between September 2015 and January 2016 with overall compliance ranging from 85% to 95%. Twenty-four components were checked which included medicines, allergies, immunisations, vital signs, orientation to the ward, MRSA screening, malnutrition score, paediatric early warning score and peripheral venous cannula. Senior nursing staff monitored the results and developed action plans to support staff where improvements were required.
- There was an audit for the completion of rounds to assess a child or young person's comfort during the same period. Twenty-eight standards were checked including regular changes of the position of the child in the bed or chair to make them more comfortable, and help to keep their skin from damage from sitting in the same place too long. The child was also asked if they needed the toilet and checks were made to ensure the call bell was within reach and equipment was checked to ensure it was functioning properly. An overall completion rate ranged from 88% to 100%. Fluid balance charts were also audited during this time with overall compliance ranging from 80% to 100%. Areas requiring improvement were identified and actions put in place to address the shortcomings.

- This issue of discharge summaries was discussed at the divisional board meeting. It was agreed to review the discharge processes being followed in other areas to share good practice. Meetings had been held with the IT department to look at options of creating a simpler electronic admission/discharge form for the paediatric assessment unit. The aim was to enable the population of the discharge to be started from the moment the child arrived on the unit. A timeframe for this development was awaited by the board. Further work included two portable computers which had been identified for deployment to the paediatric assessment unit to support real-time data entry. The team had also completed further analysis of the performance of discharge summaries by time of day and day of the week. This was to identify if there were any obvious periods of time when the systems worked better.
- The overall number of discharges had been higher in the later part of 2015 by around 100 per month compared to the first part of the year. With the majority of discharges taking place during the week in the daytime. Performance in the paediatric assessment unit was more variable than on the main ward and the team were focusing first on improving the process of discharge summaries in the paediatric assessment unit before moving onto the ward.

Safeguarding

- There were policies, systems and processes for safeguarding children and young people. The Safeguarding Children and Young People's Policy replaced the Child Protection Policy and was ratified in February 2016. The new policy was consistent with and referenced safeguarding children legislation, national policy, guidance and local multi-agency procedures. The policy clearly described the roles and responsibilities for staff in reporting concerns about children. It covered issues including possible abuse from evidence of bruising to a child, child sexual exploitation, female genital mutilation, human trafficking, fabricated or induced illnesses, and domestic abuse. It included guidance for staff where a child did not attend clinic appointments, which were cancelled for no good reason or the patient did not arrive as booked. A safeguarding children flowchart set out guidelines and the paperwork to be used to ensure effective reporting and information sharing when any safeguarding or vulnerability concerns were identified.

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- Staff we spoke with were knowledgeable about the trust's safeguarding children policy and processes, and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of child abuse. They described what actions they would take should they have safeguarding concerns about a child or young person.
- Staff were trained to the appropriate level relevant to their role and responsibilities. These were set out in the intercollegiate document 'Safeguarding children and young people: Roles and Competencies for Health Care Staff'. They were familiar with government guidance 'Working Together to Safeguard Children'. Records indicated that safeguarding training was up to date for all staff with compliance exceeding the 90% target (level 1: 96.4%, level 2: 93.6% and level 3: 91.4%). Staff were knowledgeable about female genital mutilation (FGM) and aware of their responsibility to report to the police suspicions of FGM in girls up to the age of 18.
- The trust safeguarding department was located in the offices at the end of the children's ward. This was an integrated department consisting of a children's team, an adult team, a learning disabilities team, an independent domestic violence advisor and administrative support. Staff reported the effectiveness of a department that worked together with a team approach across the whole trust.
- There was a trust board executive director with specific responsibility for safeguarding children. This included accountability for ensuring the trust employed audit processes, and safeguarding children practices were efficient and effective. The trust had an identified named individual to attend its Local Safeguarding Children Board. There were nominated individuals to attend their committees and to promote the welfare of children and young people (including unborn). There was a safeguarding named nurse, doctor, specialist nurse and administrator for safeguarding children who provided support for each other. They had arrangements for peer review and supervision.
- The implementation of safeguarding supervision was identified as an area for improvement during the Care Quality Commission (CQC) Safeguarding Inspection in January 2012 and the CQC Looked After Children Survey review in June 2014. A safeguarding supervision audit was completed in September 2014. The audit report provided evidence that supervision was being implemented; however, some departments were finding it more challenging than others to embed supervision within the service area. An action plan was developed and actions were monitored at the children & young people's safeguarding committee. It was recognised that a number of staff would need to be trained to provide safeguarding supervision. Over 30 members of staff in the women's and children's division had attended safeguarding supervision training and the named nurse had established a programme of quarterly one to one supervision for the safeguarding lead nurse within the paediatric and neonatal teams.
- The safeguarding supervision implementation group continued to meet to provide support for supervisors. The implementation of supervision remained a challenge and safeguarding supervision remained on the trust risk register.
- Staff confirmed they were offered opportunities for debriefing and learning following difficult safeguarding events. They were encouraged to use reflection to record their learning.
- Staff told us if a child protection issue was suspected the policy and procedures were followed and were dealt with as a matter of urgency. The paediatric registrar and the named nurse for safeguarding children and young people were contacted for ongoing management and advice. The named nurse and / or doctor was informed of all referrals made to social services. The trust cooperated with any request from the Local Safeguarding Children Board to contribute to multi-agency audits, evaluations, investigations and serious case reviews, including the production of individual management reports.
- Assurances were in place in relation to safeguarding children which included an annual report and audit plan. We saw the trust Safeguarding Children and Young People's Annual Report. This provided an overview of safeguarding activity within the trust between 1 April 2014 and 31 March 2015. The report concluded that arrangements were improving to safeguard children and to meet statutory guidelines.
- Children and young people with a learning disability were identified when they were pre-assessed and / or admitted to the hospital. This was then recorded and filed in their medical records and an electronic flag was entered on the hospital patient administration system as part of their care pathway. This alerted staff to contact the learning disability liaison team who could then provide appropriate support.

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- There was a flagging system to identify children looked after or under child protection but there was an issue relating to the removal of the flag. An active group was looking at this issue in conjunction with the IT department.
- A missing patient procedure was in place if a child or young person went missing or absconded from the ward. Staff told us they followed the guidelines set out in the policy and the hospital security team and the police were notified.

Mandatory training

- The trust provided a programme of mandatory training for staff which included fire safety, infection prevention and control, information governance, moving and handling, resuscitation, safeguarding children, fire training, hand hygiene and equipment training.
- The subjects were reviewed and agreed by the mandatory training review panel and profiles had been developed for all staff groups. Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions, e-learning and e-assessment.
- Staff training analysis reports were available to enable attendance to be reviewed, thereby enabling staff to check their compliance with mandatory training. Information could be divided by personal, managerial and subject level. Staff were able to see whether their mandatory training had been completed and when it needed to be renewed. This supported the appraisal / medical revalidation discussion and personal development planning. Managers saw which members of their team were in date and were able to plan when team members needed to complete refresher training. A subject compliance view was also available to analyse compliance by division for single subjects or groups of subjects. This enabled identification where training needed to be targeted and provided reports to present to assurance and governance committees.
- Changes in legislation and national directives and requirements were taken into account by the training compliance manager. They ensured any implications or changes to training were identified and appropriately revised or new training organised.
- Staff told us that mandatory training updates were delivered to meet their needs and that they were able to access training as they needed it. Most staff said they were up-to-date with their mandatory training or had

dates booked to attend training in the near future. Data provided by the trust showed the current compliance rate, at February 2016, as 88.4% against a target of 90%. This meant that most staff remained up-to-date with their skills and knowledge to enable them to care for children and young people appropriately.

- Releasing staff for face-to-face and e-learning training was critical to the success of the achievement mandatory training compliance. There was a clear focus on improving compliance for mandatory training. The divisional board had approved an approach to focus on one area of training at a time to ensure it was delivered in a systematic and sustainable way. The current training priority was safeguarding for children at level two and three with clear trajectories having been set.

Assessing and responding to patient risk

- Patient risk assessments were completed and evaluated. There were clear processes to deal with children where their medical condition was deteriorating. There were paediatric early warning scores (PEWS) completed within 15 minutes of a child's arrival. Each chart recorded the necessary clinical observations such as pulse, temperature and respirations. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the child to be seen by medical staff. There were details of the escalation required, depending on the scores, on each PEWS chart, and details of the actions taken to respond to the risk.
- Records demonstrated all nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support.

Nursing staffing

- There were adequate nursing staff levels to safely meet the needs of children and young people. At the time of the inspection levels of nursing staff and other clinical staff levels were close to the planned establishment. Data from January 2015 to December 2015 showed total establishment ranging from 103.8 whole-time equivalent nursing staff to 109.5 This included sisters, specialist nurse practitioners, staff nurses, nursery nurses and health care assistants.
- Data for planned registered nursing cover from August to December 2015 showed minor variations from month to month on the children's ward. Staffing levels were

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generally met for both day and night shifts with cover between 94.8% and 98.6%. On the neonatal unit data showed planned staffing levels were almost met with staffing levels between 97.9% and 99.0% of establishment. A senior nurse was always present in the unit which meant senior nursing advice was always available. We looked at rotas on the children's ward and the neonatal unit for the month prior to our inspection and saw that most shifts were covered with bank staff filling any gaps.

- The ratio of nurses to patients on the children's ward met recommended levels. The children's ward staffing levels for children over two years of age were currently one nurse to four patients in the day and one nurse to six patients at night. This was in line with Royal College of Nursing recommended staffing levels. Staffing levels were able to be adjusted based on how many nurses were needed to safely care for patients admitted. Paediatric intensive care standards recommend one nurse for two patients for children requiring high dependency care.
- During periods when high dependency beds were required it was necessary to close four other beds on the ward. This ensured the appropriate level of nursing was achievable within the existing nursing establishment. During busy periods this was not always possible and this was reported as an incident.
- The neonatal unit adhered to the British Association of Perinatal Medicine standards and achieved safe staffing levels. Staffing levels were adjusted accordingly and monitored. The unit aimed to meet the staffing standards which recommended care for intensive care and high dependency babies should be provided by 'qualified in speciality' nurses. This recommendation was calculated based on the intensive care one to one basis, the high dependency one to two basis and special care one to four basis. The recommendation also stipulated a supernumerary team leader should be present on all shifts and this was reflected in the rotas
- The nursing workforce was monitored with the director of nursing at the monthly matrons' meeting. A review of staffing establishment levels was undertaken through the budget setting process. There was proactive recruitment management and this ensured the efficient and timely recruitment of nursing staff.
- Rostering was completed in a fair and equitable fashion and most staff were expected to cover day and night

shifts. Staff who were appropriately trained in paediatric and neonatal care, were flexible in providing additional cover across the children's ward and the neonatal unit when required.

- During the period from May 2014 to March 2015 the average use of bank or agency staff was 7.8% (ranging from 2.7% to 15.6%) on the ward and 1.8% (0% to 3.4%) on the neonatal unit.
- There was time built into shift changes to allow for nursing handover. We observed good handovers on the ward and the neonatal unit and saw the resulting comprehensive notes. Staff said the handovers were well structured and worked well with opportunities for learning. Issues discussed included the 'theme of the week' with a brief high level update, looking at general cover and who was on call and the allocation to individual nurses followed by a detailed individual patient handover. Nursing handovers were attended by nurses, nursery nurses, health care assistants, play specialists and students.
- There was a mixture of short term and long term sickness absence which was being managed in line with trust policy. We were told short-term sickness management was the key priority for the division. There were a variety of sickness interventions across the children's division in conjunction with the human resources department. This was designed to support a continued reduction of sickness absence. Sickness rates were, however, mostly below NHS average rates of around 4%. In the period October 2015 to February 2016 they ranged from 1.7% to 4.1%.

Medical staffing

- Medical staffing levels and skill mix were compliant with the Royal College of Paediatrics and Child Health and the British Association of Perinatal Medicine standards. The medical staffing skill mix showed 34% consultants, 11% middle grade doctors having at least three years at senior house officer level or higher grade within their chosen specialty. There were 47% specialist registrars in years one to six and 8% trainee doctors at foundation years one and two.
- There were adequate medical staffing levels to safely meet the needs of children and young people. There were 12 consultant paediatricians with two designated 'consultants of the week' rotas, one for neonatal and one for paediatric covering from 8.30am to 6pm on Monday to Friday, with an on-call consultant rota out of

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hours from 5pm to 8.30am. At weekends one consultant covered both areas with ward rounds between 8.30am and 2pm and was available on call outside of these hours.

- There was a standard rota providing one appropriate grade junior doctor between 8.30am and 9pm every day for the ward and one for the neonatal unit. A third junior doctor then worked the same shift covering both units.
- A minimum of one additional junior doctor was available between 8.30am and 5pm on Monday to Friday for the paediatric assessment unit, and between 2pm and midnight for the jaundice clinic. There was additional paediatric assessment cover for peak evening hours.
- Core on-call cover was provided by a registrar who covered both units in 8.30am to 9.30pm, and 8.30pm to 9.30am shifts.
- Two additional registrars were available from 9am to 5pm with one registrar for each unit plus a clinic registrar. An additional designated paediatric assessment fellow was available on Monday to Friday from 8.30am to 5pm.
- Three advanced neonatal practitioners (ANNPs) and one neonatal specialist clinical fellow provided additional cover from 8am to 9pm on Monday and Friday, and from 8am to 6pm on Saturday and Sunday. There was an intention to extend this service in the future and move to a more advanced neonatal practitioner model. Two ANNPs had completed their training, one was in training and one was to be recruited. The specialist doctor was covering the vacant post pending recruitment
- The paediatric medical staffing rota for junior doctors was designed to optimise both training and service. Staff cover was targeted to times of high service demand, whilst maintaining continuity. The rota maximised trainee doctors' time to attend and support ward rounds and other teaching opportunities.
- There was a low use of temporary medical staff. Locum doctor use as a percentage of the total medical staffing ranged from 0.2% to 2.2% during the period January 2015 to October 2015
- There was good handover between clinical staff. We observed doctors handover on the ward and the neonatal unit. The sessions were attended by doctors, senior sisters, night registrars and consultants. There was an initial safety briefing followed by discussion about staffing, the capacity within the units, deteriorating patients, incidents, safeguarding concerns

and the 'theme of the week'. Staff worked from an on-line list of patients, and doctors held a paper copy for use as a daily plan for the day. During the handover sessions were opportunities for teaching and learning provided by the consultant.

Allied Health Professional staffing

- There was safe provision of physiotherapy and occupational therapy for children and young people. Therapy staff data for the period from September 2015 to December 2015 showed a number of vacancies in the workforce. There were occupational therapists and physiotherapists with an establishment of 19.4 whole time equivalent (WTE). From the most recent data available for December 2015, we saw there was an actual WTE of 18.2. The planned staffing levels were the number of staff allocated in the budget for a particular clinical area and there were no backfill costs in the budget for annual leave or possible absence. Therefore if staff were on annual or sick leave other staff with paediatric competency were deployed from other areas to cover if required, or the service might be reduced for that day.
- There was a good service from the pharmacist team. A paediatric pharmacist and a specialist neonatal pharmacist were available.

Major incident awareness and training

- There was a trust major incident plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the trust major incident plan and how to access this. There was also guidance for managing in severe weather conditions, the management of seasonal influenza, and an influenza pandemic contingency plan.
- There were local contingency plans for the children's ward and the neonatal unit if there were significant capacity and staffing issues, and problems with equipment. Appropriate actions were described for staff to follow depending on the status of the situation.

Are services for children and young people effective?

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Good



We rated effectiveness as good because:

- Children and young people had good outcomes as they received effective care and treatment to meet their needs.
- Treatment by all staff was delivered in accordance with best practice and recognised national guidelines.
- Children and young people were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for children and young people.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.

However:

- Appraisal performance was below the trust target and required improvement.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them.
- There were clinical pathways for the most frequent reasons where children came to hospital including head injury, abdominal pain and fever. These gave clear and consistent guidance about how to treat these conditions.
- The trust participated in an international database which was used for comparing outcomes across neonatal units. This promoted quality improvement through continuous review of conditions such as sepsis and intracranial haemorrhage. The unit reviewed the annual report, looking at trends and performance to identify key improvement projects and improve outcomes. The information was presented at a neonatal

multi-disciplinary meeting. This led, for example, to a change in practice for the insertion of central lines, which were used to deliver medicines and blood products.

- The division had established a quality improvement forum to oversee projects being undertaken on the unit. This ensured they were delivered in a timely way with positive outcomes for children, young people and their families. Projects were recorded according to the phase of development; the scoping phase, the planning phase, the testing phase, and the implementation phase. Projects in the scoping phase included a review of paediatric sepsis where new documentation had been agreed and would be trialled. Those in the planning phase included the improvement of the format of resuscitation forms. There were a number of projects in the testing phase including safer insulin prescribing within paediatrics. The implementation phase included the improving patient handover to medical staff in an emergency situation.

Pain relief

- There was guidance in care plans about pain management for children where it was appropriate, for example, after surgery. Children's pain was assessed using a variety of methods suitable for children and young people.
- Parents said staff regularly checked with their child asking them if they had any pain and gave pain relief when it was required. For babies in the neonatal unit, pain and stress were monitored and registered simultaneously with other physiological parameters such as temperature and blood pressure. This made it possible to continuously evaluate any pain and the need for analgesics or comfort measures. Every baby was assessed on admission to the neonatal unit and before and after potentially painful interventions, and at regular intervals.

Nutrition and hydration

- The assessment and response to children and young people's nutritional and hydration needs were managed effectively. Children and young people were screened to identify those who were malnourished or at risk of becoming malnourished. Snacks, sandwiches and drinks were available for children in addition to the regular breakfast, lunch and supper.

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- The service had achieved stage three of the UNICEF Baby Friendly Awards which championed evidenced based practice to promote and support breastfeeding. This meant that staff were supporting mothers to recognise the importance of breastfeeding, make informed choices and to support them with continuing breastfeeding for as long as they wished.
- Breast feeding support was provided by the nutrition team who gave advice on milk supply, initiating lactation, pumping, transition to responsive feeding, and any other feeding issues. A room for expressing was provided on the neonatal unit together with a milk kitchen and milk fridges. Once milk had been expressed the mother filled in a label with the name of their baby, date and time of expression, and her signature. A tamper-evident sticker was placed over the lid and down the side of the bottle. Breast milk was stored for 24 hours in the fridges and for 48 hours in the freezers. Temperatures of the fridges and freezers were checked daily and recorded. Paediatric dietitians provided nutritional support, advice and education to children and parents about diet, supplements and enteral feeding.
- Mealtime observation audits were completed monthly and fluid balance charts were audited with input, output and balance recorded at least fortnightly and showed average results at 89% and 92% respectively.

Patient outcomes

- A number of regular audits were carried out on the unit to monitor performance against national patient outcomes and to maintain standards. Audits were monitored at the paediatric audit meeting where action plans to address areas of improvement were regularly reviewed.
- Audits were determined from the top down from National Institute of Health and Care Excellence (NICE) guidance to local ideas and trust requirements. The service participated in the National Audit of Epilepsy 12 (Childhood Epilepsy). The audit showed there was good compliance with all indicators except one which related to the absence of an epilepsy specialist nurse. However, since the audit was undertaken, a nurse was appointed to this role in September 2015. We saw details of the National Diabetes Paediatric Audit 2013 - 2014 which reviewed patient characteristics, demographics, care processes and glycaemic outcomes. Data showed the trust performed worse than the England average for the management of diabetes. There were fewer children who had controlled diabetes compared to the England average. An action plan had been in place to improve the completion of care processes and outcomes, and results for the 2014 – 2015 audit were expected to show an improvement and be similar to the national figures for England.
- The neonatal unit contributed to the National Neonatal Audit Report. The results for 2014 which were published in November 2015 showed the trust scored above average in a number of measures. These included all babies having their temperature taken within the first hour after birth; and 94% of babies having retinopathy of prematurity screening. However, the unit achieved below average results in the documentation of consultation with parents by a senior member of the neonatal team within 24 hours of admission and the administration of antenatal steroids.
- There was a clinical audit programme for the service with 26 audits currently in progress which included feverish illness in children, febrile neutropenia management in children and young people with cancer and the UK cystic fibrosis registry.
- Action plans were in place following participation in audits to address areas requiring improvement. Regular reviews were undertaken to monitor progress.
- Quarterly reports were submitted to commissioners to demonstrate progress against the measures of the quality schedule and the Commissioning for Quality and Innovation (CQUIN) for the appropriateness of admissions for pre-term babies on the neonatal unit.
- There were variable outcomes for multiple readmissions. Multiple admission rates for asthma for children between the ages of one and 17 years from July 2014 to June 2015 were lower (better) than the England average. There was a multiple admission rate of 14.7%, compared to the England average of 16.8%. For epilepsy the rates were higher (worse) than average, with 36.7% readmissions compared to the England average of 27.8%. For diabetes there were fewer than 6% readmissions, compared to the England average of 13.6%.
- Physiotherapy used the goal attainment scale (GAS) light as a standard to regularly audit outcomes for children and young people by capturing the extent to which individual goals for treatment were achieved. The data was used to inform business planning and budget setting for the service.

