

Great Western Hospitals NHS Foundation Trust Great Western Hospital Quality Report

Marlborough Road Swindon Wiltshire SN3 6BB Tel: 01793604020 Website: www.gwh.nhs.uk

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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	Requires improvement	
Critical care	Good	
Services for children and young people	Requires improvement	
Outpatients and diagnostic imaging	Requires improvement	

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection between 21 and 23 March 2017 and an unannounced inspection at Great Western Hospital on 27 and 28 March 2017 and 3 April 2017. This was a focused inspection to follow up on concerns from a previous inspection. As such, not all domains were inspected in all core services.

The inspection team inspected the following six core services at Great Western Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Services for children and young people
- Outpatients and diagnostic imaging

We also inspected:

• Urgent care services (provided as a community service).

We did not inspect end of life care or maternity and gynaecology services (previously rated good). We did not inspect the effective, caring or responsive domains for services for children and young people (previously rated good). The effective domain was inspected but not rated for outpatients and diagnostic imaging.

Overall we rated Great Western Hospitals NHS Foundation Trust as requires improvement.

Safe

We rated the safe domain as requires improvement overall. Urgent and emergency services, medical care, surgery, critical care, services for children and young people and outpatients and diagnostic imaging were all rated as requires improvement.

- As a result of high demand we found the emergency department was frequently full, with patients in all cubicles and around the nurses' station. There were occasions where the emergency department was deemed to be unsafe as a result of the number of patients within the department. However, this was improving. We also found that as a result of pressures for beds in surgery some patients had to use facilities which were not always suitable for recovering from their surgery.
- Compliance with safe systems to ensure medicines were stored at the correct temperature needed to be improved. Daily checks of medicines were not always completed in the emergency department or critical care. We found in medical care that some areas did not have regular temperature checks. This meant there was limited assurance that medicines were being stored within required temperature ranges to ensure they were fit for use.
- The storage of medicines needed to be improved. In medical care we found that some of the storage shelves did not allow for stock rotation, which increased the risk of medicines being out of date. We also found in critical care that the fridges used to store medicines could not be locked. This meant that medicines could be removed without authorisation.
- Equipment used was not always checked in line with guidance to ensure it was fit for purpose. Daily checks of emergency equipment did not always take place. In services for children and young people that heated water blankets did not have expiry dates or water change dates recorded.
- There were areas throughout the hospital which did not have sufficient numbers of suitably qualified staff on duty to keep people safe. This included the emergency department observation unit where we observed a patient walking

out of the department without staff knowing. Within medical care and surgery, services for children and young people and critical care there were wards and theatres which went through periods of understaffing, which meant that staffing numbers did not always meet national guidelines. In medical care we found that ambulatory care was sometimes left with no staff in it for short periods of time due to lone working arrangements.

- Mandatory training rates needed to be improved in the emergency department for medical staff, in medical care, outpatients and diagnostic imaging, critical care, and surgery. In services for children and young people all medical staff fell below trust targets for all mandatory training and paediatric basic life support training was below target in all staff groups.
- Safeguarding practices needed to be improved in outpatients and diagnostic imaging and in services for children and young people. In outpatients and diagnostic imaging only 20% of medical and dental staff had completed level two safeguarding adults training against a trust target of 80%. In services for children and young people staff did not have ready access to relevant safeguarding information on a patient due a filing backlog.
- The security and completeness of records needed to be improved. We found in medical care and critical care that patient records were not always stored securely. We also found that in critical care patient allergies and venous flushes were not always documented. In medical care we found that not all patient documentation was completed in full and handovers between wards was not consistency provided to a high standard. This meant that patients' full needs may not always be met.

However:

- There was a positive incident reporting culture. Openness and transparency was encouraged. Opportunities for learning were sought when an incident occurred and learning was shared between teams. Where never events occurred in surgery we found they were investigated fully and actions had been taken to prevent them from happening again.
- We found all areas within the hospital, with a few exceptions, were visibly clean and tidy. Staff followed National Institute of Health and Care Excellence standards for hand hygiene and audit results were positive.
- We found that staffing levels for both medical and nursing staff were in line with recommended guidance in the emergency department, and critical care. Within medical care there were sufficient doctors to provide safe care for patients.
- Risks to people who use services were appropriately assessed in the emergency department where we found observations and treatment decisions were made in a timely way. We found that patients' records were legible, complete, up to date and accurate in the emergency department, surgery, and critical care.

Effective

We rated the effective domain as good overall. It was rated as good for urgent and emergency care, medical care, surgery, critical care. It was inspected but not rated for outpatients and diagnostic imaging.

- In the emergency department, medical care, surgery, services for children and young people, critical care and outpatients and diagnostic imaging we found that patients' care and treatment were planned and delivered in line with guidance, standards, best practice and legislation. This included guidance from the National Institute of Care Excellence and the Royal College of Emergency Medicine.
- Information about people's care and treatment was routinely monitored and action was taken to improve the effectiveness of treatment where shortfalls had been identified. In surgery the trust had a better rate for re-admission compared to the national average. The emergency department performed well in the latest Royal College of Emergency Medicine audits. In services for children and young people outcomes were either in line with or better than the national average.
- Staff had the skills required to carry out their roles effectively. In all services we inspected we found that staff had qualifications, experience and had received competency training in line with their role requirements. Most services performed better than the trust target for completion of appraisals.

- Patients received care and treatment from different disciplines who worked together in a coordinated way. All departments communicated well with each other to ensure effective treatment for patients. This multidisciplinary working approach continued over weekends where there were 24 hour diagnostics, critical care outreach, physiotherapy, pharmacy, and mental health liaison services.
- Within all services we found that the nutrition and hydration needs of patients were fully assessed and that actions were taken to address concerns as soon as they were identified. Within the trauma unit innovative systems were in place to improve nutrition and hydration for patients.

However:

- In some areas of the trust outcomes required improvement. In medical care areas of the national stroke audit, MINAP audit and the national heart failure audit required improvement.
- In critical care the provision of therapy services did not meet national standards. We found there was insufficient access to physiotherapy and dietetic services.

Caring

We rated the caring domain as good overall. Medical care, surgery, critical care, outpatients and diagnostic imaging were rated good. Urgent and emergency care was rated outstanding.

- In all areas feedback from patients was consistently positive. Patients, relatives and carers told inspectors they had received care that was compassionate, they had been involved as partners in care, and they were supported to cope emotionally with their care.
- Inspectors observed patients being treated with kindness and respect and saw that patients and their relatives were active partners in their care. They were well informed of treatment options and were involved in decision making.
- Emotional support was available to patients. Staff took time to sit with patients and talk to them. A psychiatric liaison nurse was available to provide psychological support. There were good examples of staff listening and acting supportively to patients suffering from emotional distress.

However:

• Privacy and dignity was compromised in the discharge lounge, the surgical assessment unit, theatre recovery, and ophthalmology. Conversations with patients could be overheard in the discharge lounge and in the ophthalmology department. We found that in the surgical assessment unit, the discharge lounge and theatre recovery, privacy was difficult to maintain when a patient required the toilet or to use a bedpan.

Responsive

We rated the responsive domain as requires improvement overall. It was rated as requires improvement for urgent and emergency care, medical care, surgery and outpatients and diagnostic imaging. It was rated as good for critical care.

- Patient flow through the hospital required improvement. The trust found it difficult to discharge patients from medical, surgical, and critical care services who required social care or patients who had a complex discharge.
- This resulted in the emergency department regularly being full to capacity, which meant that patients could not be seen in a timely way for assessment or treatment. The emergency department regularly breached targets for time spent in the department, with most breaches being attributable to unavailability of beds in the hospital.
- Although medical outliers were managed well, the number of them impacted on the number of elective operations which could take place.
- Facilities were not always fit for purpose, as a result of the numbers of patients being treated at the hospital. The medical expected department was not always able to separate male and female patients, which compromised privacy and dignity. In the emergency department patients were regularly accommodated around the nursing station without screens to protect their dignity.