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Competent staff

- All staff had specialist knowledge and skills to treat children with their presenting conditions.
- Records showed all nursing staff within the children's ward and the neonatal unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support.
- There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and that there was good teamwork. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training and development in paediatric specific areas. Staff said funding requests for external training were generally approved.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training.
- Most staff we spoke with were positive about the quality and the frequency of clinical supervision they received. Attendance was monitored by managers with follow up for non-attendance.
- New nursing staff attended a two day trust induction and were supernumerary on the unit for the first six weeks to achieve their competencies.
- All the staff we spoke with said they had received an appraisal during the last year. The figures provided by the trust showed a compliance rate at February 2016 as 80.4%. Staff learning and development was identified through the appraisal process and through supervision meetings. The divisional management team had asked that all appraisals were booked and undertaken as a matter of priority. An appraisal action plan had been implemented to address the appraisal compliance. Reports detailing outstanding appraisals and those that required completion over the coming three months were sent to managers on a monthly basis in line with reporting procedures within the rest of the trust. There were monthly appraisal performance meetings with divisional managers to escalate overdue appraisals ensuring management accountability. The appraisal training being delivered to managers across the trust had been updated to reflect the need to raise compliance. The principles of the training were being rolled out in management meetings across the division.

- Paediatric nurses on the children's ward were complimented by healthcare assistants and play specialists. On the neonatal unit, nurses were supported by nursery nurses who were specifically trained to care for this group of babies.
- Physiotherapist and occupational therapists were paediatric trained. Surgeons and anaesthetists had appropriate training and competence to handle emergency surgical care of children and nurses were required to maintain paediatric competency.

Multidisciplinary working

- We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations. This was to ensure care was coordinated to meet the needs of children and young people. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment. Staff said they were most proud of the integrated work across all disciplines. A multidisciplinary team office was located in the footprint of the neonatal unit. One member of staff said their colocation enabled "opportunistic interaction" between medical staff and strengthened multidisciplinary working.
- There was access to an integrated therapy service which provided paediatric physiotherapy and occupational therapy. Therapists worked closely with community speech and language therapists who were funded by another provider. Therapy was conducted on the children's ward, the outpatient department, and the neonatal unit. In addition therapists worked in a variety of other settings such as mainstream and specialist schools; at the child's home; early year's settings; and outreach clinics in community settings.
- Physiotherapists assessed, treated and managed children and young people with a variety of conditions affecting gross motor function, which are the bigger movements, such as rolling over and sitting, that use the large muscles in the arms, legs, torso and feet. The conditions could be neurological, developmental, orthopaedic, musculoskeletal, and respiratory or as a result of trauma. Occupational therapists focused on maximising children and young people's cognitive, physical, sensory, and motor skills with treatment plans to enhance their self-esteem and sense of accomplishment.

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- The pre-school therapy assessment provided a service for a child from birth to school entry age with a combination of difficulties. A co-ordinated assessment and a therapy plan to help the child's ongoing development were developed for difficulties including a physical disability, complex feeding difficulties, visual impairment, sensory difficulties, autism and social communication difficulties. Referrers included paediatricians, GPs, therapists, health visitors, teachers and Special Educational Needs Co-ordinator. Once a referral had been accepted the family were offered a screening assessment which might lead to further specialist assessments with individual therapists. A report was produced summarising the child's strengths and needs, and contained a multidisciplinary therapy plan. Where appropriate the child was offered a series of sessions with a therapy support worker who also provided one to one support for parents / carers. This aimed to positively support them in the care of their child. Intensive bursts of therapy were provided with the aim of improving the child's skills. Families might also be offered assessment appointments and specialist equipment. Once a child was discharged, a referral could be made back to see them again should the situation change. Therapy teams worked together to minimise the number of appointments children and families were asked to attend, and produced a coordinated therapy plan.
- Other professionals were called upon to care for babies, children and young people including pharmacists, dietitians, audiologists, and a consultant ophthalmologist. There were two paediatric radiologists who provided clinical imaging including x-rays, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, imaging and ultrasound. Urgent cases were arranged as required and there was a waiting list for MRI scans under general anaesthetic. There was a team to undertake child protection skeletal surveys and these were carried out in the emergency department
- Play specialists helped children to understand their condition and medical treatment. They provided preparation and support for potentially stressful experiences such as medical or surgical procedures. The play team visited all ward areas to assess need and to set up play areas with toys and materials. Play specialists supported siblings and other children to help them understand what their brother, sister or friend was

experiencing. The play team were accountable to the ward sister, to whom they turned for advice and support. Funds were available through trust funds and voluntary supporters.

- The clinical teams on the children's ward and the neonatal unit were assisted by a dedicated team of administrators. This ranged from medical secretaries to ward clerks. They provided comprehensive support to consultants, doctors and nurses with a host of administrative tasks from preparing and despatching letters, preparing discharge reports, answering telephone calls to arranging appointments.

Transition

- A framework was available for all healthcare professionals to enable them to deliver a well-planned transitional process for young people with long-term health conditions and complex health needs as they moved from child-centred to adult-orientated services.
- The transition policy set out best practice principles to ensure that all young people aged 14 to 25 years received a high quality service that was coordinated, uninterrupted, patient-centred, age and developmentally appropriate.
- Most young people transferring to adult services were following a 'Ready Steady Go' transition pathway. Young people and their family were initially introduced to the concept of transition; moving to developing an understanding of their condition and finally feeling confident about leaving the paediatric system. The transition encouraged young people to have a considerable degree of autonomy over their own care.
- Young people and their families were introduced to the pathway through a 'Transition moving into adult care' information leaflet followed by a series of questionnaires at each stage of the pathway and key documents in the form of a transition plan.
- The process commenced at the age of 13 years and a young person was introduced to the adult team at least a year prior to transfer. The timing of transfer was tailored to individual need depending on emotional maturity and cognitive and physical development.
- Transition for those with neurological disorders and complex disabilities, with or without a learning disability, presented particular problems. This was because often there was no single equivalent adult

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service able to take on all of their long-term health care and medical supervision. A lead adult specialty was identified so that care could be coordinated with an emphasis on a holistic approach.

- The specialist nurse for learning disabilities was made aware of those patients with learning disabilities before they were transferred to adult care to assist in planning coordinated care.
- Staff highlighted the achievements in engaging with increasing numbers of adult teams to ensure seamless transition. The development of an IT programme had helped to track young people through the process. This allowed ease of access to transition plans as part of electronic patient records and a web-based hub provided useful information. There was training for staff around the trust and national principals though the transition process. Staff were able to liaise with other agencies which had improved transition across services. Patient experience measures were used to monitor progress.

Seven-day services

- There was 24-hour medical cover seven days a week on the children's ward and the neonatal unit.
- There was access to pharmacy on Monday to Friday between 8am and 6pm and 9am and 5pm at weekends with and on-call pharmacy available via the main switchboard. A paediatric pharmacist was always available for advice on the phone. Access to radiology support at weekends was also available.

Access to information

- Information to deliver effective care was readily available. There was a range of documentation on both units and this was easily accessible. Patient paper notes and records were held in an electronic booking system and they were tracked when they moved around the hospital. An audit of the number of patient paper notes that were prepped for elective admissions and clinics showed that above 99% of notes were available in good time. Staff confirmed records were provided relatively quickly.
- The medical teams said there was good and quick access to test results and diagnostic and screening tests.

Consent

- Staff said they obtained consent from children, young people and their parents / carers prior to commencing

care or treatment. They said children and young people were given choices when they accessed their service. Staff told us about how they dealt with consent issues for young people who did not want to tell their parents. They always tried to sensitively manage the situation while ensuring that the young person received the help they needed.

- Staff were aware of and knowledgeable about the use of Gillick competency principles (used to help assess whether a child or young person has the maturity to make their own decisions and to understand the implications) when assessing people's ability to consent to procedures. We saw nurses involving children and young people in making decisions about their care and treatment and using terminology they could understand.
- The teenage policy contained advice about obtaining consent for examination and treatment of young children. It described what routine procedures would be necessary and advised that consent was obtained in advance.
- Throughout the inspection we saw staff explaining the assessment and consent process to parents / carers and any need to share information with other professionals such as GPs, nursery or school before obtaining written consent. We saw consent forms signed appropriately by parents.
- We heard staff discussing the treatment and care options available to children, young people and their parents.

Are services for children and young people caring?

Outstanding



We rated the care given to children, young people and their parents as outstanding because:

- Children and young people were treated as individuals and as part of a family. Feedback from children, young people and parents had been exceptionally positive. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.

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- Parents said staff were caring and compassionate, treated them with dignity and respect, and made their children feel safe. Staff went above and beyond their usual duties to ensure children and young people experienced high quality care.
- Staff were skilled to be able to communicate well with children and young people to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Parents, siblings and grandparents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- We observed staff treating patients with kindness and warmth. The units were busy and professionally run, but staff always had time to provide individualised care.
- Staff talked about children and young people compassionately with knowledge of their circumstances and those of their families.

Compassionate care

- Throughout our inspection, we observed children and young people being treated with the highest levels of compassion, dignity and respect. We saw all staff going the extra mile to support families' personal and cultural needs.
- We observed a large number of interactions between staff and children and their families. Staff were open, friendly and approachable but always remained professional. Children, young people and families were often delighted when they saw staff they knew and greeted them as if they were old family friends.
- We observed all staff taking time to talk to children in an age appropriate manner. They involved and encouraged both children and parents as partners in their own care. Parents were aware of the named nurse caring for their baby, child or young person.
- The trust used the NHS Friends and Family Test to find out if children, young people and their parents would recommend their services to friends and family if they needed similar treatment or care. The response rate was below target in December 2015, although this was unusual as response rates before this had been above the target. The dip in the response rate was related to the high number of attendances in December 2015 combined with the levels of staff sickness. Staff were therefore less able to promote the questionnaire with as many patients as they otherwise would. Consequently, out of 256 eligible patients, only 11 had completed Friends and Family Test cards. Ward sisters had identified Friends and Family Test 'champions' among the staff. They were focused on ensuring cards were provided even in busy periods, and promoting the importance of the Friends and Family Test. We saw a plentiful supply of cards displayed in both units and an improvement in performance in January and February 2016.
- There were positive results from NHS Friends and Family Tests. Data from April 2015 to February 2016 showed that on the children's ward 81% to 100% of parents would be either likely or extremely likely to recommend the service to friends and family if they needed similar treatment or care. Data for the neonatal unit showed results ranging from 88% to 100%.
- The trust participated in the Care Quality Commission's National Children's Inpatient and Day Case Survey 2014. The survey focused on young patients who were admitted to hospital as inpatients or for treatment as day case patients. It covered every aspect of a child's stay in hospital and included questions relating to caring. The report showed how a trust scored for each evaluative question in the survey, compared with other trusts. Based on their responses a score out of ten for each question was allocated and showed most results about caring were the same as other trusts. The trust performed better than most other trusts in staff introducing themselves, friendly staff and being treated with dignity and respect. They also felt listened to and staff told them what to do or who to talk to if they were worried about anything.
- During our inspection we observed excellent interactions between staff, children, young people and their families. We saw these interactions were very caring, respectful and compassionate. The staff were skilled in talking and caring for children and young people. Parents, siblings and grandparents were encouraged to provide as much care for their children as they felt able to, while young people were encouraged to be as independent as possible.
- Children, young people and their parents we met spoke highly of the service they received. All the feedback we received from the parents was very positive about the care their children received. The comments we received from parents on the children's ward included, "the staff

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have been fantastic", "I'm very happy with the care given to my child", "staff kept my child at the centre of everything", "I've come here for five years and they have always been wonderful", "they always do what they say. "Parents on the neonatal unit were also unanimous in their praise and comments included, "the staff are amazing, kind and lovely. I can't fault them. They are very knowledgeable", "I know my baby is in safe and caring hands", and "staff clearly love their work and the babies... they go beyond the expected."

- The children and young people we spoke with said how good the staff had been in looking after them. Comments from children and young people included, "I love the play room... the doctors are nice and explain things to me", "they help me to be brave" and "the nurses help me to feel better."
- We observed good attention from all staff to children and young people's privacy and dignity. Curtains were drawn around bed spaces for intimate care or procedures, and doors were closed in private rooms when necessary. Voices were lowered to avoid confidential or private information being overheard. All parents said their privacy and dignity was maintained. Children under the age of 12 were supervised at all times by hospital staff when they did not have a parent visiting. One parent told us "I feel very confident in the staff and I'm fine about leaving (my child) overnight in the care of the staff."
- Care from the nursing, medical staff, play specialists and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

Understanding and involvement of patients and those close to them

- Children, young people and their families were involved with their care and decisions taken. We observed staff explaining things to parents, children and young people in a way they could understand. For example, during a complex explanation, time was allowed for either the child or their parents to ask whatever questions they wanted to. One parent commented that they had been "updated on everything in a language I understand."
- Parents were encouraged to be involved in the care of their children as much as they felt able to. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke with all confirmed this was the case. One

parent on the neonatal unit told us how staff had taken time to advise her about developmental care, positioning and turning of her baby, and the parent had gained a good understanding of the reasons why.

- Staff made sure children, young people and parents knew who the staff were and what they did. All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities.
- Staff recognised when children, young people and their families needed additional support to help them understand and be involved in their care and treatment. They were knowledgeable about the trust framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for families with hearing or visual impairment, or who had learning disabilities.
- We observed a doctor in the waiting area of outpatients taking time to talk to a child who was reluctant to go into the clinic room. Through calm persuasion and play the child was encouraged to go into clinic.

Emotional support

- We observed staff providing emotional support to children, young people, their parents, siblings and grandparents during their visit to the unit. Children's individual concerns were promptly identified and responded to in a positive and reassuring way. One parent whose child regularly attended the unit said that "nothing was too much trouble for the staff... from the doctors and nurses to the administration team."
- Children, young people and their families were spoken with in an unhurried manner and staff checked if information was understood. When speaking to parents on the telephone, we overheard staff encouraging them to call back at any time if they continued to have concerns, however minor they perceived them to be.
- Difficult information was discussed in a sensitive manner and a parent told us how supportive the entire team had been during "one of the most difficult periods of my life" adding that "they are always there for me and my family ... they're my guardian angels and I can't thank them enough."
- Staff understood the impact the care, treatment or condition might have on the child or young person's wellbeing and on those close to them both emotionally

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and socially. There was good support from the hospital multi-faith chaplaincy team who were on call at all times for children and young people, and their family and friends.

Are services for children and young people responsive?

Good



We rated responsiveness as good because:

- Services were tailored to meet the needs of individual children and young people and were delivered in a flexible way.
- There were good facilities for babies, children, young people and their families.
- There were no barriers for those making a complaint. Staff actively invited feedback from children and their parents or carers, and were very open to learning and improvement. There were, however, few complaints made to the unit. Those that had been made were fully investigated and responded to with compassion.

However:

- Some other areas used by children in the hospital were not child friendly, particularly theatre recovery rooms.
- There were ongoing concerns about the sustainability of safe provision of high dependency beds on the children's ward with the current workforce establishment.
- The performance for discharge summary completion within 24 hours required improvement.

Service planning and delivery to meet the needs of local people

- The environment on the children's ward and the neonatal unit were designed to meet the needs of babies, children and young people and their families. Staff had been involved in the design and planning phase of the development of the neonatal unit. However, some other areas used by children in the hospital were not child friendly, particularly theatre recovery rooms.
- Parents were encouraged to stay with their child on the children's ward and there were no restrictions to visiting times. Accommodation was provided for one parent to

stay overnight with their child. There were 11 single cubicles each with a wall mounted parent bed. The other beds within the bay had a reclining chair to enable the parent to sleep next to their child. The two bed bay within the baby area of the children's ward had a wall mounted bed as well as a reclining chair and the other two bed bay had reclining chairs. There were also three bedrooms each with two single beds and four family rooms each with a wall mounted bed, en suite facilities and a kitchen. Separate shower and toilet facilities were available for parents and visitors to use and a sitting room with kitchen was also provided.

- There were four double rooms with en suite facilities located within the footprint of the neonatal unit for parents to stay overnight. One of the rooms was suitable for disabled access. The rooms were provided for use by parents of babies who were getting ready to go home, or for parents whose baby was extremely unwell. Both parents or a significant other supporting person, like a grandparent, or friend, were welcome to stay. There were, however, no facilities for siblings to stay overnight. Reclining chairs were available beside each cot side to enable parents to rest as they needed. Other facilities included a parent's coffee room where there were facilities for making tea, coffee and cold drinks, and a microwave to heat food. There was a quiet room, a breast milk expressing room, and a play area for siblings. A quiet and secluded garden was available to families and there was direct access to the garden from each of the double rooms. Linen and baby clothes were available for parents to use for their babies.
- A small chill-out room was available for young people. The room had an area with sofas, a TV, a games' console, a guitar, and table football. One young person told us the room was, however, very small and they would prop the door open with one of the chairs to feel "less trapped." A family were trying to set up the games' console with limited success and were disappointed that it was not "ready to play." There were plans to reconfigure an area next to the school room to provide a larger and brighter area for young people.
- A quiet room was available on the children's ward where staff could talk with parents about difficult or sensitive issues. The Child and Adolescent Mental Health Services (CAMHS), provided by another NHS trust, also used the room for individual sessions with children and young people.

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- For parents of children with diabetes, there was direct access by phone and / or in person to the paediatric registrar for advice if their child was unwell. There were information evenings for children using insulin pumps to attend for advice and guidance.
- Babies and children requiring local paediatric intensive care were transferred to a local specialist children's hospital. Guidelines were in place and transfers were arranged by consultants. Babies, children and young people would be accompanied by an anaesthetist and paediatrician during the journey.
- There were close links with the external provider of community nursing palliative care services. Services were provided for children and young people with life limiting and life threatening conditions. The children's ward liaised with the provider about matters including the criteria for admission and timely discharges, pain management and symptom control. This ensured there was a range of options for children requiring palliative care. Palliative care on the neonatal unit was rare as most babies requiring palliation would be cared for at a specialist centre.

Access and flow

- Data showed the total number of admissions for July 2014 to June 2015 was 7,928 of which 17.7% were day cases, 5.8% elective and 76.5% emergency. National levels showed a total number of spells for the same period with the corresponding percentage division of 23%, 9%, 67%. The number of emergency admissions to the trust were higher than national figures. Neonatal occupancy was 100% in 10 months out of 29 between May 2013 and September 2015.
- There were no emergency readmissions after planned admissions within two days of discharge, for the under one age group, between June 2014 and May 2015. However, readmission rates after emergency admission during the period were higher than the England average. Emergency readmission rates for the age one to age 17 group were higher than the England average following both planned and emergency admissions. Multiple readmission rates were higher than the England average for epilepsy but lower for asthma.
- Primary diagnosis groups recorded on emergency admissions for children under one year of age included acute bronchitis, other perinatal conditions, other respiratory conditions, viral infection and intestinal infection. For children and young people between the ages of one and 17 the diagnosis ranged from viral infection, other upper respiratory infections, abdominal pain, poisoning by other medications and drugs and intestinal infection. The average length of stay for all children and young people from 0 -17 years was similar compared to the England average.
- There had been an increased demand for emergency admissions with a greater concentration of sicker children with complex issues requiring additional work. The medical team were working with commissioners to look at ways of sustaining the current trends in increased admissions. They were also working towards a shift in focus to admission avoidance and were keen to develop the existing helpline for GPs and to further develop the paediatric assessment unit.
- In order to provide safe nursing cover when a high dependency bed was required it was necessary to close four other beds on the ward. This ensured the appropriate level of nursing was achievable within the existing nursing establishment. During busy periods this was not always possible and this was reported as an incident. The paediatric sub-group of the clinical reference board were looking at the whole pathway and had a well-developed business plan to present to commissioners. In the meantime the issues with under-resourced nursing staff for high dependency provision had been entered on the divisional risk register.
- The bed management in situations when four beds were closed required a high degree of planning both in terms of the physical relocation of children and the flexibility of the nursing workforce. Senior staff were required to work clinically alongside specialist and research nurses and bank nurses to cover shortfalls. We observed the process in action with the imminent arrival of a child requiring a high dependency bed. There was a swift response by the entire team from nursing staff to cleaning staff. They relocated patients and reassigned staff. It was evident that this was a well-practised and efficient process.
- The paediatric assessment unit (PAU) was situated in the children's ward. There was one trolley bed in a curtained area along with 12 chairs. There were four lockers and access to the internet, TV, radio and phone, and a range of games. Acutely unwell children and young people were assessed and treated in the paediatric assessment unit between the hours of 9.30am and 10pm. This was unless otherwise directed

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by the need for additional infection control measures or a requirement for resuscitation in the emergency department. There was a dedicated doctor who took phone calls and accepted admissions of children from GPs, midwives and paramedics. From the paediatric assessment unit, children might be admitted to the ward for ongoing treatment, discharged home the same day, or remain in the paediatric assessment unit for a longer observation period. This was to help the team determine if an admission was required.