- For three months out of the past 10 the trust was performing worse than the national standard for two week urgent cancer referrals There were a high number of patients waiting for non-cancer outpatient appointments, with the most in ophthalmology. There were also delays in sending out of letters to patients after their appointment.
- In medical care and outpatients and diagnostic imaging translation services were available, but they were not always utilised. In medical care relatives were sometimes used to translate, which compromised confidentiality.

However:

- A number of steps had been taken to improve patient flow. This included re-locating the ambulatory care service to increase capacity and the introduction of the medical expected unit. There were also effective patient flow meetings to establish who could be discharged.
- High numbers of patients were streamed from the emergency department to the urgent care centre.
- Reasonable adjustments were made to support patients in vulnerable circumstances throughout the hospital. Staff had a good understanding of the adjustments needed to support people living with dementia and patients with learning disabilities.

Well Led

We rated the well led domain as requires improvement overall. It was rated as good for urgent and emergency care, medical care, critical care, and outpatients and diagnostic imaging. It was rated as requires improvement for surgery and services for children and young people.

- Services for children and young people felt disconnected from the rest of the trust. The leadership had not been embedded locally and there was no representation of services for children and young people on the board.
- Nurses in services for children and young people did not recognise the trust as a good place to work. We were told that they often had to work long hours without access to a drink and without having a break. Nurses did not know the strategy of the women's and children's division.
- In the emergency department, and surgical services staff felt that the executive team was not visible enough and that attempts to engage with staff could be better.
- In surgery there were areas where there was a lack of management oversight. Also, actions identified to mitigate risks on the risk register were not always effective.

However:

- There was a clear vision and strategy within the services which was underpinned by realistic goals. This strategy was being acted upon with innovative workstreams through the emergency department, medical care, surgery, services for children and young people and outpatients and diagnostic imaging.
- Governance functioned effectively in all of the core services we inspected and where reviews were underway (in services for children and young people), there were clear action plans.
- Leaders of services throughout the organisation had a good understanding of the challenges in their departments and had the knowledge, skills and experience to lead effectively. Staff throughout the organisation spoke positively about their leaders and were confident to go to them if they had concerns or they required support.

We saw several areas of outstanding practice, including:

- The work of the education lead in the emergency department to improve education through various initiatives and work steams, including improved appraisals, training as part of the governance days and introduction of structured workbooks and teaching sessions.
- The understanding and involvement of patients and those close to them in the paediatric emergency department during triage. We observed that the nurse put the patient at ease and made sure that the process was explained in a compassionate way.

- The understanding of the emergency department leadership team of performance, governance, risks and its impact on patient care.
- The use of an emergency department monthly governance day to engage staff with governance and learning from incidents, concerns or near misses.
- The use of social media in the emergency department to engage staff to be more engaged with governance, share learning and discuss concerns with senior members of staff.
- The work of the clinical trials team in the emergency department to increase trial recruitment from very few patients a year to several hundred patients a year and the impact this has had on patient experience in the department.
- The medical care and outpatients services had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The medical care and outpatients services had introduced digital technology for patients living with dementia, which enabled them to access personalised reminiscence material.
- The trauma unit within surgery provided a picture menu which showed photographs of all food options that the hospital provided. This could be used for non-verbal patients or patients with learning disabilities so they could more easily identify what food they would like at mealtimes. This had been hugely successful on the ward and at the time of the inspection this was being rolled out across the hospital.
- The trust had introduced acute neurology clinics, located close to the short stay/ambulatory care unit, for patients who attended the acute medical unit and would have needed to be admitted in the past for further opinions and tests. These patients could now be discharged with an appointment, either the following day or the day after. This initiative had led to a significant number of admissions being avoided and provided a positive experience for patients.
- The cardiology department inserted the first four lead pacemaker for a patient in the world. The medical staff were monitoring the patient's recovery and rehabilitation as part of an international research project to assess the advantages of the new technology.
- A GP was employed in ambulatory care four days a week. The purpose of this new position was to improve communication with GPs to ensure basic tests had been completed prior to the patient attending the ambulatory care unit. It was anticipated that this would help to increase the flow of patients through the department and prevent patients attending the unit unnecessarily.

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

Importantly, the trust must:

- Ensure that the emergency department observation unit is sufficiently staffed to keep people safe.
- Ensure that medical staff in the emergency department receive appropriate mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that daily checks are conducted on resuscitation equipment and medicine fridges in the emergency department to assess that they are safe to use.
- Continue to develop and initiate plans and work streams in line with the improvement plan to improve flow in the emergency department at pace to improve safety and patient flow in the department.
- Ensure the promotion and control of infection at all times and in all areas within medical care.
- Ensure the security of patients' confidential and personal information at all times within medical care.
- Ensure the safety of patients at all times within medical care, including ensuring sufficient staff are on duty to monitor and provide care and treatment to patients. The trust should ensure patients are not left unattended in the ambulatory care department as a result of staff lone working.
- Ensure that the privacy and dignity of patients in medical care is respected and ensure that breaches of the national mixed sex accommodation standard do not occur.
- Ensure that staff in medical care consistently meet the trust target for mandatory training.

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- Ensure that handovers take place consistently in medical care when transferring patients between wards and departments. The trust should ensure that patients are assessed promptly by doctors following admission to the medical expected unit.
- Ensure that there are clear pathways in medical care, including staffing levels, regarding the care of patients who require non-invasive ventilation (NIV).
- Ensure nurse staffing levels on surgical wards meet expected standards as per hospital guidelines to keep patients safe.
- Improve the number of staff on surgical wards who have completed all their mandatory training in line with the hospital target.
- Improve access to patient toilet facilities within the surgical assessment unit and theatre recovery area.
- Improve the response times to patients' complaints within surgery.
- Improve the timely completion of discharge letters to GP's, including reducing the large backlog of letters which have not been sent within surgery.
- Ensure that in critical care there are adequate allocated hours from allied healthcare professionals to meet national recommendations.
- Ensure there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff in areas where children are cared for, in line with national guidance.
- Ensure all staff involved with the care of children are up-to-date with paediatric basic life support and mandatory training.
- Ensure medical and dental staff in outpatients and diagnostic imaging have received training in level two safeguarding vulnerable adults.
- Ensure medical and dental staff in outpatients and diagnostic imaging are up to date with mandatory training, including adult basic life support, fire training and paediatric life support

In addition the trust should:

- Ensure that there are suitable quantities of cardiac monitors and trolleys in the emergency department to ensure that they keep people safe at times of crowding.
- Ensure that alcohol and substance misuse support is available in the emergency department for patients who require it.
- Ensure that the executive team is more engaged with staff in the emergency department and plan times of visits better to prevent a negative impact on staff morale.
- Ensure that equipment used for personal care within medical care services is fit for purpose and that staff can provide assistance promptly if the patient becomes unwell while using equipment. This relates to showers which were not easily accessible.
- Ensure that clinical equipment in medical care, such as needles and blades, is stored securely.
- Ensure the safe storage of medicines, including creams and ointments at all times. This should include ensuring that medicines are stored in accordance with manufacturers' guidelines.
- Ensure that where oxygen cylinders are stored in medical care, there is appropriate signage to inform staff and visitors to the area.
- Ensure that staff working in all departments in medical care have access to emergency equipment and medicines in order to be able to respond promptly to medical emergencies.
- Ensure within medical care that care documentation, including care plans, and risk assessments, are completed in sufficient detail to inform staff of the individualised care and treatment that is required for each patient.
- Ensure that nursing staffing levels in medical care consistently meet the assessed and agreed staffing establishment for all wards and departments.
- Ensure that within medical care performance against national audits is improved.
- Ensure that within medical care patients' confidentiality is consistently respected when they require assistance with interpretation and/or translation.