- Access to Child and Adolescent Mental Health Services (CAMHS) services were managed by the local NHS mental health trust. However, the children's ward had close links with a CAMHS liaison nurse. They contacted the ward every morning, seven days a week. They discussed the children and young people currently on the ward who either had mental health and / or social care conditions or issues. The liaison nurse used a password to confirm their role before discussing any patients. There were arrangements to assess any young person on the ward who was at risk of self-harm within 24 hours of being medically fit.
- There was a 24 hour on-call service with access to a consultant child psychiatrist provided by the local mental health trust. Discussions were ongoing with the local NHS mental health trust to formalise the informal agreement that this consultant would also cover the role of a responsible clinician for mental health services (paediatric) should this be needed. A further business case had been presented by the local NHS mental health trust to commissioners in late 2015 for additional liaison nurse-time for the children's ward and the emergency department.
- There was a dedicated paediatric / emergency department guideline for self-harm in children and young people. This specified that all children under the age of 16 presenting with an episode of self-harm should be admitted to the paediatric ward. Those between the ages of 16 and 18 should get a choice of emergency department observation or ward admission. All children and young people in these clinical circumstances were referred to social care. The data of referrals was not formally collected. However, we were advised that anecdotally in the last 12 months there had been approximately five patients with an eating disorder admitted to the children's ward, typically for more than seven days. This had resulted from the lack of beds available elsewhere to provide medical management of

physiological parameters such as slow heart rate, monitoring of electrolytes, and the potential need for nasogastric feeding, as well as CAMHS care. In addition each year there were a small number of individuals (approximately three to six) admitted from the community with self-harm or other distressing behaviour who were unable to be discharged because of the lack of an appropriate mental health bed. This had, on occasion, necessitated a stay of many weeks.

- Outpatient clinics requiring a paediatrician included dental and dermatology, diabetes, ophthalmology, ENT and orthopaedic. The children's outpatient clinics were situated at one end of the children's centre and were accessed through secure locked doors from the ward and a separate access from the main corridor. There was a large reception area which served the clinics. It was very busy during the time of our visit with orthotic, community and nephrology clinics running that afternoon for dermatology, diabetes and allergy. The receptionist checked children's details for accuracy and updated and recorded children who did not attend.
- The majority of open appointments were on the allergy pathway. Outpatient waiting times for allergy had increased with patients joining the waiting list in January 2016 not being given an appointment for 30 weeks. This had increased to a 32-week wait by February 2016. This was the longest waiting time reported for the year. Remedial actions had been taken by way of ongoing discussions with local commissioners in relation to referral management and advice and guidance to reduce demand. Additional clinics had been set up to reduce the waiting times in the short term. A locum consultant was providing extra clinics and the service was being increased with the appointment of an allergy nurse who was due to start in April 2016.
- Parents we met told us they were satisfied with the speed of appointments and waiting times were kept to a minimum, and they were always informed if the clinics were running late.
- For babies requiring enhanced nursing care on the postnatal wards a neonatal nurse would deliver care and treatment on the ward.
- Surgical services for children were provided in various operating theatres across the hospital. Most day surgery was carried out in the surgical short stay unit with general theatres being used for emergency or trauma surgery. Over a four week period there was a total of 37 day case lists and three main theatre lists. Of these,

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eight lists were dedicated to paediatric patients. The remainder had slots allocated for paediatrics and the children were scheduled to be the first cases on the list. The re-introduction of surgical pre-admission for children was being discussed by the reconvened children's surgical group. The intrathecal route of drug delivery for children was carried out in the day surgery theatre.

- Children and young people were admitted and discharged through the children's ward in line with theatre schedules. Staff from the ward, including nurse and play specialists, accompanied children and young people to the operating theatre. They returned to collect them from the recovery area when they were ready to go back to the ward. Parents were also able to accompany their child.
- We followed a child through surgery from the anaesthetic room, to the theatre and to recovery. There was no dedicated paediatric recovery area. Although there were child appropriate posters on the wall of the anaesthetic room and the recovery area, and a distraction box of toys, the areas were not child friendly. Although recovery nurses were not paediatric trained nurses they were required to achieve and maintain a set of paediatric competencies.
- Oncology services were provided for children with leukaemia, brain tumours, and haematology conditions. The services were part of the South West shared care system, with the local specialist children's hospital as the regional unit. There was a close working relationship with the specialist children's hospital team with integrated care meetings to discuss what part each trust played in the care of oncology patients. Staff attended weekly multidisciplinary meetings by conference call. Minutes were circulated to the oncology team for those children being treated at the trust. A generic email address for the oncology team enabled all staff to share information. Staff had identified a need for psychology input to support many families whose child was receiving treatment.
- Parents told us the oncology service was of a very high standard. One parent said how doctors and nurses "kept to their word about phoning us with updates and blood results." An annual two-day training course was provided by the oncology team for administration of chemotherapy on the ward to ensure there was a core of staff to deliver the treatment.

- An on call oncology service was provided by nurses from the charity organisation 'CLIC Sargent' who also provided palliative care on a rotational basis.
- There were a number of clinics held at the Royal National Hospital for Rheumatic Diseases (RNHRD) for children and young people. These services were planned to be relocated to the Royal United Hospital in the near future. The clinical support for the services was currently provided by paediatricians who were based at the local specialist children's hospital and there was a service line agreement between the trusts regarding their secondment to the RNHRD for the purpose of the clinics. Clinics were held on the upper floor of the RNHRD away from adult clinics. There was lift access and a waiting area with books and toys.

Meeting people's individual needs

- Children and young people were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.
- The learning disability team were notified of admissions of children or young people with a learning disability. Children and young people with a learning disability, and their parents or carers, were encouraged to use the Hospital Passport when they came into hospital. The Passport gave hospital staff important information about children and young people and reasonable adjustments that might be required. It outlined the "Things you must know about me; Things that are important to me; My likes and dislikes". This alerted staff to contact the learning disability liaison team who could then provide appropriate support.
- Outpatient appointments were made via the NHS Choose and Book system. They were triaged daily by a consultant paediatrician. Children were referred for specialist clinics or seen for initial assessment in a general paediatric clinic if appropriate. Requests for more urgent outpatient review were made by letter and were reviewed daily.
- The areas we visited in the children's ward and the neonatal unit were accessible to disabled people, and there were appropriate toilet facilities.
- The trust had recently updated the interpreting and translation policy. It provided a framework to support communication with patients and carers who were non-English speakers, people for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. The policy

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set out clear standards to promote good practice and covered the use of face-to-face interpretation, telephone interpreting, and written translation services. It covered processes for booking an interpreter. British Sign Language interpreters were available and the Royal National Institute for Blind People provided translation into braille. The policy ensured the communication of accurate information so that consent and clinical procedures, symptoms and their meanings could be understood.

- A number of advice leaflets for parents were seen during our visit. These included conditions such as asthma, croup, eczema, grommets, nasal surgery, wheeze management, febrile convulsion. There were also leaflets with advice on going home. One parent told us this information was “very reassuring” and helped them “to know what to look out for and what to do.” Developmental care booklets were available on the neonatal unit about topics such breast feeding, positive touch and the need for rest.
- There were parent information boards on the children’s ward giving details of meal times, infection control, parking, shops, activities and chaplaincy services.
- The hospital’s chaplaincy team provided pastoral support and spiritual care to children, young people and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community. There were five Chaplains providing a 24-hour emergency on-call service, and 15 lay volunteers trained in listening skills. They visited patients and carers on a daily basis. A further 50 volunteers from local churches ran a weekly “Songs of Praise” service for patients in the hospital chapel on a Sunday evening. A shared chapel/prayer room was available 24-hours a day and provided facilities for Christian, Muslim, and multi-faith worship.
- A young persons’ group had been set up for those aged between 13 and 18 years who were interested in healthcare and helping their local hospital. It was intended to be a central hub for young people of things that were happening in the trust and local community.
- The large play room in the children’s ward was inviting and contained an impressive range of toys and activities. This included books, DVD players and films, and a craft table with a host of materials. There were dolls and prams, cars, lorries and ships, jigsaws, dressing up costumes, a den, a toy cooker, and experienced play specialists assisted with child-led

creative sessions. A doll called Ernie was used by the team to act out operating theatre procedures ahead of anaesthesia. Distraction boxes containing toys and items to absorb children were also available. Play specialists provided an outreach service to other areas in the trust. From the completed summary sheets of their departmental visits we saw they visited x-ray and the emergency department. The play specialists were popular with children, parents and staff and they encouraged children to think about the creative activities they could engage with.

- There was a range of other equipment and services intended to help distract and absorb children. A ‘sensory trolley’ was available for stimulating or calming children. A range of other services visited the ward regularly such as ‘Giggle doctors’, who were professional performers trained to work in hospital environments with children with disabilities; dogs visited the children from the charity ‘Pets as Therapy’; and the local mounted police division had visited the hospital and introduced them to their horses. A musician also visited the ward on weekly basis to teach and entertain children.
- Other areas with play facilities included paediatric outpatients, the paediatric assessment unit, and an area for siblings of babies on the neonatal unit.
- Children who were well enough and were in hospital for more than five days received schooling from the local education authority. There was a school room within the footprint of the children’s ward. Medical staff identified children and young people who met the criteria for educational input. Each child was allocated a designated teacher, who coordinated schoolwork, liaised with the child’s school if appropriate, and attended any specific meetings. Children were taught in the schoolroom, in their side room or on the ward. School operated during term-time. Arrangements could be made for children to take exams in hospital. Some school work was displayed on notice boards in the corridor outside the school room and included poems, essays, projects, pictures and feedback about learning.
- As part of the trust’s creative engagement led by ‘Art at the Heart’ (the trust’s own art project) there was a programme called ‘Artsparks’. This was led by an ‘artist in residence’ who ran a weekly creative workshop in the playroom and bedsides on the children’s ward. It enabled children to enjoy producing their own creative work. During our visit we observed children and young

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people creating artwork for a display to be exhibited in the main atrium of the hospital. This was to take the form of a tapestry for the 100 year commemorations of World War One. The hospital was also producing an illustrative book about play in hospitals to send to children prior to their visit.

Learning from complaints and concerns

- Parents knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Most parents told us if any issues arose they would talk to the senior nurse available. Information about making complaints was available in all the areas we visited.
- Prior to the inspection the trust provided details of the complaints in the period from April 2015 to February 2016. There had been two complaints about appointments and we saw details of the outcomes, actions taken and lessons learned.
- Staff encouraged children, young people and their parents or carers to provide feedback about their care. Comment cards were readily available which asked children and parents to indicate how likely they were to recommend services to friends and family, and what was good and or could be better about the ward. The form was available to complete online if preferred.
- Staff were aware of complaints and any learning that had resulted. The staff we spoke with were all aware of the complaints system within the trust and the service provided by the hospital's patient advice and liaison service (PALS). Staff were able to explain what they would do when concerns were raised by parents. They said they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the clinical manager or the trust complaints' process.
- Divisional staff involved with the management and administration of formal complaints met on a weekly basis. They discussed the current status of any complaints, identified themes, and agreed any immediate actions that were required. Learning was disseminated back to the teams involved in a complaint.
- A quality report which highlighted any complaints was produced each month and presented to the quality

board management and the board of directors. The trust's quarterly council of governors meetings included a report from the chief executive which summarised patient experience feedback including any complaints.

Are services for children and young people well-led?

Good



We rated the leadership of the children and young people's service as good because:

- The leadership, governance and culture were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the children and young people in their care, their staff and the unit.
- Frontline staff and managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.
- There was a high level of staff satisfaction with staff saying they were proud of the unit as a place to work. They showed commitment to the children and young people, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Children and young people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

However:

- There were concerns about the impact of the ongoing tendering processes for inpatient therapy provision for children and young people.

Vision and strategy for this service

- There was an integrated business plan for the division and this was aligned with the trust vision where "everyone matters, working together, making a difference.
- Staff had a good understanding of the core values of the service and were committed to providing family-centred care.

Services for children and young people

- Some staff had been involved in the creation of the trust's 'values' in October 2015. They were pleased they had been listened to and were proud to be associated with the resulting core values.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance with and regular meetings. Minutes from the audit and governance meetings from July to December 2015 showed that issues affecting the service were discussed and actions taken. These included a review of incidents reported, risks identified on the risk register, feedback from the Friends and Family tests, complaint reports, updated national guidance, safeguarding updates, pharmacy updates, pilot projects, and new guidelines' presentations. The meetings fed into the trust governance meeting and any actions were tracked to keep them reviewed and updated.
- Regular auditing took place with evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.
- There was a clear performance management reporting structure with regular meetings looking at operational performance and team analysis which fed into the executive performance reviews.
- The units understood, recognised and reported their risks. A risk register was in place and we noted that this had been kept up to date. Risks were identified on the risk register with actions required and taken and a review date. Reference was made to known risks, for example, the risks posed by the storage of some patient's notes at the reception area which at times was not staffed which might result in an information governance breach. Discussions were underway with the information governance lead and the reception team to consider the options.
- There was a range of meetings in different parts of the service. Minutes from the weekly staff meetings on the ward and the neonatal unit showed discussions about clinical incidents, safeguarding issues, training / study days and staffing vacancies. Other regular departmental meetings included, for example, diabetic nurses' team meetings and Band 7 nurses on the neonatal unit.
- Clinical policies and guidelines were available for all staff via the trust intranet system.

- A full review of risk was undertaken each month. Risks were shown by specialty and risk level and mitigating actions were recorded.

Leadership of service

- The local leadership of the services had the skills, knowledge and integrity to lead the teams. The clinical managers were an experienced and strong team with a commitment to the children, young people and families who used the service, and also to their staff and each other. They were visible and available to staff, and we saw and heard about good support for all members of the team.
- The senior management team communicated with staff by email and face-to-face. We received consistently positive feedback from staff who had a high regard and respect for their managers.
- Through the content of governance papers and talking with staff, we saw the leadership of the unit reflected the requirement to deliver safe, effective, caring and responsive and well-led services.

Culture within the service

- The staff we spoke with during the inspection said they were proud to work on the units and were passionate about the care they provided. Managers we spoke with said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality services to the children and young people. One member of staff told us, "I feel supported by my colleagues and a valued member of the team... we are like a family and do the best we can." Another member of staff told us, "this is the most welcoming hospital I've worked in."
- Staff were positive about working for the trust, although there had been times at the end of last year when they felt stretched and under pressure because of the volume of their work.
- The culture within children's services encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their line manager.
- Staff were aware of the trust whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and that concerns would be taken seriously.

Services for children and young people

- The staff teams told us that they were always keen to learn and develop the service. Innovation and improvement was encouraged with a positive approach to achieving best practice.
- It was apparent during our inspection that all the staff had the child, young person and their families at the centre of everything they did. They were dedicated to their roles and approached their work with flexibility.
- A number of staff had been involved in fund-raising activities for the units such as undertaking the Bath Half Marathon. Some staff were involved in development of the 'charity expenditure plan', where wish-lists for the units were discussed. The top wishes included funding for high dependency beds, development of the paediatric assessment unit, a dedicated day surgery area, and development of the play specialist team.

Public engagement

- There were systems to engage with the public to ensure regular feedback on services. This was used for and learning and development. Parents and young people were encouraged to complete Friends and Family Test comment cards. Ward-news notice boards displayed articles about the children's ward that had featured in the local press. This included team awards and visits to the ward by actors appearing in the local pantomime.
- Children, young people and their parents and carers were encouraged to contribute to service development. Various specialist services within paediatrics had support groups and an 'In Your Shoes' listening event was held in September 2015. At this event, children, young people and their families were asked what their ideal ward would look like, to identify the things the ward were doing well, and the things that could be improved. Most comments at the listening event were positive about the quality of care and the staff. A parent commented that the "confidence in the staff allows me to leave my child on the ward and feel safe doing it". Feedback about improvements included suggestions for better technology particularly for families staying for longer periods. People also mentioned knowing more about the ward timetable, not having to give the same history repeatedly at each visit, and having more staff at weekends. A parent commented that "It feels as if you're just waiting for Monday when things get done".
- The trust participated in the Care Quality Commission's National Children's Inpatient and Day Case Survey 2014. The survey focused on young patients who were admitted to hospital as inpatients or for treatment as day case patients. It covered every aspect of a child's stay in hospital from interactions with staff, pain management, and facilities for parents and carers. There were 137 acute and specialist NHS trusts across England participating. Feedback was received from nearly 19,000 young patients. The report showed how a trust scored for each evaluative question in the survey, compared with other trusts. An analysis technique was used to determine if the trust performed about the same, better, or worse compared to other trusts. Results were presented for two main groups: children and young people, and their parents or carers.
- Children and young people were asked to answer questions about different aspects of their care and treatment. Based on their responses a score out of ten for each question was allocated and showed most results about the same as other trusts. Questions were divided into issues relating to safety, effectiveness, caring, responsiveness and well led.
- The trust performed better than most other trusts in how safe parents felt their child was on the ward, staff introducing themselves, friendly staff and being treated with dignity and respect. They also felt listened to and staff told them what to do or who to talk to if they were worried about anything.
- During the period 1 July 2015 to 31 December 2015 the trust conducted an inpatient survey with 86% (25) submitted on the ward and 96% (30) on the neonatal unit. Children and young people and their families were asked to answer questions about different aspects of their care and treatment. Based on their responses a distribution of results was shown and an overall score was shown for each question. Scores were represented in percentages and for the ward ranged from 59% for how they rated the hospital food to 100% for who to contact if they were worried about their condition after they left hospital. For the neonatal unit 87% did not find the environment noisy with 100% answering they had confidence and trust in the doctors and nurses caring for their baby.
- The trust participated in 'Project Search'. This was a one-year course providing training and education for students with learning and/or physical difficulties. It helped them to develop the employment skills needed within the current job market. A student from Project

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Search was working on the children's ward. They were supported with their training by a member of staff to develop experience, knowledge and the confidence to reach the goal of being offered employment.

Staff engagement

- There were systems to engage with staff. All staff we met said they felt valued and part of the team. They were able to express their opinions and raise concerns through unit and trust-wide forums. Information was provided to staff which included pay-slip bulletins where information pertinent to everyone was circulated to every member of staff with their monthly pay-slip. An email newsletter was sent to all staff every Monday via their individual email account. A newsletter was shared with managers across the trust containing information to be shared in team meetings. There were open staff meetings held monthly and the @RUH newspaper published once a month. There was a quarterly Insight Magazine for the hospital membership; a 'Bright Ideas and Innovation Programme' to encourage staff to put forward and implement ideas for innovation and service improvement.
 - Regular meetings and emails provided opportunities for feedback about governance issues such as incidents, complaints and risk assessments. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies.
 - Clinical managers worked on the wards at times to be able to engage with staff and see for themselves any issues staff faced. Staff confirmed they were visible and approachable.
 - There was a trust 'team of the month' system where staff were nominated for particular projects and selected by managers to receive recognition for their achievements. Staff on the neonatal unit were proud to tell us they were awarded 'team of the month' during 2015.
 - Access to 'talking therapy' was available for all staff through the trust Employee Assistance Programme. This was a programme based around cognitive behavioural therapy and provided staff with an independent counselling service and advice line.
- Staff were clear that their focus was on improving the quality of care for children, young people and their families. They felt there was scope and a willingness amongst the team to develop services.
 - There were a number of examples of projects and programmes undertaken. These included the children's ward participation in the Royal College of Paediatrics and Child Health, situational awareness for everyone (S.A.F.E.) programme. This brought together paediatric units from 12 hospitals from across England with each running a local quality improvement programme aimed at improving outcomes for paediatric patients. The two year programme involved trialling a variety of quality improvement techniques with the aim of reducing preventable deaths and errors. The programme trialled models of care including the 'huddle' technique: a ten minute free and frank exchange of information between clinical and non-clinical staff involved in a patient's care. This was in a bid to encourage information sharing and to equip staff with the skills to spot when a child's condition was deteriorating as well as preventing missed diagnosis.
 - Other projects included a specific paediatric insulin prescribing chart, and on-line calculator with the aim of reducing prescribing errors. Another project involved the giving of colourful beads to young oncology patients as meaningful symbols of their accomplishments at each step of their treatment journey. This was designed to support and strengthen children and families coping with serious illness.
 - The paediatric anaesthesia team, together with the ward play specialists, had been awarded team of the month. This was for their work in improving the experience for young patients through the use of iPads for distraction in the anaesthesia room, and placing bandages on toys' arms. Two films had been made at the hospital with the aim to reduce the anxiety for children and their parents. There was one for children up to the age of eight, and the other for children over the age of eight. The films prepared children and their parents for an upcoming operation. They showed what to expect from the time of admission right through until discharge from the hospital. There were details of these films in the patient's admission letter and a link to the trust website to view the films.

Innovation, improvement and sustainability

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- Children`s therapies had introduced new ways of assessing children with developmental coordination disorder. There were `stay and play groups` for children having treatment for talipes to support parents and improved efficiency.
- The neonatal team had worked closely with colleagues in maternity to ensure that optimal delayed cord clamping had become part of standard practice. Implementation of this included the use of special mobile resuscitation trolleys. The team had also worked together on the prevention of cerebral palsy in pre-term labour (PreCEPT) project to increase the use of magnesium sulphate as a treatment to protect the brain of pre-term babies.
- The medical teams were proud of their reputation for teaching and supporting trainees and students. This was reflected by the award of an `excellent` rating for paediatric medical training from Health Education South West`s quality panel. Awards had also been received from the Deanery and Local Education and Training Board for both trainees and educational supervisors.
- The therapy team had been subject to a tendering process and a further round was ongoing for community services. There had been uncertainty for the team with any vacancies being filled with staff on fixed term contracts. Staff were concerned about the future and felt the tendering process was fracturing the integrated therapy services. The team did not feel supported by the division and were frustrated by the lack of communication about the process.