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- Ensure that within medical care the complaints process is followed in a timely way and in accordance with the trust policy and procedure.
- Ensure that staff within medical care are consistently informed and knowledgeable about the risk registers for their wards and departments.
- Improve the completion of NEWS within surgery.
- Improve referral to treatment time target compliance for surgical patients.
- Ensure fabric curtains in critical care are replaced by disposable curtains to meet national standards.
- Ensure there are processes to monitor and audit compliance with cleaning processes in critical care.
- Ensure effective processes are put in place in critical care to learn from mortality and morbidity meetings.
- Ensure staff in critical care check essential equipment daily in line with policy.
- Ensure that in critical care, patients' allergies are always documented and that staff sign for all medicines they administer.
- Ensure the safe storage of medical gasses in critical care.
- Ensure all patient medical records in critical care are stored securely.
- Ensure practice guidance is regularly reviewed and updated in critical care to comply with national recommendations.
- Review the training and competency assessment of medical staff in critical care to ensure there are always staff on duty that are competent in airway management.
- Review nurses' paediatric competencies and training in critical care, to ensure they are up-to-date and current.
- Explore the improvement of the patient toilet in critical care to include shower facilities so that these facilities are not shared with relatives.
- Review the arrangement in critical care for the provision of follow-up clinics to ensure these are sustainable.
- Ensure staff have access to appropriate equipment necessary in children's services to carry out their roles and provide care effectively and efficiently.
- Ensure all staff involved in the care and assessment of children and young people have safeguarding training in line with intercollegiate guidance.
- Ensure that systems are in place to ensure case conference notes of vulnerable children are filed in their records in a timely manner.
- Consider the wellbeing of staff within children's and young people's services in terms of regular access to rest breaks and hydration.
- Consider mechanisms which could improve the connection of, and communication between, front line staff and divisional leaders within children's and young people's services.
- Consider options for improving the connection between the women and children's division and the rest of the trust, and review the representation of children's services at board level.
- Ensure patients within all of the diagnostic imaging waiting rooms can be monitored by staff.
- Ensure that departments within outpatients have access to resuscitation equipment in line with hospital policy.
- Provide patient information leaflets within departments in outpatients and diagnostic imaging that are available in different languages.
- Ensure access for bariatric patients in outpatients is improved so patients can be assessed and treated without compromising their privacy.
- Make improvements on the follow up backlog waiting list to meet people's needs and minimise possible risk and harm caused to patients through excessive waits on outpatient appointments and excessive waits on the reporting of images.
- Make improvements on the backlog in typing time times in outpatients and the delay in letters being sent to GPs.
- Ensure arrangements are in place to replace aging diagnostic imaging equipment identified at risk of failure.

Professor Sir Mike Richards Chief Inspector of Hospitals

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Our judgements about each of the main services

Service

Rating

Urgent and emergency services

Requires improvement



Why have we given this rating?

We rated this service as requires improvement because:

- Patients experienced long delays in the emergency department. Four and 12 hour targets were consistently missed, with many breaches being attributable to patients waiting for either medical or surgical beds. Some patients were in the emergency department for over 30 hours, with 25% of patients being in the department for over 12 hours.
- This was compounded by the lack of physical space within the department to accommodate patients. There were regular occasions when there were over 35 patients in the 18 bedded majors' area, which impacted how the needs of patients could be met.
- Patients were frequently cared for in the corridor when there were no available cubicles. There was no privacy or dignity in this area and we saw regular nursing observations and blood tests being carried out in full view of other patients. Due to the location of this area by the doctors' and nurses' station, confidential conversations could easily be overheard and there was nowhere for relatives to sit.
- Despite how busy the department was, we found that risks to patients were being assessed and managed by staff in the department. All of the patient records we looked at had risk assessments completed in full.
- Staffing was not always sufficient in areas such as the emergency department observation unit. We found that staff in this area were managing too many competing priorities to care for their patients fully. This included tasks such as answering telephones.
- Mandatory training rates for medical staff required improvement. Of the ten modules required for medical staff to complete none were above the trust target. This included paediatric life support.

• Not all daily equipment and medications checks were completed. We found that on multiple occasions, daily checks of paediatric resuscitation equipment and medicines fridge temperatures were not completed.

- There was an active and positive culture of reporting incidents and near misses. Where incidents had occurred there was debriefing and learning was always sought. We were given examples where learning had changed practice.
- Staffing numbers in the emergency department had increased. Additional nursing staff had been employed to manage risky areas such as the corridor and additional medical staff had been employed at night.
- Care and treatment was delivered in line with best practice, legislation, guidance and standards. There was a multidisciplinary approach to achieving this in the emergency department, and in the wider hospital and health and social care community.
- Staff had effective appraisals and supervision, including clinical supervision. All staff were given opportunities to develop and poor practice or concerns were quickly identified and rectified. There was a structured approach to ongoing education and development which responded to the needs of the department.
- Feedback from patients was consistently positive about the way staff treated them. Staff were consistently compassionate towards their patients. Patients we spoke with and comment cards received were positive about the staff and recognised that staff made time to speak with them and to understand their needs.
- The department had strong governance processes in place and a clear strategy, with quality and safety the top priorities.
- The trust had taken significant steps to improve patient flow, including the relocation of the ambulatory care unit, the introduction of

consultant of the day, and the introduction of a rapid discharge team. However, the impact of these initiatives continued to be impacted by continuing increasing demand for services.

• The leaders within the emergency department were well respected and made a positive impact to morale within the department. Staff we spoke with were positive about the leadership team and recognised the challenges the department faced.

We rated this service as requires improvement because:

- At times infection control was not managed well or promoted during the provision of care and treatment.
- Not all clinical store cupboards were kept locked which meant a risk of visitors or patients accessing the areas. Clinical areas where medicines were stored were not monitored to ensure the temperature did not exceed the recommended limits.
- Patients' personal and confidential information was not stored securely in all areas. Not all documentation relating to patient care and treatment was completed in full which meant that staff were not fully informed of the actions they were to take to meet the patients' care and treatment needs.
- Handovers did not consistently take place between wards and departments when transferring patients. This meant staff were not consistently provided with full and detailed information regarding patients' identified care and treatment needs.
- Patients were not consistently monitored in all departments. Staff told us that at times they were working alone in the ambulatory care department. This was due to staff needing to leave the department to deliver specimens to a collection point. Patients were sometimes left alone in the department which did not ensure their safety.
- The staffing establishments were not consistently met on some wards due to high numbers of vacancies. The number of nursing staff on duty did not always meet national guidelines.

Medical care (including older people's care)

Requires improvement

- Staff within the unscheduled care division were not meeting the trust target for their mandatory training. This did not ensure staff were aware of the trust policies, procedures and systems.
- The unscheduled care division participated in a programme of local and national audits. Some areas required improvements to meet the national average. For example, the national stroke audit, the national MINAP (heart attack) audit and the national heart failure audit.
- Patients did not always receive the care they required seven days a week, for example, rehabilitation therapy was not available at the weekends.
- Patients were able to be referred to the medical expected unit by their GP for assessment, care and treatment. At times patients had to wait for their treatment and physical tests to commence. There was no audit or monitoring to identify how long patients had to wait.
- The privacy and dignity of patients who were admitted through the medical expected unit was not always met as both male and female patients shared accommodation. This is known as a mixed sex breach. At times confidential information regarding patients' medical conditions was discussed in front of other patients. This did not ensure their privacy and dignity was fully respected.
- Whilst staff had access to translation and interpretation services, at times the patients representatives were asked to support them. This did not ensure their confidentiality was protected and did not comply with national best practice guidelines.
- Not all staff were aware of how to access, view or input into the risk registers for their wards or departments.

However:

• Care and treatment was delivered in line with national legislation and recommendations. Staff were provided with up to date policies and procedures to inform them of the action they were required to take to meet the care needs of patients following recognised pathways. Between

January and December 2016 the trust's referral to treatment time (RTT) for admitted pathways for medicine had been better than the national average. The latest figures for December 2016 showed 94% of patients were treated within 18 weeks compared to the national average of 90%.