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Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Outstanding	☆
Well-led	Good	●
Overall	Outstanding	☆

Information about the service

Palliative and end of life care at Royal United Hospital Bath encompassed all care given to patients who were approaching the end of their life and following death. Care of the end of life patient could be delivered on any ward or within any service of the trust and included aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months, as well as patients whose death is imminent.

The hospital palliative care team comprised a team of a lead nurse, palliative and end of life care, three whole time equivalent clinical nurse specialists, a part time occupational therapist and part time administrator. The palliative and end of life service was a nurse led service, with the lead nurse also being the end of life lead for the trust. The director of nursing was the board lead. Palliative care consultant hours were organised through an honorary contract arrangement with a local hospice. This was for five sessions per week.

During the period July 2014 to June 2015 the trust reported there had been 1446 deaths in the hospital. During this period there were a total of 652 referrals made to the specialist palliative care team. Of these, 85% were cancer related.

During the inspection we visited sixteen wards and the critical care department. We also collected evidence in relation to the emergency department and spoke with the

nursing discharge team. We spoke with 10 patients and eight relatives. We spoke with four consultants, three junior doctors, 16 nurses, and four health care assistants. We looked at 32 sets of patient records, on the wards and in the bereavement office. We visited the bereavement office and the mortuary area and spoke with staff working there. We also visited the chaplaincy service.

End of life care

Summary of findings

We have judged end of life care overall to be outstanding because:

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams.
- The staff in the palliative care team, bereavement and mortuary service were all up-to-date with their mandatory training.
- People's care and treatment was planned and delivered in line with the latest guidance, standards and legislation. The trust had undertaken a range of service developments over the 18 months prior to our inspection to support the improvement of effective care for patients with end of life care needs. New documentation had been introduced to record a personalised care plan for a dying patient.
- The trust had undertaken a project over the 12 months prior to our inspection called the Conversation Project, whose objective was to improve the identification of patients with end of life needs and their subsequent care.
- Patients were respected and valued as individuals and were empowered as partners in their care. The evidence was universally positive about the way they were treated by staff. Several patients and relatives stated they could not think of how the care could have been improved.
- We found that people's individual needs and preferences were central to the planning and delivery of end of life care. The trust worked with services in the local community to provide continuity of care where possible and engaged with commissioners and community services to drive improvements. Staff were proactive in their approach to understanding individual patients' needs and wishes and in their approach to meeting the needs of vulnerable people.
- We found some aspects of leadership, particularly that of the palliative care team to be outstanding. We found that nursing, medical and healthcare staff across the hospital were being engaged and motivated to improve the service they provided in respect of end of life care. There were clear

governance structures for end of life care with the objectives of the end of life working group being clearly laid out and monitored. There was positive leadership at board level for end of life care.

- All staff we spoke with were very positive about the trust as a place to work.

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Are end of life care services safe?

Good



We judged safety to be good because:

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams.
- Equipment was readily available and properly maintained for the use of patients.
- Records were completed and stored appropriately to protect patient confidentiality.
- Safeguarding vulnerable adults was given sufficient priority. Staff took a proactive approach to report concerns and prevent abuse from occurring.
- Staffing levels and skill mix were planned and reviewed to keep people safe.

However:

- We found there were some inconsistencies in the completion of records, particularly on wards where the staff had not yet received the training input from the palliative care team.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and they reported them appropriately. Staff were aware of the process to report incidents. There had been a recent change to the recording documentation which enabled incidents connected with end of life issues to be more clearly identified. Staff gave examples of incidents that had been reported and the feedback they had received. One incident involved a medication error and another related to a concern that had arisen around a patient discharge.

Duty of Candour

- Staff we spoke with were aware of the new duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This regulation requires the trust to be open and transparent with a patient when things go wrong in

relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff we spoke with said they thought the reporting culture was positive.

Cleanliness, infection control and hygiene

- The mortuary areas were visibly clean and appeared hygienic. The building was purpose-built two years ago. There were clear arrangements for the areas to be cleaned by the cleaning staff and the cleaning that was the responsibility of the mortuary technicians. Cleaning schedules were in place and were being followed. The public areas, which were the waiting area and viewing room, were clean, fresh and appeared well maintained.
- On the wards we visited we saw clear signs reminding staff and visitors to follow the infection control guidance. We saw that staff observed appropriate precautions when attending to patients who were located in side rooms and were being isolated due to infection. We saw staff wearing the appropriate protective clothing and disposing of this correctly. There were hand hygiene dispensers in place and written reminders for visitors to clean their hands

Environment and equipment

- The mortuary was a modern purpose-built facility. It was located in close proximity to the pathology department, the operating theatres and opposite the bereavement office. This helped with the interaction between the different disciplines in the various departments. The staff told us it provided a good working environment and a better patient experience than the previous facility.
- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end of 2015. In response to this guidance the trust had provided alternative equipment throughout. There was guidance about the use of the new equipment was on every ward.
- Staff told us there was a sufficient supply of syringe drivers and pressure relieving equipment and this equipment was provided promptly when requested.
- The mortuary was well organised and well maintained. Equipment servicing was up-to-date and recorded.

Medicines

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- Patients receiving end of life care were prescribed anticipatory medicines. These were prescribed in advance to promptly manage any change in the patient's pain or symptoms. There were satisfactory arrangements in place for the management, prescription, storage and security of medicines. Advice could be sought from the palliative care team and the on call consultant from Monday to Friday. There were arrangements in place for evenings and weekends for advice via the on-call service provided by a local hospice.
- Information and advice about medicines was provided on the wards. Documentation for end of life patients contained information about medicines and there was additional material on the trust's intranet. On two wards we looked at the storage of medicines and saw that all the normal end of life medicines were there. We saw that the controlled drug book was securely located and completed correctly. In the patient records we looked at the prescription and administration of medicines was correctly and clearly recorded.
- Staff told us there was a sufficient supply of syringe drivers and this equipment was provided promptly when requested. Nursing staff told us the preparation of medicines for patients requiring rapid discharge was done effectively and did not cause delays. This included weekend discharges.

Records

- We looked at a total of 32 patient records. These were located on wards and also we looked at a sample of 10 records located in the bereavement office. We found that patients' nutritional and hydration needs had been recorded and risk assessments in relation to falls were completed and updated when required.
- There was a new personalised care plan document being implemented for patients in receipt of end of life care, known as 'The Priorities of Care'. The implementation of version 2 had begun 4 months prior to the inspection and was now being implemented across the whole hospital. We found there were some inconsistencies in the completion of these records, particularly on wards where the staff had not yet received the training input from the palliative care team.
- Records were stored securely and patient confidentiality was maintained. The palliative care team audited a sample of patient notes on a monthly basis and provided feedback to the wards.

- There were clear recording systems in the mortuary for the admission and storage of deceased patients and their discharge to the care of funeral services.

Safeguarding

- Systems, processes and practices were in place to keep people safe identified, through policies, procedures and training for staff. Nursing staff were able to explain the process to be followed if they needed to make a referral. Nursing staff told us the hospital safeguarding team were responsive and supportive. We saw the documentation in one patient's notes where a referral to the safeguarding team had been made. Following discussion and liaison between different professionals it had been agreed there were no concerns that needed further action. We saw this was all correctly documented. We saw that the process had been started promptly and the concerns raised had been looked into without delay.
- The palliative care team, the bereavement team, mortuary staff and the chaplaincy staff we spoke with had completed the trust's mandatory safeguarding training. We saw that safeguarding information was displayed on all the wards we visited.

Mandatory training

- The trust overall figure for the completion of mandatory training was reported as being 91%. The staff in the palliative care team, bereavement and mortuary service were all up-to-date with their mandatory training. We saw the evidence to support this.

Assessing and responding to patient risk

- In the sample of patient records we looked at all the appropriate risk assessments had been completed in respect of nutrition and hydration. The risk of falls was also assessed and documented.
- We observed the morning whiteboard meetings on four of the wards we visited and observed how concerns about any deteriorating patients were identified and shared.
- We saw that comfort rounds were carried out regularly, every two to three hours, and patients' records were updated to reflect this.
- Not all patients at the end of life were referred to the palliative care team but staff told us that when referrals were made the team always responded quickly. If they

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could not attend a meeting immediately they always ensured the ward staff knew when they would be contacting them. All the ward staff were very positive about the responsiveness of the palliative care team.

Nursing staffing

- Palliative and End of life care at the hospital was a nurse-led service and was staffed with four full time clinical nurse specialists. The lead nurse was also the trust lead for end of life care.
- The team provided a hospital-wide service that worked across all settings. They provided advice and support to patients, relatives and staff on all aspects of end of life care, including complex symptom control, patient involvement in decision-making and discharge.
- The team also had a responsibility to deliver education and training to the staff across the hospital. The team supported the work that was being undertaken by the end of life working group
- All wards had a nursing end of life “ambassador” who had received training from the palliative care team. The ambassador was the named link person on the ward who staff could go to for immediate advice or information. They also had an oversight of the individual wards’ implementation of the new documentation and initiatives that the palliative care team were developing. We spoke with five ambassadors who explained how they promoted and championed the provision of consistent and good quality end of life care on the wards they worked. All said they were well supported by the palliative care team. Two junior doctors we spoke with said the input of the end of life ambassadors was really valuable on the ward they worked.

Medical staffing

- Palliative and End of life care was a specialist nurse-led service with specialist palliative care medical cover provided as required. We found there was a sufficient cover provided to ensure the team were appropriately supported and advised about patients’ care and treatment.
- Medical support for palliative care was provided through an honorary contract with a local hospice that provided five sessions of consultancy a week. We met with the consultant who was currently providing this cover. They were positive about the working relationship with the hospital team. The hospice provided out of hours consultant advice and would attend the hospital if

requested. They were able to visit all the patients that required visits and felt they had good communication with the nurse led service at the hospital. They often provided telephone advice and also attended the weekly multi-disciplinary meetings of the team. They received referrals from the team and also directly from consultants. These were usually by telephone and then followed up with the paper referral. The consultant said they felt fully part of the hospital palliative care team and were proud of the work around end of life care that was being undertaken in the hospital.

- The hospice consultant was periodically rotated and annual leave and sickness was covered by other consultants working from the hospice.

Major incident awareness and training

- The mortuary service had a major incident contingency plan that was reviewed annually and was linked to the trust’s overall major incident plan. Mortuary staff were aware of the incident plan. The mortuary had the capacity to utilise temporary storage equipment if required.

Are end of life care services effective?

Good



We judged effectiveness to be good because:

- Patients’ care and treatment was planned and delivered in line with the latest guidance, standards and legislation. The trust had undertaken a range of service developments over the 18 months prior to our inspection to support the improvement of effective care for patients with end of life care needs. New documentation had been introduced to record the personalised care plan for a dying patient.
- The trust had undertaken a project over the 12 months prior to our inspection called the Conversation Project. The objective of this was to improve the identification of the dying patient and their subsequent care.
- The trust had introduced a new Treatment Escalation Plan (TEP) which had replaced the previously used Do Not Attempt Resuscitation (DNACPR) forms. This form recorded the decision about the ceilings of care and treatment a patient should receive and also an assessment of the patient’s capacity to make decisions.

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- Information about patient's care and treatment and outcomes was collected and monitored and this information was used to improve end of life care. Information about the effectiveness of end of life care was shared internally and used to improve the service.
- Staff were appropriately qualified and had the skills and knowledge to carry out their roles effectively and in line with best practice. The expert knowledge of the palliative care team was effectively shared with, and utilised by, the staff on the wards. On each ward there was an end of life care "ambassador" who had received training from the palliative care team and were point of contact for information and support to their colleagues on that particular ward.
- There was evidence of good multi-disciplinary working across the trust and with professionals in the community.

However:

- We found there was some inconsistency in the completing of the priorities of care documents and capacity assessments.
- We found one example where a patient's syringe driver had not been checked at the correct intervals and also examples of nursing staff setting up the drivers without having completed the appropriate competency training.

Evidence-based care and treatment

- People's care and treatment was being planned and delivered in line with the latest guidance, standards and legislation. The trust had undertaken a range of service developments over the 18 months prior to our inspection to support the improvement of effective care for patients with end of life care needs. The trust had based their improvements on the priorities set out in the Leadership Alliance for Care of Dying People publication "One Chance to get it Right". The trust had never used the Liverpool Care Pathway, which was discontinued nationally in July 2014, but had developed their own care pathway for end of life patients which was now discontinued.
- The trust had undertaken a project over the 12 months prior to our inspection called the Conversation Project. This aimed to improve the identification of the dying patient and their subsequent care. The training supported staff to discuss end of life needs with patients and families and also included the introduction of a new personalised care plan called 'The Priorities of Care'. At

the time of our inspection visit 9 wards had been supported to embed the new process. The documentation included the medical assessment that a patient was in the dying phase; a comfort care for the dying nursing record; a daily medical review sticker for the medical notes to identify there was an individual plan of care for the dying patient; and an information leaflet for the family informing them of the support that was available. The documents had been revised recently and the sticker had been replaced with a coloured binding system, to clearly identify the paperwork in the patient file.

- The priorities of care documents had recently been revised and updated to take account of the latest guidance NICE (National Institute for Health and Care Excellence) guidance, (NICE 31). The lead nurse palliative and end of life care and the palliative care clinical nurse specialists had visited all the wards on the trust to discuss the new paperwork and guidance. One senior consultant told us they had found the new guidance and input from the palliative team had "enhanced the staff thought processes" on the ward around end of life care. Another consultant said they believed the palliative care team had, over the previous twelve months prior to our inspection, improved and increased their presence beyond the oncology and care of the elderly wards into areas such as respiratory medicine, surgery and gastroenterology wards. A band 6 nurse told us they thought the new documents and guidance had helped a lot of nursing staff and health care assistants to talk about end of life care more freely and confidently. We found that on wards where the new process had been formally introduced the personalised care plan was being completed and the involvement of the patients and their family in discussions about care and treatment choices was being recorded. Nursing and medical staff were positive about the impact the new care plans were having on the provision of end of life care. There were some inconsistencies in the starting of the priorities of care documents and these were on wards which had not yet been fully introduced to the new process. We saw twenty-two patients who were deemed to be at end of their life and of these eight were yet to have the priorities of care documents started or completed. The palliative care team continued to provide input to the wards with the aim that all staff would be trained to use the new documentation by April 2016.

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- There was a process for all staff to highlight on the ward board, any patient they wished to discuss in relation to possible end of life care, this was done by placing a magnetic “speech bubble” against the name on the ward board. This ensured that the patient’s needs were discussed at the next board round. After an initial roll out across six wards, followed by a further three, this was being implemented across all wards in the hospital at the time of our inspection. Staff were well informed and enthusiastic about the new personalised care plans. Across all wards there was a positive culture to provide high quality end of life care and that the majority of staff were able to explain the key elements of this.
- The trust had introduced a new ‘treatment escalation plan’ which had replaced the previously used ‘do not attempt resuscitation cardiopulmonary resuscitation’ forms. This form recorded the decision about the ceilings of care and treatment a patient should receive and also an assessment of their mental capacity to make decisions. Trust policy had changed in the four months prior to the inspection. As a result it was required that all patients should have a new treatment escalation form completed. We saw examples on one ward of them being discussed at a daily ward round and one junior doctor explained how they ensured the forms were all up-to-date on Friday, ready for the weekend. However, we saw that on some wards a number of these forms were not completed. Nursing staff said that often patients would arrive from the medical assessment unit without the treatment escalation form having been completed. On Forester Brown Ward several treatment escalation forms had not been completed for patients who were deemed to be receiving end of life care. On the William Budd Ward, the Acute Stroke Ward and Helena Ward that all the treatment escalation forms had been completed. Where forms had been completed they had been correctly signed by a consultant.
- The trust had produced a new policy, ‘Care of the Dying Patient and the Deceased Patient’. This policy was ratified by the board in February 2016. We saw that the policy took into account the latest NICE guidance on end of life care, ‘Care of Dying Adults in the Last Days of Life’ (2015). The policy included an updated ‘Last Offices’ policy.
- On the intensive care unit we found that the new documentation was not as embedded there as elsewhere in the hospital. Staff were not as familiar as

on other wards about the priorities of care documentation. The ambassador for end of life on the ward had been in this role for three months. Not all the staff had completed training on end of life care but the nursing staff had good links with the palliative care team and were aware of how to access advice and support when required.

Pain relief

- Patients identified as requiring end of life care were prescribed anticipatory medicines. Records showed anticipatory medicines had been prescribed. Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Wards had an adequate supply of syringe drivers and staff told us these were provided promptly when requested.
- The new priorities for care document had an information section and guidance section about medication. Two junior doctors we spoke with told us they had found this helpful.
- Patients’ pain was regularly monitored and the observations recorded in their records. For some patients staff used the Abbey Pain Scale assessment tool. This was used when there may be communication difficulties as a patient had learning disabilities or a patient had signs of dementia. However, we were told by a ward matron that not all nursing staff had had training in the use of this assessment tool. For other patients we saw that a more detailed narrative was recorded in the nursing notes. On one ward we observed the nursing staff discussing their concern for a patient who was agitated and distressed. A decision was made to escalate the concern to the consultant who subsequently reviewed the medication in consultation with the nursing team.

Nutrition and hydration

- Patient’s nutritional and hydration needs were met. Nutrition and hydration needs were included in patient’s individual care pathways and in the patient records we looked at we saw assessments had been completed and were regularly updated. In the Priorities of Care document, guidance was included around feeding and fluids.

Patient outcomes

End of life care

- Information about patients' care and treatment and outcomes was collected and monitored and this information was used to improve end of life care in the hospital. Information about the effectiveness of end of life care was shared internally and used to improve the service.
- The trust had participated in the national care of the dying audit in 2014 and failed to meet a number of the clinical and organisational outcomes. Work streams and improvement plans were in place which were monitored against these indicators. This work was reported to the end of life working group and from there to the trust board. The Priorities of Care documents addressed many of the areas where improved recording was required. For example, improved recording of spiritual needs, nutritional needs and hydration needs were required. Other organisation indicators which had been addressed included the guidelines for a referral to the pastoral team and a leaflet explaining the grieving process for relatives and friends.
- The palliative care team completed monthly audits of patients' records and these were collated into quarterly reports. The audits were completed on the wards where the 'Conversation Project' had been implemented by the team. Information from these audits was fed back to ward staff and also to the end of life working group. During the twelve month period from April 2014 to April 2015 147 patients' records were audited. Of these 51% of patients died during admission and 49% were discharged from the hospital. There was further breakdown of where patients were discharged to. The data from these audits showed that the project had produced positive results in a number of outcomes. For example it showed that in 95% of cases there was evidence that there had been a discussion with the patient's family and in 96% of cases there was a clear care plan in patients' records.
- The trust undertook a project to receive feedback from families about their experience of bereavement. Feedback was requested via the hospital website, through the Patient Advice and Liaison Service or by telephone contact with the palliative care team. The option to provide feedback was also promoted on a new information leaflet about the bereavement service. Whilst the feedback was positive the sample number, of eleven responses over a five month period, was low and the trust was reviewing the process for capturing this feedback.

Competent staff

- Staff were qualified and had the skills and knowledge to carry out their roles effectively and in line with best practice. The expert knowledge of the palliative care team was effectively shared with, and utilised by, the staff on the wards. Three members of this team had completed a master's degree in palliative care and all nurses had completed an advanced communication training qualification. One nurse had completed an advanced symptom management course, which was run over two days and a further four nurses would be completing this by the end of the year.
- As of September 2015 there were 39 trained end of life ambassadors and 23 of the 31 wards had these staff in place. It was planned that all wards would have trained ambassadors for end of life in place by the end of April 2016. One ward matron told us they no longer had a designated ambassador as they felt confident that all staff on the ward were fully competent with the principles and that all the nursing staff on the ward considered themselves ambassadors for end of life care.
- Staff working as ambassadors had been supported to complete training and further days training for newly designated staff in this role was planned for April 2016.
- The palliative care team had developed some bespoke training for end of life care. This e-learning course was adapted for doctors, nurses, allied healthcare professionals and health care assistants and included the use of two case studies. The training was due to be rolled out in March 2016 and a proposal was being put to the trust board that the training should be mandatory.
- Training on end of life was provided by the palliative care team to new trust staff on their induction. The trust reported that as of September 2015, 300 nurses and healthcare assistants had completed the end of life induction training, 72 junior doctors, senior house officer, nurses and specialist registrars had completed training on the new 'Priorities of Care' documentation and 60 Occupational Therapist and Physiotherapists had completed a training session on palliative rehabilitation. The team had also provided 23 training sessions for junior doctors on palliative care.
- The palliative care consultant provided teaching to the junior doctors. They provided training sessions in the form one hour sessions for foundation year one and foundation year two doctors. The consultant said they

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also provided informal training whilst on the ward and occasionally met with smaller groups of doctors for extra input at their request. We observed one junior doctor receiving advice about potential medication changes for one patient.

- There were clear procedures for making referrals to the palliative care team. There was a proforma document, but referrals could be made by phone and the paperwork provided later.
- Nursing and medical staff told us the palliative care team were very quick to respond to referrals. They explained that not all patients at end of life were referred, only when additional advice or support was required. Ward staff were confident of the ability of their team to provide the appropriate end of life care that was required. There was evidence of end of life care being “everyone’s responsibility” being embedded across the hospital. Staff were able to talk empathetically about the needs of end of life patients.
- Members of the palliative care team all took on particular responsibilities that they reported back to the team on. This included initiatives that were linked to the end of life strategy group work streams.
- Staff we spoke with in the bereavement and mortuary service, the chaplaincy team and in the palliative care team had all had appraisals completed within the 12 months prior to our inspection and were up to date with the required mandatory training.

Multidisciplinary working

- Care and treatment was well coordinated across the range of services that patients accessed. We saw that staff worked collaboratively to understand and meet the needs of the individual patient, and involve the family where appropriate.
- There were weekly multi-disciplinary meetings of the hospital specialist palliative care team. These were attended by nurses, doctors, therapists, administration staff and the chaplain. We attended a meeting and observed discussion of physical, psychological and spiritual needs, nutritional support and discharge planning. We observed there was complex and insightful discussion on all patients on the team’s current case list.
- The palliative care team were developing a project with the pulmonary rehabilitation team regarding advance care planning and end of life care issues. The team also had weekly meetings with the oncology service and the pain team. A member of the palliative care team visited

the medical admissions unit daily and liaised with the ward co-ordinator. The emergency department contacted the palliative care team if they required support or advice about an end of life concern.

- Where appropriate, patients who were discharged had information about advance care planning in their discharge letter. The intention was that the patient’s GP could then continue this discussion with the patient.
- There was evidence of effective and productive working with professionals outside of the hospital. The palliative care team had strong links with the local hospices and a consultant geriatrician explained how they had attended local GP forums to discuss advance care planning. We were told that the palliative care community nurse team would contact the hospital when they knew that a patient they were caring for was being admitted to the hospital. The trust had engaged with the local commissioning groups to review the implementation of Electronic Palliative Care Coordination Systems (EPaCCS), with the aim of improving the electronic sharing of information. The trust was also represented on a local commissioning group’s end of life care programme board, a steering group and an operational group.

Seven-day services

- The hospital did not currently provide a 7 day service from the palliative care team. A business case for seven day working had been put together by the end of life care lead and was due to be submitted to the board in May 2016.
- Out of hours advice was provided by a helpline run by a local hospice. The hospice had a close working relationship with the hospital. Nursing staff and consultants knew how to access this advice service. We were told the system worked effectively and staff gave examples of using the out of hour’s advice helpline and receiving appropriate advice. Two junior doctors we spoke with said they felt supported in the evenings and weekends by the services that were available.
- The chaplaincy provided an on call service over the weekend. Ward staff we spoke with said the service responded promptly to requests for attendance or telephone advice over the weekend. Occasionally religious services were organised at weekends.

Access to information

End of life care

- Staff had access to the information they required to provide good patient care.
- Each ward had been provided with an information folder about the new Priorities of Care documentation to be used for end of life patients. There was also information provided on the hospital intranet about the palliative care support accessible on every ward. These resources had been reviewed and updated during the twelve months prior to our inspection. Staff had access to all hospital policies and guidance via the trust intranet. Guidance and documentation to support anticipatory medicines was available in the information bundle as well as on the intranet. Patient information was transferred effectively between wards when patients were moved. Nursing staff on the wards and the nursing discharge team liaised with local GPs when a patient at end of life was being discharged into the community. Information was also transferred to district nurses if required and to care homes if this was the destination of the patient.
- In the evenings and at weekends staff had access to a local hospice helpline for advice and information.
- The trust produced a regular 'End of Life Care Awareness Bulletin' which contained a variety of recently published articles on end of life care and palliative care issues. This was available to all staff through the hospital academy library.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and, where appropriate, their mental capacity to make decisions was assessed and recorded. The trust had introduced the new treatment escalation plans form which replaced the 'do not attempt cardiopulmonary resuscitation' documentation previously used. There was a new policy, implemented in the four months prior to our inspection, which required that all patients admitted should have a treatment escalation completed. The form allowed staff to record the fact that a patient was assessed as not to having the mental capacity to make decisions and identify who had been consulted in the decision making process. We found some inconsistency in the completion of the forms. Not all forms we looked at had the detail recorded of how a decision had been reached.

There was an assumption of capacity if not recorded otherwise, which was correct, but the new trust requirement for the form to be completed in all cases was not yet embedded across all the wards we visited.

- Not all nursing staff had completed training on the Mental Capacity Act 2005 but senior staff understood the process and procedures to be followed if a patient's capacity to provide informed consent was in doubt.
- Nurses were aware of the Deprivation of Liberty Safeguards and we were shown the process that was followed and the forms that were used. We saw the documentation that had been completed in respect of one patient who had a safeguard in place. This had been completed and updated when required. We saw the documentation that had been completed following a best interest meeting that had been held for a patient who had been assessed as not having capacity. It was clearly recorded who had attended and the reasons for the treatment decisions taken.

Are end of life care services caring?

Outstanding



We judged caring to be outstanding because:

- Patients were truly respected and valued as individuals and were empowered as partners in their care. The evidence was universally positive about the way they were treated by staff. Several patients and relatives stated they could not think of how the care could have been improved.
- There was a strong patient-centred culture and staff truly were motivated to provide high quality end of life care and support that promoted patients' dignity and respect.
- Staff ensured as best they could that relatives were supported, involved and treated with compassion. There was strong and consistent positive feedback from relatives regarding their interaction with all the ward staff.

Compassionate care

- Patients were truly respected and valued as individuals and were treated with kindness and compassion. The

End of life care

evidence was strongly consistent and universally positive about the way they were treated by staff; several patients and relatives stated they could not think of how the care could have been improved.

- We observed compassionate care in the approach from all the staff we saw on the wards. This included consultants, nurses, care assistants and cleaning staff. Descriptions of the care from relatives and patients included, “brilliant, so caring I cannot say any more”, “absolute magic, they are so gentle with mum, very compassionate”. A patient said the nursing staff were “amazing people, the care is fabulous”. They told us they enjoyed being in side room, and explained how the nursing staff had answered all their questions. They felt fully informed about their condition and prognosis. They told us how the nursing staff had liaised with a local hospice to ensure that they had the right support when they were discharged home. We found staff were compassionate in their approach to the needs of patients and understanding of the needs of relatives. One nurse explained how they were ensuring that relatives of a patients with dementia were supported to take a break. The nurse had organised for volunteers to sit with the patient for short periods to ensure the family were supported.
- Another patient told us “all the staff have been absolutely marvellous, with a smile on their face”. They said the care was excellent and that the cleaning staff were friendly.
- A third patient used a preferred name which was different to the name recorded in their records. They told us that all the staff remembered to use their preferred name, including the cleaning staff. They said “I do not want to suffer but I know the team here will give me all the support I need...everyone has cared for me well, from the cleaner to the sister”.
- We saw a number of letters received on different wards from relatives thanking staff for their care and compassion. One stated they thought the ward staff were “an absolutely wonderful group of people” and they would never forget the ward staff, who they described as “extraordinary in their compassion...I will never forget the kindness”.
- We spoke with the cleaning staff on a ward where several patients were receiving end of life care. They demonstrated awareness of their role in supporting the provision of compassionate care for dying patients and being sensitive to the needs of relatives. They explained

how they always respected the privacy and dignity of the patients and relatives and organised the cleaning around their needs. They told us they liked to keep the rooms clean but communicated with the nursing staff when they felt they should delay the cleaning if patients were near to death. We observed how the cleaning staff escalated a maintenance fault with the hot water in a side room, as they thought it was important for the dying patient’s dignity.

- Deceased patients were transferred by hospital porters to the mortuary in a discreet and respectful manner. The mortuary staff ensured they were aware, from the documentation, that any particular religious or cultural wishes were respected. Mortuary and nursing staff said the porters treated the deceased patients with respect and were sensitive to the feelings of other patients on the wards.
- We observed the process for the recording, storing and returning of a deceased patients possessions by the bereavement staff. This was done in a sensitive and respectful manner.

Understanding and involvement of patients and those close to them

- All the relatives and patients we spoke with were consistently and strongly very positive about their involvement and understanding in the care and the decisions that needed to be made. We were told several times that the staff were excellent at communicating and ensuring they had the information they needed.
- We observed two instances where the medical and nursing staff discussed symptom control with patients and their relatives. This was done in a sensitive yet direct manner that also ensured the information was communicated effectively. These discussions took place, taking into consideration the privacy and dignity of the patients concerned.
- Relatives commented upon the honesty of the staff and how information was communicated in clear terms but always with sensitivity. Relatives described how they had full and open discussions with staff about treatment and prognosis. We spoke with members of one family who explained how the consultant had explained the transition to the end of life care pathway and the documentation they would be using to ensure the best care possible was provided.
- One patient we spoke with explained how the communication between the staff, their GP and the local

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hospice, where she was hoping to go, had been carried out by the nursing staff. They explained how the treatment escalation form had been discussed with them and how they were happy with the decision and their involvement in this.

Emotional support

- Staff demonstrated they understood the impact a person's care and condition had on their wellbeing and their relatives. Patients and relatives told us how the staff were supportive and understanding and listened to their concerns. We observed a consultant providing reassurance and compassionate advice to two patients, both of whom were distressed about their treatment and prognosis.
- Patients and relatives were given appropriate support and information to cope with their care and treatment. One relative explained how they had been supported by one of the nurses when they had become very distressed during their first visit to the ward. They had later tried to apologise but had been told that no apology was necessary.
- Two relatives told us how the ward had arranged for the chaplaincy volunteers to visit and how this had been of comfort. We saw how patients with few or no visitors were supported to access the pastoral and chaplaincy service.
- We saw how a patient with mental health needs and a learning disability was supported to see one of the chaplains. This had helped provide some reassurance to the patient and increased their acceptance of their prognosis.
- In three patients records we saw that regular assessments were being updated in respect of the patient's mental health, which had been identified as a concern by the nursing staff.

Are end of life care services responsive?

Outstanding



We judged responsiveness to be outstanding because:

- People's individual needs and preferences were central to the planning and delivery of end of life care. The trust

worked with services in the local community to provide continuity of care where possible and also engaged with commissioners and community services to drive improvements.

- Staff were proactive in their approach to understanding the individual patient's needs and wishes.
- Staff were positive in their approach to meeting the needs of vulnerable people.
- Rapid discharge was provided for patients when the appropriate packages of care or placements were available in the community.
- Complaints were responded to in an open manner and improvements made when an opportunity was identified.

Service planning and delivery to meet the needs of local people

- There had been 1446 deaths in the hospital during the period April 2014 to April 2015. The last completed annual audit showed that there had been 652 patients referred to the palliative care team between April 2014 and April 2015, which was a 10% increase on the previous year.
- Work was being undertaken with commissioners and other providers to improve the service planning and delivery for the community. The trust was also represented on a local commissioning group's end of life care programme board, a steering group and an operational group.
- When possible side rooms were provided for patients who were on the end of life pathway. Relatives were supported to stay on the wards and were provided with folding beds and reclining chairs. Additional beds had been purchased during the 12 months prior to our inspection. There was also a "comfort box" provided for visitors that contained items to help with the stay, including blankets, music cds and colouring books and crayons for any children who might be visiting. Relatives told us they were able to get drinks and food. On several wards there were also designated small side rooms where relatives could talk privately to staff and make themselves refreshments. Subsidised parking was available and publicised to relatives. The end of life working group had a plan to undertake a review of the quiet rooms and facilities for relatives of patients at end of life across all wards.

Meeting people's individual needs

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- We saw that patients received care that was tailored to meet their needs and preferences. A key aspect of the 'Conversation Project' was the promotion of staff having a discussion with a patient, or their relatives, about any particular wishes they had for their end of life care. We saw that a patient's treatment took into account their disability, age religion or beliefs or other individual needs they had. Vulnerable adults were treated with respect and with the appropriate reference to safeguarding guidance when needed.
- Staff had completed dementia awareness training and nurses explained how they approached pain assessment in patients who had dementia. We saw the notes for one patient where the nurse had recorded details about the signs that staff should be aware of in relation to the patient being in discomfort or pain. The trust employed two dementia coordinators to provide support and training to staff and also support for relatives. The Priorities of Care documentation also helped identify patients who were living with dementia.
- A patient with a learning disability spoke positively about how the nursing and medical staff had explained their illness and the treatment options. The staff on the ward had ensured the patient was communicated with effectively and supported through their decision making. There was recording in the notes of the decisions and discussions that had occurred. The patient was very positive about their care and it was evident they had trust in the nursing staff.
- A pain assessment tool was available to be used by staff if required, when providing care for patients with a learning disability. The palliative care team had produced an advanced care planning leaflet specifically for patients with a learning disability and their families. There was also a leaflet called 'This is Me' which could be completed for patients with a learning disability. There were two specialist nurses who staff could contact for advice. One nurse explained how they liaised with the staff from a care home to ensure they had accurate information about a patient's needs and, in particular, the person's communication needs.
- Staff told us about two incidents in the two months prior to our inspection where the ward staff had made arrangements for patients to see their pets. There had also been three weddings arranged and supported for end of life patients during the 12 months prior to our inspection.
- Relatives told us of various acts of kindness by staff. One told us how they had noticed that the staff had applied their mother's hand cream which they had brought with them to the hospital. Another explained how they arranged for a favourite piece of music to be found.
- There were various leaflets and information available for patients and relatives. These included booklets on the chaplaincy service, the bereavement office and the Conversation Project, as well as information about specific conditions. There was a Macmillan office on the site which had various information leaflets for patients and relatives. Relatives we spoke with said they were satisfied with the written information the hospital provided.
- The hospital had a chapel which had made adaptations to accommodate different faiths. There was a designated area for male and female Muslim prayer and an area for non-denominational meditation. A facility next to the chapel had been provided for people to complete ablutions. The chapel was located on the first floor of the hospital but was not well signposted from the main entrance of the hospital. The chaplaincy was staffed with one full time chaplain, four part time staff and fifteen volunteers. They were organised in order to ensure every ward was visited and there was a daily visiting list made up from the various referral sources. Volunteers were allocated to specific wards, which they visited regularly.
- The bereavement and mortuary service helped families arrange viewings of the deceased if these were requested. These were generally only available in the afternoons between Monday and Friday but if specific requests were made they could be arranged for weekends, although we were told this rarely happened.
- The mortuary was a modern purpose built facility which had been in operation for approximately two years. It was located in close proximity to the pathology department, the operating theatres and opposite the bereavement office. This helped with the interaction between the different disciplines in the various departments. The staff told us it provided a good working environment and a better patient experience than the previous facility.

Access and flow

- Patients were able to access the expertise of the palliative care team without delay. Nurses on the wards and consultants explained how the team responded

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promptly to referrals or to requests for support or advice. In an audit of 147 patients records completed in March 2015 on wards where the Conversation Project had been run it was shown that in 99% of cases there was evidence it had been identified that a patient was approaching the end of their life 96% of the records audited showed there was a clear, documented multi-disciplinary care plan.

- The trust did not have data for the number of rapid discharges completed, or those achieved within 24 hours, for end of life patients. However, we spoke with the discharge team who explained that rapid discharges for end of life patients could always be arranged, provided the appropriate package of care was available either in the community or a nursing or care home. Sometimes the lack of these care packages resulted in delayed discharges.
- The trust was engaged with local commissioners and also with a local hospice to improve the discharge pathways for end of life patients. The recruitment of a specialist nurse for Continuing Health Care was planned for April 2016, to be funded by a local commissioner, and to be based within the hospital. This would improve communication with, and access to, the community facilities that could be used for end of life patients who wished to be discharged from the hospital.
- The director of nursing, who was the board lead for end of life care, chaired the discharge project board whose role was to improve and highlight areas of capacity and which also linked in with the local commissioning groups. Discharge capacity was on the trust risk register.
- The most recent audit completed by the palliative care team completed in March 2015 showed that 51% of end of life patients died during admission and 49% were discharged. Of these 31% were discharged home, 49% to a nursing or residential home, 12 % to a community hospital and 4% to a hospice. At the time of our inspection the trust did not audit if a patient achieved their preferred place of dying or care. However, information related to discussions about the preferred place of death that were undertaken with the patient and their family were recorded in the priorities of care documents. Despite the absence of audit data we were assured of the quality of service being delivered to patients the service had identified as dying, and the recording of the ensuing conversations undertaken about preferred place of death. This was evidenced by an audit which was undertaken on the records of 147

patients who had died on the wards where the Conversation Project had been run, which showed that in 98% of the records there was evidence there had been discussions with the patient or family about their end of life care wishes.

- Audit of the preferred place of dying was planned to be undertaken after April 2016 as the trust continued to evaluate the impact of the Conversation Project and the new care planning documentation. The trust was working with local commissioning groups to improve the sharing of electronic records which would also improve the accuracy of data to support a preferred place of dying audit.

Learning from complaints and concerns

- There were few complaints received in respect of end of life care but we saw evidence that, when received, they were investigated appropriately. We saw two examples of changes that were made following complaints or concerns raised by patients or relatives. In one instance, changes were made to the procedure for returning a patient's valuables and belongings. Another example was a new policy on "care after death" which clarified the procedure for a hospital doctor to travel to a community hospital to sign the death certificate if they were the last doctor to see the patient before discharge. This ensured an improved experience for relatives following bereavement. We saw the minutes from an end of life working group meeting where the learning from complaints was shared and documented.
- We saw that concerns were documented in patients' notes on two wards. The nurse had recorded the concern and the outcome. In both cases this had involved providing additional information and reassurance to the relatives. One of the relatives who had raised a concern told us the staff responded positively, listened to their concerns and that the matter was resolved very quickly.
- Other relatives and patients we spoke with told us they felt very confident about approaching ward staff about any issues or concerns as staff were very approachable.

Are end of life care services well-led?

Good



We judged leadership to be good because:

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- The leadership, governance and culture were used to drive the improvement of end of life care. The objectives of the end of life working group were stretching and innovative but clearly designed to bring about trust-wide improvement across the scope of end of life care. We found some aspects of leadership, particularly that of the palliative care team, to be outstanding. We found that nursing, medical and other healthcare staff across the ward were being engaged and motivated to improve the service they provided in respect of end of life care.
- There was a clear governance structure for end of life care. The objectives of the end of life working group were clearly laid out and meetings were well attended. Meetings were chaired by the director of nursing.
- All staff we spoke with were very positive about the trust as a place to work.
- There were a number of initiatives in place to further develop and improve the service, including developing links with community-wide services and commissioners.

However:

- There was limited formal public engagement to involve people and seek their views on the end of life care at the trust.

Vision and strategy for this service

- The vision and values for end of life care were widely understood across the trust; although the wards where greater input had been provided by the palliative care team were completing the new documentation more consistently. There were defined objectives and a clear action plan that was being reviewed and monitored by the end of life working group. Nursing and medical staff we spoke with on the wards were aware of the improvements that were being implemented.
- The trust had a policy for end of life care which had been ratified in February 2016. This policy encompassed a wide range of areas, including care of the dying patient, privacy and dignity statements and care after death, including the Last Offices policy. The end of life working group had identified the development of a trust-wide end of life strategy as a new work stream to be developed after April 2016.

Governance, risk management and quality measurement

- There was a clear governance structure for end of life care. The objectives of the end of life working group were laid out in work-streams and reported back to the group.
- This group met quarterly and reported good attendance. The group was chaired by the director of nursing. Membership included consultants, representatives from the chaplaincy, and patient experience team, clinical nurse specialists and representatives from community services and the local hospice.. We saw minutes from the previous two meetings which showed a full range of issues were discussed, including the various work streams and information sharing around NICE guidance
- The palliative care team had monthly team meetings, as did the bereavement office staff and the mortuary team. Staff explained they could raise concerns and ideas and these would be discussed. Staff reported that they received relevant and up-to-date information through their staff meetings.
- There was not a specific end of life risk register, as risk registers were held within the individual areas or divisions. However, risks related to end of life could be placed on the trust- wide register. The risk of delayed discharge was the only current risk relating to end of life that was on the register.

Leadership of service

- We found that there was effective leadership that promoted and supported the delivery of high quality person-centred care. This was evident in the leadership of the palliative care team and at trust-wide level. We saw that individual nurses, sometimes working as ambassadors for end of life care, provided good leadership and direction to other staff working on their respective wards. We found that staff were engaged and motivated to provide a high quality service which they were proud of.
- Palliative and end of life care was a nurse-led service. The lead nurse palliative and end of life care nurse met regularly with the director of nursing every six to eight weeks, in addition to the meetings of the end of life strategy group, which met quarterly. The end of life lead presented the annual report to the board and reported to other senior management teams, including the trust board of directors and the trust quality board. We were told how senior consultants had supported and championed the Conversation Project which had been

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introduced across all the wards. The lead nurse palliative and end of life care and palliative clinical nurse specialists had visited all the wards to discuss the principles of the project and share its objectives with as many staff as possible. The director of nursing and lead palliative care nurse told us there was excellent engagement from senior consultants across the trust on end of life matters.

- Consultants and junior doctors we spoke with were very positive about the palliative care team. We were told the palliative care team had raised its profile over the 18 months prior to our inspection and appeared to have very positive leadership and direction.
- Nursing staff on the palliative care team said they were well supported by the director of nursing who was the lead on the board for end of life care. They could approach them with ideas and concerns and would be listened to.

Culture within the service

- All staff we spoke with were very positive about the trust as a place to work. We found staff were proud of their teams and colleagues and felt able to approach managers with concerns or ideas. Many staff we spoke with had completed their training at the hospital and worked there for many years. The director of nursing described the palliative care team as a “can do” team that never failed to recruit as it provided such a positive work experience.