- Staff were knowledgeable and competent to safeguard patients from abuse.
- Patients received their care and treatment from staff who were kind, empathetic and showed understanding. The feedback from patients we spoke with regarding the services provided to them was consistently positive. We saw that staff strived to respect and promote the privacy and dignity of patients in their care. Patients and their representatives were included in discussions and decisions regarding their care and treatment.
- The culture of the hospital was a positive learning environment and staff were encouraged and confident to report incidents to drive improvement.
- The trust sought feedback from patients, visitors and staff to drive improvements.
- The hospital environment generally appeared clean and hygienic.
- There were sufficient numbers of medical staff, for example junior doctors, mid-grade doctors and consultants employed to meet the needs of the patients admitted through the unscheduled care division.
- Information was shared at the start of shifts between doctors and nurses to ensure the imminent care and treatment needs of patients were met.
- Multidisciplinary team working was apparent throughout the wards and departments to ensure the care and treatment needs of patients were met in a holistic way.
- Services had been implemented and developed to meet the needs of local people. For example, the medical expected unit and ambulatory care.
- The trust had a vision and strategy for the service and the unscheduled care management team were able to inform us of a number of work streams that were on-going to support this.

 A risk assessment system was in place to improve the quality and safety of the care provided. Governance systems were in place to provide assurance that safe care was provided to a high standard.

Surgery

Requires improvement

- We rated this service as requires improvement because:
 - There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again.
 - Due to pressure for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients.
 - Elective operations were being cancelled due to the pressure on the beds within the trust, and surgical wards were being used to accommodate medical patients.
 - Mandatory training compliance required improvement, particularly in basic life support and dementia awareness.
 - Some patients' dignity was compromised by a lack of toilet facilities in the surgical assessment unit and theatre recovery.
 - Complaints were not always dealt with within 25 working days as per the hospital policy.

- The service encouraged openness and transparency from staff. Incident reporting, and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- Staff could demonstrate the patient outcomes were improving.
- The trauma unit had used innovative ideas to improve nutrition and hydration for patients.
- Patients living with dementia were well cared for on surgical wards.
- There were improved governance arrangements across the surgical service, with a holistic view of care and performance across surgical services.

Critical care

Good

We rated this service as good because:

- There was a good incident reporting culture, learning was identified and staff received feedback from incidents.
- There were safe nursing and medical staffing levels to deliver effective care and treatment.
- The service provided care and treatment in line with evidence-based guidance.
- There were experienced nursing and medical staff who received annual appraisals and were supported with training and professional development.
- The service monitored patient outcomes and these were good when compared nationally and to other similar units.
- Staff cared for patients with compassion and kindness. Staff treated patients with respect and dignity at all times.
- The provision of the service met the needs of most people.
- Patients' individual needs were met wherever possible.
- There were clear governance and risk management processes.
- There was strong leadership and teamwork.

- Provision for therapy services did not meet national guidelines. There was not sufficient physiotherapy and dietitian support, and limited support from other therapies.
- There was a slightly higher than national average of delayed discharges for patients. However, this did not result in any significant delays in admitting new patients.
- There was only one junior doctor in the unit at night, when standards recommended a unit of this size should be covered by two at all times.
- Junior medical staff were not all 'airway competent' with skills in advanced airway techniques.
- Patients were occasionally transferred to general wards at night, which was not optimal for their care.

Services for Requi children and young people

Requires improvement

This was a focused inspection to follow up on concerns from a previous inspection. We found the trust had not addressed all of the requirement notices from our inspection in 2015 and had not made improvements in the safe and well-led domains. These two domains have remained at requires improvement. Our inspection team only inspected the safe and well-led domains. During this inspection we rated safe and well-led as requires improvement because:

- Nursing staffing levels did not consistently meet recommended levels on the children's unit or the special care baby unit. There were high levels of nursing vacancies.
- The children's service did not use an acuity assessment tool to help plan staffing levels.
- Medical staff in children's services failed to meet the targets for any mandatory training courses.
- Out of hours medical cover was shared with numerous other areas of the hospital which meant the service did not always have the medical cover it needed to care for children as per Royal College of Paediatric and Child Health RCPCH recommended levels.
- There was a lack of some basic equipment available to nurses on the children's unit.
- Numerous staff told us they were working for long periods without a break, or in some cases access to a drink.
- The strategy for the women and children's division was unknown to many of the staff who worked within it.
- The women and children's division felt disconnected with the rest of the hospital, and staff did not feel connected with their leaders. There was no paediatric representative at board level, which compounded this issue.

- We saw examples of positive learning from case reviews that were embedded in practice, and staff at all levels were aware of these.
- There were creative initiatives in place such as consultant led simulation training which was well received by staff.

Requires improvement

• Staff understood their roles and responsibilities to safeguard children from potential risks or abuse and received supervision on a regular basis. The trust's safeguarding teams worked with community and social care colleagues to identify and support children who may be at risk.

Outpatients and diagnostic imaging

We rated this service as requires improvement because:

- Access to resuscitation equipment could be compromised due to the sharing of equipment between departments.
- Within some departments people were waiting too long for appointments.
- There were delays in the typing and sending of letters to GPs and the reporting on images.
- Aging and failing equipment had resulted in lost clinic time and cancelled appointments.
- Not all staff were up to date with mandatory training.
- There was an inconsistent approach to the provision of clinical supervision and peer review.
- Services were not always able to deliver and take account of the needs of different people.

- There was a good incident reporting culture where openness and transparency was encouraged.
- There were clearly defined systems and processes to keep people safe and safeguarded from abuse.
- People's care and treatment in both outpatients and diagnostic imaging was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Staff worked effectively together in a coordinated way in the patients' best interests. There was clear evidence of multidisciplinary working within departments, the hospital, as well as other acute and community health services
- Feedback from patients and relatives had been consistently positive. They praised the way the staff really understood their needs and treated them as individuals.

• There was a clear statement of vision and values for each department and division, driven by quality and safety. It was translated into a credible strategy for outpatients with defined objectives that were regularly reviewed and relevant.



Great Western Hospital Detailed findings

Services we looked at

Urgent and emergency services; ; Medical care (including older people's care); Surgery; ; Critical care; ; Services for children and young people; ; Outpatients and diagnostic imaging;

Detailed findings

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Background to Great Western Hospital

Great Western Hospitals NHS Foundation Trust provides a number of services across a wide geographical area covering Wiltshire, parts of Hampshire, Dorset, Oxfordshire, West Berkshire and Gloucestershire. The trust serves a population of around 1,300,000 people. Acute services are provided at the Great Western Hospital, Swindon. The hospital was built under the Private Finance Initiative at a cost of £148million and opened in 2002. The trust became a foundation trust in 2008.

Wiltshire Local Authority is in the 40% least deprived areas in the country. 19.% of the population are under 16 (equal to the percentage in England). The percentage of people aged 65 and over is 19.5% (higher than the England figure of 17.3%). There is a lower percentage of Black, Asian and Minority Ethnic (BAME) residents (3.6%) when compared to the England figure (14.6%). We conducted this inspection as part of our in-depth hospital inspection programme. The trust was identified as a low risk trust according to our Intelligent Monitoring model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The inspection team inspected the following six core services at the Great Western Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Services for children's and young people
- Outpatients and diagnostic imaging

We also inspected community services and looked at:

• Urgent Care Services

Our inspection team

Our inspection team was led by:

Chair: Julie Blumgart, invited independent chair.

Head of Hospital Inspections: Mary Cridge, Head of Hospital Inspections, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: An emergency department nurse, two junior

doctors with experience of working in the emergency department, a matron with experience of working in medicine, a medical doctor, a theatre nurse, a surgery matron, a consultant surgeon, a critical care consultant, a critical care nurse, a paediatric consultant, a paediatric nurse, two outpatients nurses, a board level director, a pharmacist, a clinical fellow and an expert by experience.

Detailed findings

How we carried out this inspection

We carried out the announced part of our inspection between 21 and 23 March 2017 and an unannounced inspection at Great Western Hospital on 27 and 28 March 2017 and 3 April 2017.