Public engagement

- There was limited formal gathering of views from the public about end of life care. There was an option for relatives to feedback about their experience but the publicising of this had produced a limited response. The working group were looking at ways of improving this engagement.
- We saw on all the wards we visited examples of cards and letters that had been sent to the staff by relatives of patients to express their appreciation for the care and treatment.

Staff engagement


- Information was provided to the staff through a regular trust newsletter and also via email updates from the chief executive.

- The palliative care team had plans to establish a social networking forum for hospital staff to share information and learning in end of life care.

Innovation, improvement and sustainability

- The end of life working group had a work plan in place which was aligned to key objectives, many of which were drawn from the results of the last national care of the dying audit.
- The board lead for end of life care explained how they were working to improve the integrated working of professionals across the wider community. This included supporting of generic documentation, such as a new Treatment Escalation Plan which was being introduced nationally later in 2016. The trust had engaged with the local commissioning groups to review the implementation of Electronic Palliative Care Coordination Systems (EPaCCS), with the aim of improving the electronic sharing of information. The trust was also represented on a local commissioning group's end of life care programme board, a steering group and an operational group.
- There were plans to second junior nurses, who may wish to become clinical nurse specialists in the future, to the palliative care team. Innovative methods of funding were being considered for these posts, including possible secondments from local hospices.
- There were plans to locate a new specialist nurse for Continuing Health Care in the hospital, who would be funded by one of the local authorities. This would help with liaison with community hospitals and other local care providers and reduce the frequency of delayed discharges.
- The trust was working with a local hospice on a discharge project to improve safe and timely transfer of patients to their preferred place of care.
- The trust had also worked with the same local hospice to provide secondment and shared training opportunities for staff. During the 12 months prior to the inspection, a physiotherapist and an occupational therapist worked part-time on secondment with the hospital palliative care team.
- There were plans for the end of life working group to develop a trust-wide strategy on end of life care. This would further support the implementation of the trust policy on end of life care and the various initiatives that the palliative care team had implemented.

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

Information about the service

The Royal United Hospitals Bath NHS Foundation Trust provided outpatient and diagnostic imaging services at the Royal United Hospital. These departments provided care and treatment to a local population of over 410,000 people across Bath and North East Somerset, Wiltshire, Somerset and South Gloucestershire.

The outpatient departments saw over 680,000 patients from January 2015 to December 2015. The diagnostic imaging department completed over 290,000 patient examinations each year. These ranged from plain x-rays, CT and MRI scans, nuclear medicine scans and ultrasound.

During our inspection we visited the outpatient departments for consulting and treating pain, oral/maxillo-facial, neurology, phlebectomy, dermatology, urology, breast, diabetes, cardiology, general surgery, ENT, audiology, eye, orthopaedic and fracture, haematology, respiratory and vascular. We visited the diagnostic imaging department including general radiology and nuclear medicine. We spoke with 40 patients and 23 relatives and carers. We also spoke with 45 members of staff including managers, clinical (doctors, nurses, allied health care professionals and health care assistants) and non-clinical staff.

Summary of findings

We rated this service as good overall because:

- There were good systems in place for incident reporting and learning from when things went wrong.
- Systems were in place for the safe administration of medicines and for the prevention of infection.
- The departments were clean and tidy and they scored well within cleaning and hand hygiene audits.
- Nursing staffing was good in terms of numbers and skills within outpatients and diagnostic imaging departments,
- Staff were competent in the roles they were being asked to perform. There was good multidisciplinary working both within the trust and with other external organisations such as other health care providers. A comprehensive audit programme was in place across outpatients and diagnostic services.
- Staff treated patients as individuals, and showed them respect and treated them with dignity. Patients told us how professional, kind and caring staff were towards them and how they provided emotional support for their patients. The family and friends test showed very positive results. This was reiterated in the positive comments of the 40 patients we spoke with during our inspection.
- Good governance systems were in place across outpatients and diagnostic imaging. Staff told us how their immediate line managers and divisional managers were always available and felt their view were listened to and respected. Managers also told

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us how proud they were of their teams and the care they provided to patients. Staff put patients at the centre of everything they did and the trust supported them to do that with an open and honest culture. Staff and patients had opportunities to give their feedback on services and they felt listened to.

However:

- Staffing was more problematic with the medical staffing numbers. This was mainly because of senior doctors retiring and subsequent problems in recruiting suitably experienced and qualified staff.
- Within some specialties patients were waiting long periods of time for their appointments. The trust was working to resolve the waiting times and acknowledged they still had improvements to make. We saw evidence that complaints were discussed at departmental meetings and changes were made where necessary to help prevent further complaints. We observed good practice for patients with dementia and learning difficulties.

Are outpatient and diagnostic imaging services safe?

Good



We rated this service as good because:

- Systems were in place for the recording, investigation and learning from incidents. Staff reported incidents when they occurred and we saw evidence that lessons were learnt.
- The outpatients and diagnostic imaging departments were aware of their responsibilities around Duty of Candour and gave examples of where they had been open with patients and apologised.
- Equipment was checked regularly to make sure it was fit for purpose and medicines were stored and checked in line with trust policy.
- Medical records were available for 99.9% of all outpatient appointments.
- Staff within the outpatients and diagnostic imaging departments were up to date with their mandatory training including infection control and resuscitation.
- There were sufficient nursing staff to meet the needs of patients.
- All the outpatient and diagnostic imaging departments scored well with their hand hygiene audits.

However:

- Patients were not always able to access timely appointments due to the lack of medical staff. The provider was aware of the problem which had occurred because of the retirement of a number of senior consultants and subsequent problems in recruiting experienced and qualified staff.
- Some outpatient departments in the older parts of the hospital had experienced environment and maintenance issues. This was being addressed through the new building and refurbishment work taking place at the time of our inspection.

Incidents

- Systems were in place across the outpatient and diagnostic imaging departments for recording, investigating and learning from incidents.

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- Information provided to us by the trust before our inspection showed that the outpatients and diagnostic imaging departments had three serious incidents from February 2015 to January 2016. Two incidents involving patients falling and one unexpected death. Each serious incident had been appropriately investigated and where necessary actions taken to prevent similar incidents from occurring again. For example, the death of a patient in the imaging department had led to new procedures being put in place. This made sure that if patients on the ward were unwell, they had a nurse escort accompany them to the imaging department.
- From February 2015 to January 2016, the outpatient and diagnostic imaging departments recorded 601 incidents of which the majority (595) resulted in no or low harm to patients. This number of incidents represented 8.7% of the total number of incidents reported across the trust. The majority of incidents within outpatients and diagnostic imaging related to poor documentation (17.1%), the clinical assessment of patients (16.5%), access to appointments (12.1%) and infrastructure which included staffing and environment issues for example (6.8%).
- Staff across outpatients and diagnostic imaging were fully aware of the incident reporting procedures and their own responsibilities to raise concerns and record safety incidents. Staff we spoke with said they had no hesitation in reporting incidents and we saw evidence to confirm this.
- Information about and learning from incidents was shared at specialty governance meetings and through newsletters. Staff told us that feedback from incidents was not always consistent, but that learning from incidents was consistently shared.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology
- All staff in the outpatients and diagnostic imaging departments were aware of the duty of candour and their responsibilities to be open with patients when

things did not go as planned. Staff gave us examples of when duty of candour had been used, this included an example was where a patient had suffered from a fall within the imaging department.

Cleanliness, infection control and hygiene

- There were systems in place to prevent and protect people from a healthcare-associated infection. During our inspection we found all the areas we visited to be clean and tidy. Procedures were in place within the imaging department, should an infectious patient from a ward require x-rays or scans. These would be performed at the end of the day where possible to make sure the equipment could be deep cleaned overnight.
- The friends and family test from July to December 2015 asked patients how clean they felt the waiting/treatment area was. The survey showed that 98.6% of patients found the waiting and treatment areas to be either very or fairly clean.
- Cleaning audits were undertaken weekly and monthly and broken down into high (oncology and intensive care), medium (main ward areas) and low risk areas (outpatients and communal areas) each with their own target. For high risk areas, the target for audit compliance was 98%. The oncology outpatients department had consistently achieved 98% or above since March 2015. The pain clinic (which was classified as high risk by the trust) only managed to achieve between 89-95% compliance, against a target of 98%. For medium risk areas such as radiology, the target was 95%. The diagnostic imaging department achieved between 85-92% from December 2015 to January 2016 which was below the compliance target. For low risk areas (the majority of outpatient areas) the target was 85% and apart from the neurology outpatients department they all achieved this target consistently during December 2015 and January 2016.
- Within the diabetes clinic the cleaning schedules had been reduced from five days a week to just two days a week because the wards were more of a priority. Whilst we did not see that this resulted in the department becoming visibly dirty, we were told it had been raised as a concern especially because the clinic staff were undertaking additional cleaning duties to maintain the standards within their department.
- Hand hygiene audits were completed monthly. All the outpatient and radiology areas were compliant and

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consistently scored 95% or above from January 2015 until December 2015. Some areas such as nuclear medicine had consistently scored 100% during the same time period.

- We observed hand washing before and after patient contact. All the staff we observed adhered to the trust infection prevention and control policy by observing 'bare below the elbow' rule.
- Toilet facilities were located throughout the outpatient and diagnostic imaging departments and clearly signposted. We found these to be visibly clean. Housekeeping staff were available throughout the day to provide additional cleaning as necessary.
- Personal protective equipment such as aprons and gloves were available in all the diagnostic imaging and outpatient departments. We observed staff using these appropriately and where necessary. Special sealed bins were in place for the disposal of sharps, we saw that these were sealed and signed according to the trust policy. Systems were in place for the safe removal of these bins from the hospital.

Environment and equipment

- The hospital site was undergoing extensive building works to provide new environments for patients and staff because certain parts of the building were no longer suitable for purpose. Staff in some departments in older parts of the hospital told us they had found problems with heating and general building maintenance which although addressed each time, continued to occur. However, they were all looking forward to either moving into their new departments or having their existing departments refurbished.
- Systems were in place to ensure equipment was maintained according to manufacturer's instructions. A register of equipment was kept which showed when each piece of equipment was due for servicing or calibration. Stickers on each piece of equipment showed when they had last been serviced and when they were due for servicing again. Equipment was also tested for electrical safety. These systems made sure equipment was fit for purpose.
- The outpatients and diagnostic imaging departments were located in a number of different locations across the hospital. Some of the outpatient departments such as general surgery, medicine and oncology were larger than others such as oral surgery department and ENT. This meant that the waiting area was larger with more

seating for patients, play areas for children and the availability of refreshments. The lack of space in some of the smaller departments was being addressed through the trust's building and refurbishment programme.

- Emergency resuscitation equipment trolleys and bags were available in both diagnostic imaging and outpatient areas. These trolleys were tamper evident by means of security tags. The trolleys and bags were checked daily/weekly and was in line with trust policy and we saw evidence to confirm that these checks took place.
- Seating was available in all the waiting areas. Water machines were available for patients and staff use in the departments we visited.
- In some outpatient area such as the fracture and orthopaedic clinic there were separate play areas for children. This allowed parents to wait separately with young children. There was a dedicated children's outpatients department which had a number of specialty clinics for children. We saw evidence that some outpatient areas, such as ophthalmology, held dedicated children's clinics when there would not be adult patients in the waiting area at the same time. In the main outpatient areas, there was a selection of toys for different age groups available and systems were in place to keep them clean.
- Staff in the diagnostic imaging department and some specialist outpatient areas had access to specialised personal protective equipment for use within areas that were exposed to radiation such as lead aprons. We observed staff using this equipment where necessary. Staff wore personal radiation dose monitors which were monitored according to the national legislation.
- We observed how clinic spaces were used flexibly depending on the needs of each individual clinic. For example, the orthopaedic and fracture clinics worked together and swapped clinics around within their department to make the best use of resources. The shoulder clinic, for instance, was one of the largest clinics so these were held in the largest part of the department to keep all the staff and patients together.
- The medical physics department undertook three monthly checks on the imaging machines using nationally calibrated standards to make sure the doses given were all within a safe range.

Medicines

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- The outpatients and diagnostic imaging departments had arrangements in place for managing medicines which kept people safe.
- Patient group directives (PGDs) are special instructions drawn up to show when non-medical staff could prescribe and administer specific medicines. These were in place in some outpatient areas and these were being followed. Some outpatient areas told us that their PGDs were out of date and were not being used until they had been updated.
- We looked at how medicines were stored in the diagnostic imaging department and a selection of outpatient departments. We found that medicines were stored in locked cupboards that only staff had access to. Where necessary fridges for storing medicines were available. The temperatures of these fridges were checked on a daily basis to make sure the medicines were being stored at the correct temperature. We reviewed how controlled medicines were stored, and found that these were locked away separately and checked by two members of staff and recorded in a dedicated record book. We did not see that any medicines were stored inappropriately or were out of date.
- The outpatients departments kept stocks of two different prescriptions for the medical staff. The majority of medicines were prescribed on the 'in-house' prescription sheet that patients could take to the hospital pharmacy. External prescription forms were also kept that could be taken to any outside pharmacy. All the prescriptions pads were kept secured in locked cupboards that only the nurse in charge had access to. Audit systems were in place that documented when each prescription form had been used and for which patient.
- Radiopharmaceuticals (which were for highlighting parts of the body in some scanning procedures) were delivered in named syringes from pharmacy. This reduced the risk of spillages or mistakes with drawing up the medicine.
- The medical records department monitored how often patients were seen in clinics without their medical records. The latest data provided by the trust showed that from April 2015 to November 2015 144 appointments (out of over 600,000) took place without the medical records. This meant that 99.9% of appointments took place with a patient's medical records.
- Staff in outpatients told us that access to medical records had improved significantly. They said that us that records were missing occasionally during a week and that the medical records team had improved the consistency of the availability of medical records for outpatient appointments.
- Staff told us that the medical records department provided a good service in getting notes to clinics and trying to find any misfiled notes. Staff found requesting notes easy for both routine appointments and last minute appointments. We observed staff following trust procedures for requesting and tracing notes.
- Medical records were stored in the relevant clinic rooms. These departments were locked outside of normal clinic times to make sure they were secure.
- We looked at 10 sets of medical records and found them to be up to date and legible. Entries were dated and signed in accordance with guidance from medical and nursing professional bodies.

Safeguarding

- There were systems, processes and practices in place to keep people safe and these were communicated to staff.
- The staff we spoke with in both outpatients and diagnostic imaging departments understood safeguarding for both adults and children. Staff were aware of their responsibilities to report and document safeguarding concerns and would have no hesitation in doing so. Staff knew who the safeguarding leads were, and where they could turn for further help, support and/or advice.
- All staff within outpatients and diagnostic imaging departments were up to date with their safeguarding training for adults and for children.

Mandatory training

Records

- People's individual care records were written and managed in line with national guidance from professional bodies such as the British Medical Association. This meant that they were legible, dated and signed and kept up to date.

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- We looked at the training records for the outpatients and diagnostic imaging departments. These records showed that all staff within outpatients and diagnostic imaging were up to date with their mandatory training.
- This mandatory training included topics such as infection prevention and control and basic resuscitation. Dementia training and health records had been added to the mandatory training list just prior to our inspection and staff were in the process of receiving the training.
- Staff in both departments told us that they felt the mandatory training was of a good level to ensure the safety of patients.

Assessing and responding to patient risk

- Staff were aware of the patients in their individual departments and what to do in an emergency or if the patient was feeling unwell. Staff knew how to contact the resuscitation teams and knew where the emergency equipment was kept within their own areas.
- To reduce the risk of patients receiving inappropriate imaging, an electronic request system was used. This meant that the requesting forms could be tailored for specific investigations. For example, a chest x-ray and specific blood tests had to be requested before a Computed Tomography (CT) scan request for a pulmonary embolism could be accepted. Protocols were in place for all radiographers via the trusts intranet and hard copies were available in each screening room. All requests are reviewed by a radiologist within 24 hours to make sure they were appropriate.
- Diagnostic imaging used an adapted World Health Organisation (WHO) surgical safety checklist for all radiological interventional procedures. We saw that these checks had been carried out consistently.
- The diagnostic imaging department acknowledged that a risk for patients was the higher demand had increased the time taken to report on the images. As a result and to prevent a backlog 50% of CT and MRI reporting was outsourced to two external companies (one in the UK and one in Australia). Systems were in place for regularly meeting with the companies, quality monitoring and for radiologists to raise any queries as necessary. This helped to make sure timely reports were produced and prevented patients waiting for their treatment.
- Women were asked about the possibility that they being pregnant before having their x-rays or scans. Where

women where having radio-iodine treatment, a pregnancy test was also undertaken. This made sure staff were informed of any possible pregnancy before exposure to radiation.

- To make sure patients receiving x-rays and scans received an appropriate dose, each machine was audited every three months to make sure it was within a specified safe range. Staff working with the equipment wore radiation detection badges which were checked monthly to make sure staff were not exposed to unsafe levels of radiation.
- Measures were in place to manage any associated risk with the waiting lists for some specialties. For example, the dermatology department suffered lengthening waiting lists because of reduced consultant cover for a year due to retirement and difficulty in recruiting. One particular group at risk were children waiting to be seen with skin problems. To manage this, from April 2016 a consultant and registrar from Bristol would hold clinics at Bath to see children waiting on the dermatology list.

Nursing staffing

- There were sufficient numbers of nursing staff to meet the needs of patients within the outpatient and diagnostic imaging departments.
- Information provided by the trust before our inspection showed that in January 2016, the vacancy rate across outpatients and diagnostic imaging was 6.2% against a target of less than 2.5%. From February 2015 to January 2016 the departments average vacancy rate was 3.4% which is still above the trust target. This vacancy rate was because of the various consultant posts (rather than nursing posts) that the trust had struggled to recruit into rather than a lack of nursing staff.
- From January 2015 to December 2015 the average sickness rate for the outpatients and diagnostic imaging departments was 3.2% which was below the trust target of less than 3.7%. Within some departments such as surgical outpatients the sickness rate was less than 1%. This gave an indicator the departments were well run, staffed and that staff morale was high.
- The outpatient departments we visited were all staffed with a variety of nurse specialists, nurses and healthcare assistants. Other staff such as dental nurses and plaster technicians were used in the relevant specialist departments of oral surgery and orthopaedic and fracture clinics. At the time of our inspection there was only one nurse vacancy within the outpatient areas we

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visited. The majority of outpatient departments we visited told us they didn't usually have a problem recruiting clinical or non-clinical staff. All the outpatient areas confirmed they had sufficient staffing to care for their patients.

- Occasionally bank staff were used to cover for unforeseen absences such as sickness.

Medical staffing

- There were not always enough medical staff in outpatient clinics to make sure patients were seen in a timely way
- At the time of our inspection within the diagnostic imaging department there were 16 consultant radiologists and 78 radiographers in post. The department had plans to increase the number of consultants by 10 over the following five years to cope with the additional demand.
- The radiographers had an on-call system to cover out of normal hours. This included one for cardiology, one for the emergency department and two for the CT scanner (two radiographers worked until midnight, and another two after midnight). The on-call radiologist was available out of hours and systems were in place to report urgent scans overnight when necessary.
- Some outpatient specialties suffered from medical staffing problems which had a knock on effect for their outpatients. For example, within Dermatology a consultant retired in June 2015 which had increased waiting times for patients. The business case to replace that consultant had been approved by August 2015 but there had been a lack of suitably qualified consultants applying for the post. At the time of our inspection a consultant had been appointed and was due to start in August 2016. In addition the pain clinic had two out of their four consultants retire six months prior to our inspection and at the time of our inspection the trust had only been able to recruit one new consultant to start in April 2016. This meant patients were having to wait longer to be seen by a specialist consultant. The trust had discussed these waiting times with the clinical commissioning group and it had been agreed to close the service to new patients from May 2016. In preparation for that, all new referrals were assessed to make sure no urgent patients suffered harm because of the delays. Patients waiting for follow-up appointments were also assessed to see if a review appointment was required.

- When necessary locum medical staff were used, but this also depended on their suitability, skills and availability.

Major incident awareness and training

- Staff we spoke with were aware of the major incident policy and the action cards that related to their department. The action cards were kept in the accident and emergency department and detailed what staff needed to do in the event of a major incident being called.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Whilst we inspected this service, we did not rate it because of insufficient data being available to rate the effectiveness of these departments nationally.

- An audit programme was in place across outpatients and diagnostic imaging services. This included the use of examination protocols in place and available to radiographers.
- The outpatient and diagnostic imaging departments compliant with the necessary NICE guidance applicable their department.
- The departments had a well-trained and competent workforce and were encouraged to take on additional skills relevant to their role.
- The outpatients department ran some clinics out of normal weekday hours such as evening and weekend clinics. The radiology department provided a 24 hour a day service with onsite radiologists seven days a week.
- We saw evidence of multidisciplinary working between the outpatients and diagnostic imaging departments, the rest of the hospital and other healthcare providers.
- All clinics and wards had access to the electronic imaging system.

Evidence-based care and treatment

- We saw evidence that policies and procedures were evidence based. For example, the policies and procedures used within the pain clinic had been based on the latest national guidance from NICE on the management of chronic pain.