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 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 Great Western Hospital

The Great Western Hospitals NHS Foundation trust provides acute hospital services at the Great Western Hospital which has a total of 494 beds (including 12 critical care beds and 30 maternity beds). Since October 2016 it also provides community health services in Swindon. These services include community nursing teams, therapists and children's and young people's services and an urgent care centre. The trust employs 4,329.6 whole time equivalent (WTE) staff (as of December 2016).

Between November 2015 and October 2016 there were a total of 79,712 inpatient admissions, including day cases, 477,452 outpatients' attendances (both new and follow-up) and 125,661 attendances at the emergency department (this had increased from 78,519 emergency department attendances between July 2014 and June 2015).

In the financial year, 2015/16, the trust had an income of \pm 310.4 million, and costs of \pm 320.2 million, meaning it had a deficit of \pm 9.7 million for the year. The trust predicts that it will have a surplus of \pm 44,362 in 2016/17.

Our ratings for this hospital

Our ratings for this hospital are:

Bed occupancy was consistently above 90%, with occupancy 94% during quarter two 2016/17. This was above the England average (87.5%) and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

The executive team and non-executive team were stable, with one new non-executive joining the trust.

CQC inspection history

Since registering with CQC, there had been a total of 11 inspections covering a total of 16 outcomes. A comprehensive inspection of the trust was last carried out in September 2015. At this inspection, significant concerns were identified within the emergency department and in relation to governance processes and a section 29A warning notice was issued. A follow up inspection in April 2016 found that progress had been made but the requirements of the warning notice had not been fully met. A further inspection was carried out in October 2016 where the requirements of the warning notice were found to be fully met.

Detailed findings



Notes

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

Information about the service

The unscheduled care division provides urgent and emergency services at Great Western Hospital. The emergency department (ED) operates 24 hours a day, seven days a week. Adult ED patients receive care and treatment in two main areas: minors' and majors'. Self-presenting patients with minor injuries are assessed and treated in the minors' area.

Patients with serious injuries or illnesses who arrive by ambulance are seen and treated in the majors' area, which includes a resuscitation room. The majors' area is accessed by a dedicated ambulance entrance. There is a dedicated children's unit with a separate waiting area and a treatment area with five private cubicles.

Patients who present with minor illnesses may be redirected to nurse-led urgent care services located on the GWH site or to the co-located GP out-of-hours service. We have reported separately on urgent care services.

The emergency department is a designated trauma unit and provides care for all but the most severely injured trauma patients. Severely injured trauma patients are usually taken by ambulance to the major trauma centres in Bristol or Oxford if their conditions allow them to travel directly. Such patients are otherwise stabilised at Great Western Hospital before being treated or transferred as their conditions dictate. The emergency department at Great Western Hospital is served by a helipad. There is an eight-bed observation unit that allows for further assessment of patients who are likely to require care and treatment for between four and 24 hours but are unlikely to require admission.

Between April 2015 and March 2016 136,803 patients attended the emergency department. The percentage of ED attendances that resulted in an admission was lower than the England average for April 2015 and March 2016. Of the attendances to the emergency department between April 2015 and March 2016 22% were aged between zero and 16 years and 78% were over 17 years of age.

We previously inspected this ED in September 2015. We rated the service as 'requires improvement' overall. Effective, responsive and well-led domains were rated as 'requires improvement' and caring was rated as 'good'. Safety was rated as 'inadequate' and we issued a warning notice in December 2015. A focused follow-up inspection was conducted in April 2016 and we found that, although significant progress had been made, the warning notice had not been fully met. Another focused inspection was conducted in October 2016 and we found that the warning notice had been met.

Two weeks prior to the inspection commencing there was a significant change in processes around patient flow. Medically expected patients were being directly admitted to the medical admissions unit. This was going to have positive impact on patient flow. However, sustained impact of this could not be assessed at the time of the inspection.

We undertook this inspection from 21 to 23 March 2017 and performed an unannounced inspection on the evening of 26 March 2017. A team of inspectors, specialist advisors and experts by experience spoke with 62 members of staff, 25 patients and their relatives and examined 15 sets of patient records. We also received 42 comment cards from patients and visitors who had visited the emergency department in the weeks leading up to, and during our inspection.

Summary of findings

We rated this service as requires improvement because:

- Patients found it hard to access the services when they needed too. There were long delays to get patients out of the emergency department. Four and 12 hour targets were consistently missed, with many breaches being attributable to patients waiting for either medical or surgical beds. Some patients were in the emergency department for over 30 hours, with 25% of patients being in the department for over 12 hours.
- This was compounded by the lack of physical space within the department to accommodate these patients. There were regular occasions when there were over 35 patients in the 18 bedded majors' area which impacted how the needs of patients could be met.
- Patients were frequently cared for in the corridor when there were no available cubicles. There was no privacy or dignity in this area and we saw regular nursing observations and blood tests being taken in full view of other patients. Due to the location of this area by the doctors' and nurses' station, confidential conversations could easily be overheard and there was nowhere for relatives to sit.
- Despite how busy the department was, we found that patient risks were being assessed and managed by staff in the department. All of the patient records we looked in were found to have assessments completed in full.
- Staffing was not always sufficient in areas such as the emergency department observation unit. We found that staff in this area were managing too many competing priorities to care for the patients fully. This included tasks such as answering telephones.
- Mandatory training rates for medical staff required improvement. Of the ten modules required for medical staff to complete none were above the trust target. This included paediatric life support.
- Not all daily equipment and medications checks were completed. We found that on multiple occasions, daily checks of paediatric resuscitation equipment and fridge temperatures were not completed.

However:

- Feedback from patients was consistently positive about the way staff treated them despite how busy the department was. Staff were consistently compassionate towards their patients. Patients we spoke with and comment cards received were positive about the staff and recognised that staff made time to speak with them and to understand their needs.
- There was an active and positive culture of reporting incidents and near misses. Where incidents had occurred there was debriefing and learning was always sought. We were given examples where learning had changed practice.
- Staffing numbers in the emergency department had increased. Additional nursing staff had been employed to manage risky areas such as the corridor and additional medical staff at night had been allocated.
- Care and treatment was delivered in line with best practice, legislation, guidance and standards. There was a multidisciplinary approach to achieving this in the emergency department, and in wider hospital and health and social care community.
- Staff had effective appraisals and supervision, including clinical supervision. All staff were given opportunities to develop and poor practice or concerns were quickly identified and rectified. There was a structured approach to ongoing education and development which responded to the needs of the department.
- The department had strong governance processes in place and a clear strategy with quality and safety the top priorities. The trust had taken significant steps to improve patient flow, including the relocation of the ambulatory care unit, the introduction of consultant of the day, and the introduction of a rapid discharge team. However, the impact of these initiatives continued to be impacted by continuing increasing demand for services.
- The leaders within the department were well respected and made a positive impact to morale within the department. Staff we spoke with were positive about the leadership team and recognised the challenges the department faced.

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- During our inspection the department was consistently full with all cubicles full and patients around the nurses' station. However, ensuring patients were appropriately cared for was a top priority and was being managed well. Patient risks were being assessed, hourly observations were being taken and triage was being completed in a timely way.
- Daily checks to ensure that medicines and equipment were safe to use were not always completed in line with trust policy. A number of checks of the paediatric intubation resuscitation bag were missed as well as medicine fridges not being checked consistently. This meant that medicines or equipment may not have been fit for purpose.
- The emergency department observation unit was not sufficiently staffed to keep people safe. This area was busy with only one trained nurse and one healthcare assistant. As a result of competing pressures, neither member of staff had the capacity to observe patients. On one occasion a patient walked off the ward without staff knowing.
- Medical staff in the emergency department did not meet trust targets for any of their 10 mandatory training modules. This included fire safety, infection prevention and control and paediatric life support.

- Observations, medications, and treatment decisions were made in a timely way. Records we checked were found to be legible, compete, up-to-date and accurate. This was a significant improvement on our findings from our last comprehensive inspection.
- Staff and patients were being moved around the department based on risk to patients. Since the relocation of ambulatory care and medical patients being admitted directly to the medical admissions unit times the department was considered too busy became less frequent.
- Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents

and near misses. The department had the highest incident reporting rates in the trust and reporting remained consistent, even during times of extreme crowding.

- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguard them from abuse. All staff understood their responsibilities to identify and report abuse and were supported by rigorous processes to minimise the potential for error.
- Staffing levels had significantly improved since the last comprehensive inspection and there was less reliance on bank or agency staff. Additional roles had been introduced to improve safety within the department, including the employment of a second registrar overnight. Staffing initiatives, such as the introduction of the shift coordinator role had become embedded and played a crucial role in ensuring safety.

Incidents

- Incidents were reported on an electronic system, which all staff were familiar with. All staff had access to this system and said it was easy to use. There was a positive reporting and safety culture. All staff we spoke with were aware of their responsibility to report incidents and valued this as an opportunity to learn and improve. This was demonstrated in the types and numbers of incidents reported. The department was the highest reporting department in the trust, with a large number of near misses and minor incidents being reported. Even during busy times in the department, incidents were consistently reported.
- We reviewed a large number of reported incidents and saw evidence these were investigated and feedback was provided to staff. Learning points were identified and shared throughout the department, and the wider hospital where applicable.
- We reviewed mortality and morbidity reviews. Patient deaths and unexpected outcomes within the emergency department were reviewed on a monthly basis and discussed as a multidisciplinary team. Action plans were created from these and were allocated to an individual to complete. Common themes arising from reviews were the recording of observations, and documented decisions in relation to end of life care.
- All incidents and learning from mortality and morbidity reviews were discussed at department governance

meetings, which were held monthly. We saw effective dissemination of learning to all staff groups in the department. We were given examples of learning from incidents which resulted in changes to practice. Staff were given time to engage with the process and were encouraged to share their own ideas for improvements. Learning from incidents influenced the topics discussed at monthly governance days, which all staff were invited to attend. One example included a member of staff who was assaulted by a patient. The staff member prepared and delivered training as part of a debrief following the incident.

- Debriefs formed an essential part of the incident reporting process within the emergency department. Meetings called 'swarms' were held as soon as possible following an incident to discuss concerns, suggest improvements, and to support staff through traumatic situations. Swarm meetings were used as a debrief quickly after an incident occurred to share immediate experiences and learning.
- In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between January 2016 and December 2016. Each of these was coded to a different incident type category. There were three cases that resulted in an unexpected or potentially avoidable death. Of these, one was a "sub-optimal care of the deteriorating patient" incident, one was a "diagnostic incident, including delay" and the last one was a "medication incident". A serious incident occurred within the department a week before the inspection. This was immediately reported to the risk management team and a 72 hour report was conducted. Immediate actions were taken as a result of this to prevent it happening again and a full root cause analysis was underway.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events reported within the emergency department.

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 a provider to be open and transparent with a patient or other relevant person 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 we spoke with had a good understanding of the duty of candour and some were able to give examples of when they had fulfilled the requirements of the Regulation. Staff also discussed the importance of being open and honest with patients and apologising to them when something goes wrong, even when the requirements of the duty of candour are not met.
- We reviewed examples where patients had suffered moderate or serious harm and found evidence that duty of candour had been followed. We saw support had been given to patients and their families, explanations and apologies were provided and recorded, and investigation findings were shared once completed.

Safety Thermometer

- The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data collection takes place one day each month. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data from the patient safety thermometer showed that between January 2016 and January 2017 the department reported no pressure ulcers, two falls with harm (in September 2016) and four catheter urinary tract infections (in February 2016).
- The emergency department participated in the venous thromboembolism (VTE) prophylaxis audit for patients discharged with lower limb immobilisation in the year 2015 to 2016. Royal College of Emergency Medicine guidance states that patients being discharged from the emergency department should be assessed and given prophylaxis if necessary for their risk of developing VTE and all patients should be given a VTE advice leaflet before discharge. The audit identified that only 28% of patients had a documented assessment and only 2% of records documented that advice leaflets were provided. This increased the risk of patients acquiring a VTE after discharge from the department. It was recognised that this result may have been due to how the data was collected on the electronic patient record system.

Cleanliness, infection control and hygiene

- All areas within the emergency department were tidy and visibly clean. Cleaning was carried out throughout the day until 7pm. There were no dedicated cleaning staff at night, but, staff could be called for urgent cleaning tasks.
- We observed most staff, including cleaners and porters, going about their duties and found that they all followed hand hygiene processes in line with NICE clinical standards. However, on one occasion we saw a nurse insert a cannula without decontaminating their hands.
- During our last inspection we observed that staff were walking around the department wearing gloves and aprons which increased the risk of cross infection. We did not find this practice occurring during this inspection.
- We found the sluice area to be visibly clean and tidy and that relevant stock stored in this area (such as alcohol gel) was locked away securely. We also found that both high and low level dusting had been completed.
- Environmental cleaning audits were conducted within the emergency department and between February 2016 and February 2017 audit compliance rates did not fall below 92%. This showed that areas within the emergency department were regularly seen to be clean.

Environment and equipment

- The emergency department underwent refurbishment in 2013. Changes were made to the layout of the department, resulting in the creation of a central area where all clinical staff operated from. This was designed to speed up decision making and to allow medical staff to monitor an increased number of critically ill patients at the same time. There was a glass fronted office, in this central area where staff could make private telephone calls but still be visible and still maintain a view of what was going on in the department. The medical staff handover also took place here, allowing medical staff a confidential space to discuss patients, whilst maintaining observation of the department.
- During our last inspection we raised concerns that in the paediatric emergency department there was no direct line of sight of the waiting area by nurses. Since then the trust had put a desk with a computer by the waiting area from which part of the waiting area could be observed. However, not all of the waiting area was visible when sat

at this desk. The weighing scales which all patients used were behind the desk which compromised confidentiality. We saw on one occasion a nurse sat at the desk writing up patient's details with another patient and their carer directly behind them being weighed.

- Many staff raised concerns about the shortage of cardiac monitors within the emergency department. During times of overcrowding there regularly insufficient monitors to keep all patients monitored. Without monitoring equipment, clinicians will not have diagnostic information which may be vital to identify conditions which are life threatening. Staff informed us of incidents occurring where patients who required cardiac monitoring could not have it. This regularly occurred when the department was crowded but we were told that this happened less frequently since the medically expected patients went to the medical admissions unit.
- At our previous inspection in September 2015 we raised concerns about the location, design and layout of the observation unit. The department was physically separate from the emergency department and this led to a feeling of isolation and vulnerability of staff working there. During this inspection building work was commencing to move the observation unit to a dedicated area which was next to the ambulatory care unit and urgent care services. This meant that staff would have greater support from their colleagues and feel less isolated.
- There was a private room in the emergency department which had been designated a mental health assessment room. This room had been furnished to ensure there were no ligature points. There was an alarm system so that staff could summon help but the rooms were not fitted with two doors (that open both ways) as recommended by the Royal College of Emergency Medicine and the Psychiatric Liaison Accreditation Scheme (PLAN). The trust and the staff were aware of this shortfall and told us they risk assessed each situation each time these rooms were used. In addition, all staff were given a panic alarm which could call security quickly if needed. However, one member of staff said that it could sometimes take 10 minutes for security to arrive.
- The main reception to the emergency department was open and although there was a tall reception desk, patients or relatives could lean over to the staff. The receptionist staff we spoke with said they felt exposed

and would prefer to have glass panels in place to separate them from the patients. All receptionist staff were given personal alarms but still worried about being attacked.

- During our inspection we checked 13 sharps boxes within the emergency department. We found them all to be correctly assembled, dated and placed where they should be. We also checked the testing of 14 pieces of equipment (including syringe drivers, echocardiogram machines, infusion pumps and cardiac monitors) and found them all to have clear labels indicating when they were last checked, and when they need to be checked again.
- All resuscitation trolleys, apart from the paediatric resuscitation intubation trolley, had daily checks recorded. The paediatric resuscitation intubation trolley regularly had daily checks missed. In January 2017 there were six occasions where it was not checked, in February 2017 there were 14 occasions where it had not been checked, and in March 2017 there had been 12 occasions where it had not been checked at the time of the inspection. Staff explained that this was the responsibility of the theatre staff to check and not part of the emergency staff responsibilities.
- In the resuscitation area blood glucose monitors had daily checks regularly missed. In January 2017 there were 11 occasions where they were not checked, in February 2017 there were 14 occasions where they were not checked, and in March 2017 there were 9 occasions which were not recorded at the time of the inspection. This increased the risk of the equipment being faulty and giving false readings.