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- We saw evidence that the diagnostic imaging and outpatients departments were complying with local and national guidance. For example, the oral & maxillofacial outpatients complied with NICE guidance on the extraction of wisdom teeth. Another example was the pain clinic that complied with the NICE guidance on lower back pain.
- The diagnostic imaging department had examination protocols which were available to all the radiographers. The imaging department carried out regular audits on the use of the protocols. The audits showed staff were compliant with the protocols.
- Local and national clinical audits were undertaken within the outpatients and imaging departments. These audits included audits as required by Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The results and areas of learning for these audits were shared with staff via governance and staff meetings. As an example, procedures were reviewed and reinforced to all referring staff because of near misses due to incorrect referrals.
- A new manager within the pain clinic had changed the service model just prior to our inspection to bring it into line with the latest guidance. The changes that had been implemented included nurse led clinics, patient initiated follow-up appointments and a patient advice line. One stop clinics had been established so that the patient could see the consultant, nurse and psychologist all at the same appointment.

Patient outcomes

- It had been identified that patients with repeat abdominal pain were making numerous visits to the emergency department. An audit was undertaken with these patients and demonstrated that by involving the pain team with these patients it had an impact on the patient's pain and reduced their attendance at the emergency department.
- New outcome measures were being developed in the pain clinic. Because the old measures did not demonstrate patient outcomes. We were told that a patient questionnaire was to be launched in April / May 2016 to involve patients in what would define positive or negative outcomes within the pain clinic.
- We saw evidence that patients who needed specialist intravenous lines inserted in the diagnostic imaging department had their procedure carried out by

competent staff. A recent audit undertaken within imaging just prior to our inspection showed a complication rate of less than 1% for the insertion of central lines within the imaging department.

- The diagnostic imaging department undertook an audit into the radiation exposures children received when having x-rays and scans. The work looked at the quality of the diagnostic images using different doses. This audit had led to an overall reduction in the radiation doses children are exposed to when having scans and x-rays. These findings were presented nationally to imaging colleagues.

Competent staff

- Staff within the outpatients and diagnostic imaging departments had the right skills, knowledge and experience to deliver effective care and treatment to patients. This was demonstrated by the training they had received and through performance monitoring via their appraisals.
- Staff were encouraged to undertake additional training that was relevant to their roles and that would benefit the patients in their department. For example, in the oral maxillofacial outpatients department, the dental nurses were specially trained to do all the x-rays necessary in the department. The manager of the oral outpatients department realised that having their own x-ray equipment could present a risk to staff, so made sure that all the department staff had received IR(ME)R (Ionising Radiation (Medical Exposure) Regulations 2000) training.
- The senior sister in surgical outpatients told us how they fed into the 360 degree appraisal process for the surgical consultants. This meant that feedback was sought from a wide range of staff that worked with the consultants and not just their medical colleagues.
- In the departments we visited, records showed that the majority of staff had received their appraisals. Where staff had not received one there were justified explanations. For example, one out of the five staff within one outpatients department had not received their appraisal because they had been on long term sick leave.
- An electronic system was used to record equipment training for staff. Staff received training when necessary and then self-assessed themselves on new equipment. They were then assessed by suitably trained senior staff. Only when the member of staff is deemed competent to

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use the individual piece of equipment are they signed off. The equipment that staff would need to be assessed on ranged from automatic blood pressure machines through to sigmoidoscopy equipment.

- Within the orthopaedic and fracture clinics, some nurses had been trained to work in the plaster room. This gave the department more flexibility and reduced the waiting times for patients.
- The radiology department had an accreditation scheme for non-medical staff making requests for x-rays and scans. Approximately 400 staff across the trust had received the IR(ME)R training and assessed as competent to request x-rays. These included nurses, therapists, clinical nurse specialists and community staff.

Multidisciplinary working

- We observed staff within the outpatients and diagnostic imaging departments worked together and with other teams and departments to deliver effective care and treatment to patients. For example the diagnostic imaging department worked with every department and specialty across hospital through face to face contact and participation in meetings. Several outpatient departments (oral maxillofacial, breast care, gastroenterology and cardiology) held one stop clinics which involved nurses, therapists, dieticians, doctors and other professionals such as psychologists. This meant patients could see a wide range of professionals at one visit. One member of staff summed up the multidisciplinary working by saying “we fit together like a jigsaw”. We asked what they meant by this, and were told that all the different teams were there for the patient and as such working together was an integral part of how to provide the best possible care for their patients.

Seven-day services

- The majority of outpatient clinics ran during the core working hours (9am to 5pm). However, some specialties operated morning and evening clinics depending on the needs of their patients. For example dermatology outpatients were able to offer patients early appointments from 7.30am and maternity outpatients offered women evening appointments. Clinics were also held at the weekend when necessary to meet demand or where it met the needs of their patients.

- The diagnostic imaging department provided a 24 hour x-ray service for the emergency department, wards and theatres. CT and MRI scanners were available 24 hours a day for urgent scans and were in operation throughout the weekend from 8am to 4pm for routine scans.
- The diagnostic imaging department was proud that it had been delivering a seven day service since 2003 with radiologists on site every day and radiographers covering the department 24 hours a day.

Access to information

- All clinics and wards had access to the electronic imaging system results. This meant that X-rays and scans could be viewed on computer systems throughout the hospital.
- Overall, patients’ medical notes were available for 99.9% of appointments. Therefore appropriate information was available for the consultation with the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff within the outpatients and diagnostic imaging departments told us they had received training in the Mental Capacity Act 2005.
- We observed staff seeking patients consent for general care and treatment. We saw that consent had been taken by a doctor and the consent forms filed in the patient’s medical notes. The patients we spoke with confirmed that the doctors had explained the procedure, and risks and benefits before asking them to sign a consent form.
- Staff told us they had confidence to challenge medical staff over consent issues. This prevented patients from receiving treatment without proper consent.

Are outpatient and diagnostic imaging services caring?

Good



We rated this service as good because:

- We observed staff treating patients with kindness, dignity, respect and compassion whilst they received their care and treatment.

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- Staff listened to what patients had to say so they could respect each individual patient's wishes and understand their needs.
- All the patients and relatives we spoke with during our inspection were very positive about the outpatient and diagnostic imaging departments and very complimentary about the staff.
- The Family and Friends Test showed very positive results.
- Staff involved patients in their own care, and involved relatives where consent had been received from the patient.

However:

- Staff did not always respect confidentiality at the reception desks within the outpatient and diagnostic imaging departments.

Compassionate care

- We observed staff treating patients with kindness, dignity, respect and compassion whilst they received their care and treatment. The patients that we spoke with told us that the staff maintained their privacy and dignity. For example, private changing rooms were available in the diagnostic imaging departments for patients to use prior to their procedures. In another example staff in the oncology clinic were able to sit down with patients and their families together to explain their care and treatment.
- In every department we visited, we observed how staff listened to what patients had to say so that they could understand and respect people's individual needs. Staff spoke professionally and in a caring way to patients and explained what they were doing at each stage of their care and treatment. For example, we saw a member of staff listen to a patient's concerns before they left the clinic, the member of staff was able to identify that the patient needed further explanations and arranged for this to take place straight away.
- The friends and family test from July to December 2015 showed 96.5% of patients (638 patients completed the survey) felt they were greeted promptly and courteously when they arrived in the outpatient department. In addition 95.4% of patients would rate the care they received in outpatients as either very good or excellent.
- We spoke with 40 patients during our inspection and the majority of people were very positive about outpatients and diagnostic imaging. Comments included "I am not

their only patient, but they treat me like I am, the treatment is ace."; "The care is amazing, I can't fault it."; "Staff are always happy in their work and can't do enough for their patients."; and "Staff listened to me and took their time to explain things, they were very caring both to me and my relatives". Staff did not always respect confidentiality. There was very little privacy at the reception desks in the outpatient department. However, we observed some staff offer to take patients to a side room if they wanted to discuss any issue in private. In the Urology clinic, we observed two patients being asked quite personal questions within ear shot of other patients. We spoke with these patients afterwards, and one patient told us they found it slightly embarrassing and uncomfortable.

Understanding and involvement of patients and those close to them

- Staff understood and involved patients in their own care. Relatives were also included where appropriate and where the patient's consent had been given. We observed this taking place during our inspection. For example staff asking patients if they wanted their relatives to accompany them into the clinic consultation. The patients and relatives that we spoke with confirmed they had been involved in their own care. Information was displayed in every department we visited. This information included how to raise concerns through and safeguarding information through to support groups or condition specific information.
- Patients told us they were pleased at how staff always took the time to listen to them, to understand their needs and explain things properly. For example, one patient said "the staff are so caring and supportive and make time for me as an individual."

Emotional support

- We saw evidence that staff provided initial emotional support where necessary and were able to obtain further specialist support when needed. For example, one patient who had been very worried about attending the oncology clinic because they did not have much hope about their diagnosis. This patient told us how the staff had not only looked after their medical needs, but also their emotional needs. The patient also told us that staff not only looked after them but also after their

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family. Another patient, who had been diagnosed with a chronic condition a year before our inspection, told us “the staff have been very supportive; they contact me by phone, text and email just to make sure I am ok.”

- The outpatient managers and senior nurses all told us how it was very important to have nurses allocated to each clinic. They recognised that the nursing staff provided that additional support for patients and their families both during the clinic and afterwards if the patient had any concerns. For example, the nursing staff were able to spend additional time with patients where necessary to explain what the doctor had said, or to explain any follow-up arrangements.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated this service as requires improvement because:

- Patients were not always receiving timely access to initial assessment, diagnosis and treatment because of the waiting times for appointments within outpatients.
- Patients did not always receive timely follow-up appointments because the lack of medical staff meant it was not possible to see as many patients as they needed to.
- The provider did not monitor how long patients waited when then had arrived at the outpatient or diagnostic imaging departments. Some information was collected via the Friends and Family Test, but we did not see any evidence that this was used to improve the service.
- GPs were not receiving timely information on their patients because clinic letters were not always being typed within five working days.

However:

- We observed good practice for patients with dementia and learning difficulties. A sensory box was in place to help with distraction therapy within trauma and orthopaedic outpatients. Appointments were arranged to suit patients' individual needs within the oral surgery outpatients.
- Diagnostic imaging scans were reported in a timely way for both inpatient and outpatients.

- Patients were reminded about their appointments via a text alert system which they could choose to opt out of as necessary. This had reduced the number of patients failing to turn up for their appointments.
- Patients told us they had no hesitation in making complaints or raising concerns. Where these were raised, they were investigated appropriately and actions implemented where appropriate.

Service planning and delivery to meet the needs of local people

- The provider worked with the local commissioners to help inform the developments across the hospital. These discussions had led to the new building works and refurbishment plans taking place at the time of our inspection.
- The provider had recognised that some of the older parts of the hospitals were no longer fit for purpose because of the lack of space and layout of the departments. At the time of our inspection, the trust was undergoing an extensive period of building work and refurbishment. The trust is assured that once completed, these works will provide a better environment for patients and staff.
- At the time of our inspection, patients and staff told us that car parking was a problem. This had been addressed in the plans for the re-development of parts of the hospital site to increase the amount of car parking offered to patients.
- A wide range of information was available in the outpatient and diagnostic imaging departments. This information included general leaflets such as how to raise a concern or a map of the hospital site, through to condition specific information. When necessary, these leaflets could be provided in other formats such as alternative languages.
- The demand for diagnostic imaging services had increased year on year, especially for MRI and CT. The number of MRI and CT scans completed had risen from approximately 50,000 in the year 2007/8 to over 80,000 for the year 2014/15. There was a draft five year business plan in place the aim of which was to ensure that the department was developed to meet the need for increasing capacity within the service. At the time of our inspection, whilst the business plan had been discussed by senior managers and the trust board, it had not been approved.

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- Patients who attended the gastroenterology outpatients department that needed a capsule endoscopy (patient swallows a magnetic pill, pictures are then taken at regular intervals during the day using a special belt) had to go to Bristol to have this procedure. This meant patient's travelling to the hospital in Bristol and spending the day at the hospital having the procedure before travelling home again. The provider and commissioners recognised that it would be more convenient for patients if they did not have to travel to Bristol. The service was therefore introduced and provided at the Royal United Hospital Bath.

Access and flow

- Patients were not always receiving timely access to initial assessment, diagnosis and treatment.
- A number of specialty outpatient departments were breaching the national standard that patients should receive their outpatient appointment within 12 weeks of the referral being received, so that their treatment can start within 18 weeks. Out of the 31 specialty outpatient clinics, 14 specialties had patients waiting longer than 18 weeks for their appointments.
- The top four specialties with the highest number of patients waiting over 18 weeks for their appointment were: cardiology with 331 out of 1,288 waiting, gastroenterology with 202 out of 842 patients waiting, oral surgery with 455 out of 2,556 patients waiting and neurology with 164 out of 1,178 patients waiting over 18 weeks. The surgical division dashboard (February to November 2015) showed us that the rate for patients not attending their appointment dropped from 6.2% in February 2015 to 5.3% in November 2015.
- The dashboard showed that the surgical division had achieved the two week wait (patients suspected of having cancer should receive their appointment within two weeks of referral) for cancer patients to receive their first appointment.
- Urology outpatients had met the standard for the two week cancer waiting time and for seeing new patients within 18 weeks. However, for patients who required a follow-up appointment, the waiting time at the time of our inspection stood at seven months. The department recognised why the waiting times had increased (because of the additional cancer referrals received) and had plans to address this including validating the waiting list to make sure those waiting still needed an appointment. A new consultant had been appointed who was due to start in May 2016.
- The pain clinic was breaching the standard for new appointments. The manager was aware of this and explained it was because of two consultants retiring. Plans had been put in place with the appointment of a new consultant, the setting up of a patient advice line and contacting patients to explain the situation. Some outpatient departments such as the pain clinic had introduced 'patient initiated follow-up' appointments. This meant that instead of a definite appointment, a timescale would be negotiated between the doctor and patient. During that time, if the patient needed to have an appointment it could be arranged.
- Within general surgery outpatients, we saw that they were meeting their two week and 18 week wait targets. Staff told us that they had had challenges in the past to meet the targets. But the departments had worked flexibly so that doctors could be released for clinics which improved the waiting times for patients.
- Within cardiology there were long waits (up to eight months) for stress echocardiography tests. The department was also taking up to 12 weeks to send out routine clinic letters to the patients GPs. At the time of our inspection routine waiting times for appointments was between 24 and 25 weeks with a six week wait for urgent appointments.
- One patient told us how they had received an initial appointment in the neurology department and was told they needed have a follow-up appointment within six months. After chasing the appointment, a follow-up appointment had been given for 18 months after the initial appointment.
- The trust consistently met the standard for 96% of cancer patients to receive their first definitive treatment within 31 days of diagnosis between October 2013 and September 2015. Over the same period the trust consistently met the standard for 85% of patients to wait less than 62 days from urgent GP referral to first definitive treatment.
- We saw that within the oncology and haematology clinics, patients waited approximately eight weeks for routine appointments for haematology and four weeks for oncology. Urgent appointments were always seen within two weeks.

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- Inpatient MRI scans were normally carried out within 48 to 72 hours. Urgent outpatient requests were booked within 2 to 3 weeks with all other requests booked within the internally set 6 week target. The department had been consistently meeting its target from April to December 2015, but failed to meet it in January 2016 because of 10 breaches.
- At the time of our inspection for inpatient CT scans were normally were normally carried out within 24 hours. The department aimed to complete and report on the scan within the 24 hour period. Urgent outpatient requests were booked within 2 to 3 weeks and all other requests were booked within the internally set 6 week target. The department relied on the use of mobile CT scanning services to provide additional capacity in order to achieve its 6 week targets. Overall this showed the department were meeting its targets. The CT department had consistently achieved 100% against its targets from April to October 2015 and in January 2016. However, during November and December 2015, this performance dropped 98.9% and 96.5% respectively.
- Within the ultrasound department, waiting times for inpatient requests were normally within 24 hours but this could rise to 72 hours depending on demand. Urgent outpatient appointments were booked within 2 to 3 weeks and other requests booked within the 6 week targets. The department was meeting its internally set targets, however, staff told us this could only be achieved by running additional evening clinics. From April 2015 to January 2016 the ultrasound department had achieved 100% in its targets.
- There had been a progressive decline in the number of patients who did not attend their appointments across the outpatients and diagnostic imaging departments. This had been achieved through the use of an automated text prompt system reminding patients of their appointments. Only 5% of patients failed to attend their outpatient or diagnostic imaging appointments without contacting the department first to rearrange. This was below the national England average of 7%.
- We noted that the trust did not monitor how many patients waited over 30 minutes to be seen in their appointment. This information was in part available from the Friends and Family Test, which showed that from July to December 2015 showed 44% of patients were seen on time, 30.6% of patients waited for 15 minutes, 15.4% of patients waited between 15 and 30 minutes, 6.3% of patients waited between 31 minutes and 1 hour and 3.8% of patients waited over an hour. When we spoke with patients about their waiting time, some patient told us they had always been seen on time, whilst others told us the waiting times could be lengthy at times. We saw no evidence that the trust used this information in an attempt to reduce waiting times once patients had arrived at their clinic.
- The trust internally set target for clinic letters was that they should be typed and sent out with five working days. Some specialties did not meet this. In December 2015 the medical division performance stood at 83%. This performance increased in January 2016 to 88%. However, within the surgical division, the specialties varied from 66% (general oral surgery and orthodontics) to 99% (orthopaedics). Overall the division achieved only 88%. For the medical division the specialties varied from 39% (diabetes and endocrinology) to 100% for sexual health. The delays above the five working days ranged from just a few days through to 72 days for cardiology. This meant that GPs were not getting timely communication from the trust about their patients and the treatment they had received. We spoke to the managers about this and were told that they were aware of the problems. However, there were no any action plans in place to address the issue.
- Patients that required hepato-biliary surgery used to have to go to Bristol for their preparation as well as their surgery. Since the trust had introduced a clinical nurse specialist all preparation occurred in Bath. The nurse liaised between the patient and the Bristol hospital and sorts out anything the patient might need. Clinics had been established in Bath with the Bristol consultant attending.

Meeting people's individual needs

- We saw evidence that services within the outpatients and diagnostic imaging departments were planned to take account of the needs of different people and their individual needs.
- Staff told us there was no trust wide system to highlight patients that might need extra support such as those with learning disabilities. Staff also said that they did their best to highlight this within the outpatients and diagnostic imaging departments. Staff told us that when patients needed additional support, their carers or relatives were invited to attend with the patient. Appointments could be arranged to suit the individual and could be double appointments to give the patient

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more time with the consultant or nurse. For example, staff in the oral maxillofacial outpatients department told us of one particular patient who got very stressed and agitated when with other patients. Staff made arrangements for the patient to have a very early appointment before the department was officially open. This meant they could be seen in a stress free environment for that patient. Another example, where a patient with learning difficulties wanted to have their carer present during their investigations within the gastroenterology department. Preparation work was undertaken with the carer to prepare them to be present during the procedures. Consent was sought from both the patient and carer, which meant staff thought about the needs of both and could prepare the patient and carer equally.

- The phlebotomy service ran an open clinic Monday to Friday in which they saw 50 to 60 patients a day. Patients could be referred from any department in the hospital and when they arrived in the department they were seen as quickly as possible in the order in which they arrived.
- The pain clinic provided a phone line where patients could call and speak to a nurse with any concerns. The service was open on Monday to Friday from 8.30am to 5.30pm and took up to 70 calls each week. This meant patients had access to specialist knowledge about pain without the need to attend the hospital for an appointment.
- Interpreters were available for patients whose first language was not English. The staff we spoke with told us they only used interpreters rather than members of the patient's family because of issues regarding confidentiality. Information leaflets could be arranged in other languages as necessary.
- Patients were reminded about their appointments via a text alert system to their mobile phones. Patients could opt out at any time.
- Within the ophthalmology outpatient's clinic, letters were printed using black text on yellow paper with a minimum size 14 font. This was recommended by the Royal National Institute of Blind People.
- The orthopaedic and fracture clinic had a sensory box that could be used for patients with dementia, learning difficulties and children. The box had a range of sensory objects as well as appropriate picture books. Staff told us they use the box regularly as part of distraction therapy. We observed that 'This is me' documents were

also available in the department. These could be given to patients or their carers for them to complete. Staff would also help complete it if necessary. 'This is me' was designed for patients to hand to staff to guide and help staff in how to support that individual patient in an unfamiliar environment.

- To make x-ray services more accessible to patients, a GP walk in service was established which proved popular with both GPs and patients. Patients were very positive with the accessibility and promptness of diagnosis. Once patients arrived, they were seen within 30 minutes.
- Staff told us that when patients with dementia attended the department, they would fast track them through the department to make sure they did not become distressed. Staff would also fast track other patients such as children, those with learning difficulties or anyone with increased anxiety because of being at the hospital.
- A range of patient information leaflets were available for the various clinics and procedures undertaken in radiology. The leaflets were available in other formats as necessary such as other languages, audio and large print.
- Information boards were in place across each outpatient department. These gave any waiting times for the clinics and reasons for delays. Staff updated the boards throughout the day to keep patients informed of what was happening. Staff reinforced these with verbal explanations when necessary. The patients we spoke with confirmed that kept them informed of any clinic delays.