Medicines

- Arrangements for managing medicines and medical gasses mostly ensured security and appropriate use. We found that all medicines, including controlled drugs, were stored securely and were locked away if required. Within the resuscitation area and majors' area we found daily checks being completed for all drugs stored in this area (apart from two occasions in the majors' area). All cupboards containing medicines were locked, apart from one which had a broken lock. This had been reported as broken and was awaiting repair.
- Although recorded temperatures were not outside of thresholds fridges in the resuscitation area regularly had daily checks missed. In January 2017 there were 10 occasions where checks were not recorded, in February

2017 there were 13 occasions where checks were not recorded, in March 2017 there were 7 checks were not recorded at the time of the inspection. This was potentially harmful to patients as changes in temperatures may render the medicines within them unfit for consumption. This included emergency medicines for seizures and intubating patients.

- Fridges in the majors area regularly had daily checks missed. In January 2017 there were nine occasions where checks had not been recorded, in February 2017 there were five occasions where checks were not recorded, and in March 2017 there were four occasions where checks had not been recorded at the time of the inspection. This was potentially harmful to patients as changes in temperatures may implicate the medications within them.
- We saw that as part of the triage process, all patients were being asked about allergies. This was then clearly recorded in patients' documentation to make it obvious for all staff to see.

Records

- During the inspection in September 2015 we raised concerns about the standard of record keeping. When we returned in October 2016 we found improvement had been made; however records were still not always complete. During this inspection we found further improvements had been made, particularly in the four months prior to the inspection.
- During this inspection we looked at 25 sets of patient records and safety checklists and found that they were all completed to a high standard, with very few non-conformances to protocol and best practice. We saw examples where patients had been escalated and moved to the resuscitation area and good use of the identification of allergies. We found that records were legible, up-to-date, and held securely in locked storage cabinets. However, we found that on one set of notes an electrocardiogram had not been signed for and on one occasion a pain assessment had not been completed.
- Generally, computers were being locked after use preventing unauthorised people accessing them. However, on one occasion we found that patients' records were left open on computer a screen and were unattended for a period of 20 minutes.

Safeguarding

- There were systems, processes and practices in place to keep people safe from harm. These were embedded into department practices and were communicated to staff. As part of the triage process, safeguarding questions were asked as part of a checklist which covered topics such as non-accidental injury, different types of neglect, and social services' involvement. The trust's policy on safeguarding was available on the trust's intranet. Within the department there was a safeguarding notice board and a file which could be used by staff as another resource. Training updates were offered to all staff on a monthly basis to introduce new systems or receive updates from the trust's safeguarding teams.
- Staff were aware of their safeguarding responsibilities and knew the processes to follow in the event of a safeguarding concern being identified. All the staff we spoke with were able to talk through the process of reporting a safeguarding concern, and could show us where to find help and guidance to support them. They were able to tell us about the different types of abuse and knew how to manage incidents or concerns or about female genital mutilation and child sexual exploitation.
- Most nursing staff working in the emergency department were up-to-date with level two adult safeguarding training. However, compliance was variable for medical staff. All nurses in the department were trained in level one and level two child protection training and level one adults safeguarding training. However, the department did not meet the trust's 90% compliance target for level three child protection training, with only 79% of staff trained or the trust's 80% compliance target for level two adult safeguarding training, with only 68% of staff trained. The trust's medical staff met their target for the safeguarding vulnerable adults training, including learning disability awareness training. However, they did not meet the compliance targets for the four other safeguarding training modules which included level one child protection (84%), level two child protection (75%), and level three child protection (82%) against a compliance rate of 90%. Compliance with safeguarding vulnerable adults training was significantly below the trust's compliance target at only 43% against a compliance rate of 90%.

- Additional training on safeguarding adults, child protection, female genital mutilation and non-accidental injuries was delivered as part of the department induction for substantive nursing staff, rotating doctors, and bank and agency staff.
- Staff had a good understanding on the topic of female genital mutilation. Workshops had taken place for all staff to attend and staff could explain to inspectors the processes involved to keep protected from harm. Staff were able to give a lipstick to patients who suspected this harm with a contact telephone number on it. This ensured that the patient could seek help discretely.
- There were also posters within the department to raise awareness of female genital mutilation and domestic violence. The emergency department had a domestic violence lead that attended a monthly forum in the trust and brought updates back to the department.
- The computer system used in the department had a flagging system which reception staff checked when booking in a patient. This linked with the child protection information systems. When a patient flagged as a risk a sticker would be put on their departmental notes to alert staff. This also recorded the patient's last attendance within the department to allow staff to identify patterns of regular attendance.
- As part of recommendations from our last comprehensive inspection, the emergency department audited the completeness of safeguarding records for children within the department. This showed an improvement in practice from 82% of records being completed to 98% of records being completed. A re-audit date had been assigned and an action produced to improve this further.

Mandatory training

- The emergency department's nursing staff met their targets for 10 of the 12 mandatory training modules. The two modules where targets were not met were Moving Patients Equipment Training Manual handling face-to-face (71% against the target of 80%) and Paediatric Basic Life Support (66% against the target of 80%).
- The emergency department's medical staff did not meet their target for any of the 10 mandatory training modules. The compliance rate for the above training modules ranged between 19% for adult basic life

support and 74% for information governance. Fire safety awareness training was at only 23%, paediatric life support training was at only 29% and infection prevention and control was at only 48%.

Assessing and responding to patient risk

- The national early warning scores (NEWS) system a severity scoring system that is used to rapidly identify patients who are becoming critically unwell and need to be reviewed. Staff complete a full set of physiological observations and for each parameter to identify a score. The more unwell the patient it, the higher the score is likely to be.
- During the last inspection in September 2015 we raised concerns about the completeness of observations within the emergency department. Although at the follow up inspection in October 2016 we recognised improvement had been made, this was still an area for improvement. During this inspection we found that there had been further improvement in this area.
- The department audited the use of NEWS and the identification of the deteriorating patient between January 2016 and December 2016. On average, 72% of patients had observations recorded and showed an improvement over time, within the required frequency of 15 minutes, one hour or two hours. The compliance rate for observations being recorded was highest in September 2016, when 90% of patients had observations taken with the correct frequency.
- On average, 94% of patients had a NEWS score calculated every time with and showed an improvement over time. The compliance for calculations being recorded was highest in September 2016 and November 2016 where 100% of patients had NEWS scores calculated every time.
- On average, 83% of patients had the NEWS score calculated correctly every time, and showed an improvement over time. The compliance for correct calculations took place in in June, July and August 2016, where between 90% and 100% of patients had NEWS calculated correctly every time.
- Patients should receive an initial assessment (triage) by a registered healthcare practitioner within 15 minutes of arrival in the emergency department to ensure that acutely unwell patients and those at high risk of deterioration are identified.
- An observation and NEWS audit showed that there had been significant improvement in the last 12 months. For

example, in January 2016 the average time for initial assessment for adults was one hour and fifty minutes. However, by December 2016 this had reduced to 45 minutes for initial assessment. Although the observations are being taken outside of the 15 minute target, the delay was significantly less. During the inspection we found this to have improved further as no patient was waiting longer than 15 minutes for triage.