Learning from complaints and concerns

- Data provided to us by the trust before our inspection showed that the outpatient and diagnostic imaging services received 93 complaints from January 2015 to December 2015. A system was in place to record these complaints and make sure they were properly investigated. The time it took to respond to the complainant was also monitored. Themes were recorded and shared with each specialty. The most common theme was the delay in receiving appointments, followed closely by poor communication. The next most recurring theme was the attitude of staff followed by appointment letters being sent to wrong address or containing inappropriate information.

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- During the same time period the trust received 310 complaints. Outpatient and diagnostic imaging services accounted for 30% of those complaints.
- We saw examples of where both the outpatients and diagnostic imaging departments had learnt from complaints. These included in the ophthalmology outpatients; appointment letters had been amended so they were printed on yellow paper. Another example, the diagnostic imaging department changed the procedures for nurses escorting patients from the ward.
- The patients we spoke with were aware of how to raise a complaint, they also said they would raise it with staff first. One patient told us “the staff are so approachable and would have no trouble talking to them about my treatment or raising concerns”. This view was reflected by the majority of patients we spoke with.

Are outpatient and diagnostic imaging services well-led?

Good



We rated this service to be good because:

- Staff had been involved in developing the values and vision of the trust.
- The outpatients and diagnostic imaging departments had governance processes in place to make sure information was reported to various committees and eventually the trust board.
- An outpatient steering group had been established to look at strategies and systems for outpatients as a whole rather than within each individual specialty.
- Staff at all levels told us how supportive their managers were and that they were accessible and visible in the departments. Staff felt their views were listened to and respected.
- Managers told us how proud they were of their teams and the care they provided to patients.
- Staff put patients at the centre of everything they did and that the trust supported them to do that with an open and honest culture. Staff and patients had opportunities to give their feedback on services and they felt listened to.

However:

- Due to increased demand for diagnostic imaging services, the department needed to expand and had developed a five year business plan. At the time of our inspection whilst it had been reviewed by the trust board, it had yet to be approved.

Vision and strategy for this service

- Staff had been involved in developing the values and vision of the trust. The trust vision was to care, to innovate and to inspire. It set out three ambitions of being the provider of choice, a hospital without walls and a system leader. These were shaped by the values of everyone matters, working together and making a difference. The staff we spoke with during this inspection were all aware of the trust vision because they had been actively involved in its development.
- The radiology department had seen increasing demand for its services year on year. The clinical and management team had put together a five year business plan for the expansion and development of the service to not only meet the current demand but to meet future demand. At the time of our inspection the business case had been submitted to the board but had yet to be approved either in full or part.
- An outpatient steering group had been established to look at strategies for booking appointments across all of outpatients. This was a staff led group and at the time of our inspection was still in its early days.

Governance, risk management and quality measurement

- The outpatients and diagnostic imaging departments had an effective governance framework in place to support the delivery of good quality care, with processes in place to raise issues through the divisional structures but also to feedback information through to staff.
- The radiology department held clinical governance and risk meetings every month. Minutes for these meetings showed us a wide range of issues were discussed. The issues ranged from recent incidents or complaints to medicines management. Feedback was also given back to staff from the divisional governance meeting. Any concerns raised through the patient advice and liaison service (PALS) were also discussed.
- In 2015 the trust commissioned an external review into outpatient processes because of the backlog of outpatient appointments, especially follow-up appointments. Following this review, nine

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recommendations were made. We saw the action plan that had followed the review. There had been five actions identified. Three of these actions should have been completed prior to our inspection. However, the action plan showed that only one action had been completed. The other two actions were in progress but had been delayed.

- The senior sisters for the surgical outpatient clinics attended the surgical sisters meeting which took place monthly. This enabled them to share information with their colleagues from the wards, matrons, senior divisional staff and the quality assurance team. Minutes from these meetings showed the topics discussed and any actions that needed to be taken. This included specific issues or concerns that needed to be raised with the divisional management team.
- Each division produced a monthly performance report. This detailed each performance criteria. For example, the October 2015 report showed the surgical division had breached the cancer performance standard for 62 days from a GP referral. The report detailed what had caused the breach in the standard, what remedial action had been taken and when improvement was going to be seen.
- Each specialty within outpatients sat within the appropriate medical or surgical division. The radiology department was within the medical division. Senior sisters/matrons are in place within each division.
- An outpatient steering group had been established with the aim to streamline any variations in the booking systems across the different divisions and outpatient departments.
- The senior staff we spoke with (sisters, matrons and managers) were all clear on their clinical governance arrangements. One sister explained how it was a two way process with issues taken to and fed back from their departmental governance meeting which eventually fed through to the trust board (via the divisional governance meetings and divisional boards).
- Risks on the risk register were discussed at the clinical governance meetings. Incidents, complaints and quality issues were also discussed. We saw this evidence in the minutes of these meetings and from what staff had told us.
- Demand had increased substantially for all services within the radiology department and because of this;

some reporting had been outsourced to external companies. We saw evidence that regular governance meetings were held with these companies to make sure quality and confidentiality was not compromised.

Leadership of service

- All the staff we spoke with told us how supportive their managers were and were available when necessary. We heard these comments from nurses about sisters and matrons, we heard it from the matrons about the divisional management team and we heard it about the trust executive team.
- All the managers we spoke with told us how incredibly proud they were of their teams and the care they provided to patients.
- Staff told us they felt listened to by their managers and felt that the trust valued their opinion.
- The majority of the nurse managers for the outpatient departments we visited told us they had a good split between their clinical work and management time. This meant they had time to do the managerial tasks necessary to run the department effectively. It also came across that they led by example.

Culture within the service

- During our inspection, the staff kept telling us what a close knit group they were, how they felt like part of a big family working at the Royal United Hospital. Staff told us what a great place it was to work because of that 'family' culture.
- Staff constantly put the patients first, but they also told us that the trust support them to do that with an open and no blame culture. Some staff told us that they felt the trust was open to new ideas and that they felt valued and respected by their colleagues and managers.

Public engagement

- Staff within CT scanning undertook their own patient satisfaction survey. This showed very positive results. Several questions asked included: how they rated the care whilst in the department; did patients have access to toilets and changing facilities; was the procedure explained; and were they given all the information they needed before the appointment. The department scored above 95% in every question with the majority of questions scoring 97% or above.
- Comment boxes were in place across outpatients and the diagnostic departments.

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Staff engagement

- Staff in various departments told us how they had been involved in the design of their new departments. Some departments; however, told us that they did not always feel listened to by the executives and it was felt they lacked understanding of the services individual departments provided and how these could be incorporated ready for the new build. Staff we spoke with felt they were actively engaged in changes that affected their departments. They told us they had opportunities to give their views and felt listened to by their managers.
- All the staff we spoke with were very positive in how the trust had involved staff in developing the new organisational values.
- Regular staff meetings were held across both outpatient and diagnostic imaging departments. The minutes of these meetings showed a range of issues were able to be discussed. Feedback was given from previous meetings and from patient feedback.

Innovation, improvement and sustainability

- A five year business case for expansion in the imaging department had been produced and submitted to the trust board. The business case included provision for a PET CT (Positron Emission Tomography Computed Tomography) scanner which can help to detect the early

onset of disease. Support for cancer treatment, a third MRI scanner at the hospital and a fourth for the community, upgrades to the CT scanner and a third ultrasound room. Additional staffing had also been included and at the time of our inspection the trust board had yet to approve all or part of the business case.

- The oral maxillofacial outpatients department were setting up a patient support group because of a need that had been identified with patients. At the time of our inspection the group preparation work had been completed and it was anticipated the group would start within the following six months. Initially it was planned to be chaired by a member of staff until the group were able to elect a chair for themselves.
- The dental nurses within the oral maxillofacial outpatient department wanted to extend the training they provided on oral hygiene to other departments within the trust such as intensive care.
- The surgical outpatients department had set up a gastroenterology physiology clinic approximately four months before our inspection. This was a new clinic for patients that had received various investigations but no diagnosis had been confirmed. It allowed for further studies to be conducted closer to where patients lived rather than having to send the patients to another local NHS trust.

Outstanding practice and areas for improvement

Outstanding practice

- The emergency department had developed guidelines on the management of patients during periods of high demand when flow out of the department is limited. The guidelines aim to reduce the patient safety risks associated with overcrowding by minimising the number of ambulance-borne patients with undifferentiated diagnosis waiting in the corridor for assessment. The document also describes measures to maintain the comfort and dignity of patients waiting in the corridor.
- SSSU and SAU had Project Search Students. This programme provided a mixture of structured work placements and classroom learning for young people living with learning disabilities. It was evident that the students were part of the team and had a clear set of tasks and structure to their daily routine.
- The Surgical Assessment Unit operated an Emergency Surgical Ambulatory Care Unit (ESAC). As part of a Quality Improvement Project (QUIPP 5.8) it was recognised that patients waiting for emergency surgical procedures such as hernia and abscesses (category C and D as classified by NCEPOD), were not being managed properly. These patients were often starved and cancelled at the end of an emergency theatre lists due to running out of theatre time. The ESAC had two dedicated surgeons, which operated a booked emergency list, which focused on these patients and had eight spaces. It had its own dedicated ultra sound equipment, room and a Sonographer who has a dedicated inpatient clinic for two hours a day, Monday to Friday.
- The ESAC unit was run by two band seven Nurse Practitioners Monday to Friday. The Nurse Practitioners also ran a Nurse Led Clinic, which managed complex dressings, and an Accelerated Discharge Programme, which aimed to get patients home sooner but still give them the support and treatment required as an outpatient rather than inpatient.
- There was outstanding caring to children, young people, their parents and the extended family.
- Frontline staff and senior managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.
- There was excellent local leadership of the children's service. Senior clinical managers were strong and committed to the children, young people and families who used the service, and also to their staff and each other.
- The trust had run The Conversation Project, which was an initiative to improve communication between staff, patients and relatives about care for the dying patient.
- The trust had implemented new documentation called The Priorities of Care for recording a personalised care plan for the dying patient.
- We observed and heard numerous examples of outstanding, compassionate care provided by nursing, medical and cleaning staff for patients at the end of their lives from both the patients and their relatives.
- We saw some outstanding practice within the outpatients department, in how staff treated and supported patients living with learning difficulties. This included providing double appointments, rearranging appointments out of hours so patients with anxiety problems could be seen without other patients around. We saw how carers were fully involved where appropriate including working with them and the patient during potentially intimate examinations.
- The orthopaedic and fracture clinic had a sensory box that could be used for patients with dementia, learning difficulties and children. The box had a range of sensory objects as well as appropriate picture books. Staff told us they use the box regularly as part of distraction therapy.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must continue to work in collaboration with partners and stakeholders in its catchment area to improve patient flow within the whole system, thereby taking pressure off the emergency department, reducing overcrowding and the length of time that patients spend in the department.
- The trust must take steps to ensure that the emergency department is consistently staffed to planned levels to deliver safe, effective and responsive care.
- The trust must take steps to ensure that all staff in the emergency department are up-to-date with mandatory training.
- The trust must monitor and report on the time to initial assessment of patients who self-present in the emergency department.
- The trust must take steps to improve record keeping within the emergency department, so that patients' records provide a contemporaneous account of assessment, care and treatment.
- The trust must take steps to ensure that patients in the emergency department receive prompt and regular observations and that early warning scores are calculated, recorded and acted upon.
- The trust must take steps to improve recording of pain assessment scores and pre-hospital medication and ensure that patients attending the emergency department who need it receive prompt and appropriate pain relief.
- The trust must take action to ensure that staffing reviews are robust and reflect accurate and comprehensive data for all medical wards. The trust must continue to mitigate the risks associated with less than planned staffing levels to ensure safe staffing on medical wards for every shift.
- The trust must take action to ensure that relevant staff are aware of the major incident protocol.
- The trust must take action to improve the safe storage of medical notes on the surgical wards.

- The trust must employ an experienced nurse to the post of critical care matron, a post that has been vacant for 15 months.
- The trust must ensure the approved operating policy for critical care is understood and followed by hospital staff when considering moving nursing staff to work on other wards. Review nursing staff levels so they meet recommended guidance for critical care to enable the supervisors/coordinators, protected staff, and clinical educators to fulfil their roles.
- The trust must review the incident reporting procedures within critical care to ensure staff are aware of what constitutes an incident, staff are enabled to report all incidents, and they receive feedback and follow-up from those they report.
- The trust must ensure all areas of the critical care unit are clean, tidy and organised to allow good cleaning to take place.
- The trust must review the equipment on the critical care unit to ensure all maintenance and servicing is up-to-date and then accurately recorded. Ensure all equipment and medicines are checked as required and stored safely, preventing the risk of tampering, and to meet legal requirements.
- The trust must ensure the access and flow of patients in the rest of the hospital reduces delays from critical care for patients admitted to wards. Reduce the number of patient discharges at night.
- The trust must make sure policies, guidance and protocols for providing care and treatment within critical care are reviewed and up-to-date with best practice at all times.
- The trust must ensure there are specialist bereavement staff and an appropriate environment to effectively provide care and support for bereaved gynaecology and maternity patients and their families.

Action the hospital **SHOULD** take to improve Action the hospital **SHOULD** take to improve

Outstanding practice and areas for improvement

- The trust should continue to develop cooperative relationships between the emergency department and other specialties within the hospital and work towards meeting internal professional standards in respect of speciality review of patients. ensure the emergency department is supported by the wider hospital and there is more engagement from specialties in the urgent care improvement programme.
- TThe trust should continue to work with partners to improve the responsiveness of out of hours support for adults, children and young people with mental health issues.
- The trust should continue to work with partners to improve the responsiveness of the patient transport service.
- The trust should ensure there is a reliable system of staff supervision for clinical staff.
- The trust should ensure patient records are stored securely on the cardiac ward.
- The trust should ensure staff are compliant with safeguarding children level two and safeguarding adults level two training.
- The trust should take action to improve the performance of the diabetes service, particularly with regard to prescription errors and the number of patients seen by a multidisciplinary foot team within 24 hours.
- The medical division should ensure specialty clinical governance meetings occur regularly.
- The trust should ensure improvement plans to address difficulties of flow within the medical service proceed and the impact of these changes are critically monitored.
- The trust should ensure re-assessments of risk of venous thromboembolism are consistently completed.
- The trust should ensure staff identify review dates and stop dates for antibiotics prescribed.
- The trust should ensure that actions resulting from external reviews, for example fire safety reviews, are clearly documented and acted upon in a timely manner.
- The trust should make sure chemicals and substances that are hazardous to health (COSHH) are secured and not accessible to patients and visitors on the surgical wards sluice area.
- The trust should continue with their action plan to reduce their RTT in all surgical specialities.
- The trust should continue to recognise and address issues with nursing staff shortages on the surgical wards.
- The trust should make sure medical staff on the surgical wards are up-to-date with their mandatory and statutory training and meet trust targets.
- The trust should review the chairs in the admission suite as they were damaged and of the same height, which could make it difficult for patients with limited mobility.
- The trust should reduce the number of bed moves after 10pm on the surgical wards.
- The trust should make sure a doctor prescribes all oxygen therapy before being used.
- The trust should make sure all operations and procedures are included on consent forms prior to the start of the procedure/operation, especially for those who lack capacity to make the decision.
- The trust should review the SSSU meal trolley when it is plugged in as it reduces the power to the lights in the corridor, where patient's toilets were situated.
- The trust should make sure all equipment in theatres has the date of the last service recorded on them.
- The trust should repair all the equipment that was broken or damaged in theatres.
- The incident reporting system should be able to provide analysis of trends in incidents to staff to allow actions to be taken quickly to address any areas needing to be improved.
- The trust should display avoidable patient harm data within critical care so it shows long-term results and is meaningful to visitors.
- The trust should complete the process of otherwise good mortality reviews within critical care services to demonstrate the implementation of actions and responsibility for their delivery.
- The trust should make sure all confidential information relating to patients in critical care is secure.
- The trust should look to reference the guidance by The Law Society in its policy relating to deprivation of Liberty, and ensure there is flexibility within the policy when applying the 72-hour rule.
- The trust should review and risk-assess the provision of the critical care outreach team service or its equivalent, which was not being provided as

Outstanding practice and areas for improvement

recommended in best practice, with appropriately trained staff for 24 hours a day. Ensure there is a formal handover between the outreach team and hospital-at-night team.

- The trust should ensure sufficient allied health professional staff are used or employed to meet the rehabilitation needs of patients in, or being discharged from, critical care at all times.
- The trust should review the use of link roles for critical care staff to better embed this practice.
- The trust should look to provide an assessment for patients in critical care for any poor psychological outcomes or acute psychological symptoms, and provide support in line with National Institute for Care Excellence (NICE) guidance CG83.
- The trust should develop and implement approved strategies for patients admitted to critical care to keep them in touch with life around them.
- The trust should improve the quality and quantity of information provided to patients and visitors to critical care on both printed and electronic format.
- The trust should look to analyse and determine how to reduce noise levels within the critical care unit.
- The trust should progress the business care to provide patients with a consultant-led follow-up clinic for critical care.
- The trust should ensure the critical care unit looks outside of itself to the wider hospital experienced specialist teams for input into patient care and meeting the needs of patients and their visitors.
- The trust should produce a meaningful vision and strategy for the unit with action plans designed to improve quality and performance of the service.
- The trust should provide effective use and management of the critical care risk register.
- The trust should find a solution to the continuing poor relationship with the bed management/site team and ensure all sides understand and empathise with the pressures and risks to each other's services.
- The trust should improve direct feedback to the critical care unit from visitors and patients to capture their views and deliver services to meet their needs.
- The trust should ensure appropriate standards and auditing of cleanliness and infection control within the maternity and gynaecology services.
- The trust should ensure there is enough obstetric equipment to provide epidural pain relief and to monitor the foetal heart during labour.
- The trust should ensure there is evidence that all equipment on the delivery suite had been serviced and checked as required.
- The trust should ensure the safe storage of medical records on Charlotte ward.
- The trust should ensure clear, written evidence in records to identify if maternity care should be midwife or consultant led.
- The trust should ensure the obstetric consultant staffing complies with Royal College of Obstetricians and Gynaecologists (Towards Safer Childbirth, 2007) recommendations on staffing for a unit of this size.
- The trust should ensure effective systems are in place which evidence one to one care was provided to women in established labour 100% of the time.
- The trust should ensure gynaecology patients are supported by specialist trained nursing staff at all times.
- The trust should ensure systems are in place to effectively monitor and review patients for post-operative infection rates following a caesarean section.
- The trust should ensure there is regular audit and evaluation of the termination of pregnancy services to ensure and full compliance with national guidance and recommendations.
- The trust should make sure all confidential records are stored securely on the children's wards.
- The trust should ensure all areas used by children are child friendly and should particularly consider improving the environment for children in the theatre recovery rooms.
- The trust should make sure appraisal rates are closely monitored and actions taken to improve performance for the staff on the children's wards.
- The trust should ensure discharge summaries are completed in an appropriate time frame.
- Several outpatient areas were breaching their waiting time targets and had long follow-up appointment waiting lists. We acknowledge the work the trust had done to resolve these issues, but the trust should continue to work on this area and make sure patients are seen in a timely way.
- The trust should make sure that clinic letters are typed and sent to GPs within the trust target.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.</p> <p>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular to –</p> <p>(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on of the regulated activity;</p> <p>(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided.</p> <p>The incident reporting procedures in critical care did not enable staff to recognise some reportable incidents at all times. Not all incidents were therefore being reported. There was currently no feedback to staff from reporting incidents.</p> <p>The critical care unit had not recognised the out-of-date standard operating procedures and clinical guidance, or provided assurance that the maintenance and servicing of equipment was carried out as required.</p>

Requirement notices

The time taken to assess patients who self-presented in the emergency department was not consistently recorded and accurate performance data was not available. This meant we could not be assured that patients were quickly assessed to identify or rule out life or limb threatening conditions to ensure patient safety. We saw examples of patients waiting over an hour for assessment.

The management of patient records in the surgical admission suite did not ensure patients' details were safe and that confidentiality was assured. We saw patient records were left accessible to the public.

Records within the emergency department did not provide a clear and contemporaneous account of the care and treatment provided. Records of pain assessment and early warning scores were not always maintained.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

9(1) The care and treatment of service users must –

- (a) be appropriate
- (b) meet their needs.

Due to bed pressures elsewhere in the hospital, patients in the critical care service were not discharged in a timely way from the unit onto wards when they were ready to leave. Patients were also discharged too often at night.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include-

(b) doing all that is reasonable to mitigate any such risks

(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(g) the proper and safe management of medicines;

The critical care equipment programme did not demonstrate all equipment was up-to-date with planned servicing and maintenance.

The critical care medicines and fluids were not all in locked storage in accordance with legislation. There were medicines in the refrigerators and the emergency resuscitation trolley at risk from being removed or tampered with.

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 15(1) All premises and equipment used by the service provider must be-

(a) clean,

(e) properly maintained

The critical care unit was not as clean as it should have been in all areas. The unit was untidy in places and some storage was such as to hamper good cleaning regimes in all areas.

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

There had been no matron in post in critical care for 15 months and this was having a detrimental effect on the nursing staff, and the performance of critical care.

The number of supernumerary nurses in critical care was half of the recommended levels. Moving nurses to other wards, often in contravention of the critical care operating policy, meant the supervisor/coordinator nursing staff, including the clinical nurse educators, and protected nursing staff, were not able to fulfil their managerial responsibilities at all times due to providing front-line care to patients.

Actual registered nurse staffing was persistently below the planned levels on the medical wards and in the emergency department.