- An observation audit the Paediatric Early Warning Score System showed consistent and appropriate monitoring of observations of paediatric patients within 15 minutes of patients' arrival in emergency department.
 Performance had only dipped below 100% once between September 2016 and January 2017.
- NEWS scores of five or more across the parameters (or red in any one parameter) would require a medical review within 20 minutes. The department recorded time delays for patients who were escalated. Only 47% of the patients identified were seen within this timescale, 25% were seen within one hour, and 28% waited over an hour.
- The department's ability to ensure all observations and medications were completed had improved dramatically prior to the inspection. Prior to March 2017 during times of crowding the emergency department s ability to maintain safety for all patients was compromised by the amount of patients in the department. There were 23 reported incidents between September 2016 and January 2017 reported where throughout the department observations were not completed in a timely way or medicines were not given on time. However, we found that in March 2017 the number of occasions where this occurred had dropped.
- The department's ability to manage workload intensity had improved in the month prior to the inspection. Between September 2016 and January 2017 there were 64 reported incidents of adverse workload intensity, most of which triggered a 'red flag'. The 'red flag' system described situations which were considered to be unsafe and actions to address them. Triggers included delays in patient assessment and review, patients queuing, patients' essential needs not being met, staff not being able to take adequate rest periods and staff feeling overwhelmed, stressed or unable to cope. Staff reported their concerns to the shift coordinator, who, in turn, compiled an incident form, summarising all the red flag concerns raised on a particular shift. However,

through the use of the department shift situation report we found that in March 2017 the number of occasions where the department was deemed to be unsafe had dropped.

- Many staff we spoke with were concerned about patients during times of crowding. We were given examples of where patients were cared for in the corridor that should have been in the resuscitation area (including a patient with unstable blood sugar and ketones). Staff also discussed with us that at times if a patient deteriorated quickly they wouldn't be able to get to the resuscitation area due to the number of trolleys in the corridor. Paramedic staff told us of occasions where they often had to leave patients in the corridor to attend to other patients and when they return to the hospital the patient hasn't been moved to a cubicle. They also said that they had to give analgesia when the nurses were busy which had caused delays in collecting the next patient. Staff told us that incidents like this had reduced since the medically expected patients went directly to the medical admissions unit. However, it was too soon to quantify the impact until this had been fully embedded.
- Between February 2016 and January 2017 there was a slight upward (worsening) trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In December 2016, 33.1% of ambulance journeys had turnaround times over 30 minutes; in January 2017 the figure was 36.3%. In March 2016 38.3% of ambulances were turned around in 30 minutes and in October 2016 43.1% of ambulances were turned around in 30 minutes.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the staff. Between February 2016 and January 2017 the trust reported 135 "black breaches". There was an upward trend in the monthly number of "black breaches" reported between June 2016 and January 2017, from one breach in the former to 30 breaches in the latter. Over the whole 22-month period between April 2015 and January 2017, November and December 2016 and January 2017 were the three highest reporting months, with 20, 20 and 30 "black breaches", respectively. Staff told us that the pressures on the ambulance service had

reduced as a result of the medically expected patients going directly to the medical admissions unit. However, it was too soon to quantify the impact until this had been fully embedded.

Nursing staffing

- During the last inspection concerns were raised about insufficient levels of staff to manage patients safely at times of crowding in the emergency department. During this inspection we found a much improved picture. Since the last comprehensive inspection there had been an increase of 20 nurses, including additional staff to monitor patients in the corridor and the introduction of a department coordinator to oversee the department on a shift by shift basis.
- As a result of the increase in staffing establishment the department held a high vacancy rate of 24.6% (compared with 14.8% at the last follow up inspection) but many of these vacant posts had been recruited to at a recent recruitment event. Staffing was on the department risk register and many initiatives had been introduced to promote the department and to get consistent bank and agency staff.
- Fill rates of shifts for substantive registered nursing staff was consistently below 70%, and fell from 68.5% of planned whole time equivalent roles in September 2016 and 65.4% in December 2016. Fill rates for substantive healthcare assistants increased from 89.3% in September 2016 to 101.0% in December. Vacant shifts were filled using bank and agency staff to ensure 100% fill rates.
- The use of agency staff had reduced since the last follow up inspection. During that inspection on average 45% of staff (on both day and night shifts) were bank and agency. During this inspection the use of bank and agency varied between 3.4% in April 2016 and 25.1% in March 2017 and was increasing month on month.
- There were incident reports which showed that at times the department was running on a high percentage of agency nurses including on some occasions were 50% of staff were agency.
- All agency and bank staff went through a rigorous and detailed induction before they were allowed to work in the emergency department. Once completed, induction records were sent to the bank office to be checked

before the staff member was employed again. Induction booklets contained a range of useful information, including guidance on safeguarding, best practice protocols and medicines.

- Between January and December 2016, the trust reported a sickness rate of 5.6% for nursing staffing in the unscheduled care division, which was above the trust target of 3.5%. There was an upward trend in the sickness rate throughout the year. Between January and December 2016 the sickness rate increased from 4.3% to 7.1%.
- During the inspection the emergency department observation unit was not staffed sufficiently to keep patients observed at all times. In this area there was one registered nurse and one healthcare assistant who were looking after two four-bedded bays. Neither member of staff had the capacity to observe patients properly within this area due to pressures of arranging transport, admitting patients and managing flow. We observed that several times over one hour that the unit was left unstaffed. This resulted, on one occasion, with a patient leaving the department without nurses knowing. We reported this to a member of staff as soon as they returned and the patient was recovered from another part of the hospital. The next day we found one nurse managing both bays and trying to complete two separate ward rounds, admit two patients at the same time, with two phones ringing. In addition there was an incident reported where a nurse, who had not received sufficient training, was placed in the observation unit and did not understand what they were meant to be doing.
- During the unannounced inspection staff in the paediatric ED raised concerns with inspectors that there were not sufficient staff to ensure that they were able to observe patients in the waiting area as well as triage patients. We observed the waiting area for 15 minutes and during that time area was unobserved by staff on four occasions but this was for less than two minutes each time. Since the last comprehensive inspection a healthcare assistant had been employed to maintain observation of patients in this area.

Medical staffing

• Medical staffing levels were good which resulted in 24 hour consultant cover. As of December 2016, the trust reported a medical staff vacancy rate of 5.3% in the unscheduled care division, which was below the trust

target of 8%. As of December 2016, the trust reported a turnover rate of 9.5% which was below the trust target. Between January and December 2016, the trust reported a sickness rate of 2.4% which was below the trust target.

- Medical staffing levels had increased to meet demand for the service. This included the introduction of an additional overnight registrar to manage care within the department.
- In October 2016, the proportion of consultant staff working in the department was reported to be about the same as the England average (27% compared to 26% for England as a whole). The proportion of junior doctors (foundation year 1-2) working in the service was lower than the England average (11% compared to 22% for England as a whole). This meant that there was a higher number of middle grade doctors compared to other trusts.
- Similar to the last inspection, there were structured medical staff handovers at the start of each shift, led by the consultant in charge. A checklist was used to ensure that all important safety matters were discussed. All patients in the department and their plan of care were discussed. Any risks and challenges were discussed, including waiting times and the hospital's bed state. We found this to be of high quality and managed peoples need well.

Major incident awareness and training

- There was a clear major incident process in place within the emergency department. This involved a series of checklists for different situations and scenarios within the department and the rest of the hospital. There was a main major incident folder and smaller area- specific folders which information could easily be retrieved from.
- Any changes to these documents were reviewed by a committee to ensure that they were robust and reflected best practice. There was only one hole punch in the trust with the ability to fit pages into the major incident folders which prevented unauthorised paperwork being placed within them and confusing staff.
- The trust set a target of 80% for staff completion of the health and safety training module, which included major incident training. (The module also included accident reporting and minor incident investigation training.) As of 20 January 2017, 92.3% of staff in the emergency department were up to date with this

training course, and the target was therefore met. Staff also received training in dry contamination procedures (to decontaminate after exposure to hazardous chemicals) and had training every four months to ensure best practice was used.

- Staff were aware of their responsibilities in the event of a major incident and could direct inspectors to the locations of additional equipment (such as chemical protective suits) in the case of chemical, biological, radioactive or explosive incidents. There was also a designated area outside of the emergency department where additional generators and water pumps could be placed.
- Prior to the inspection the trust had held a multi-agency simulated emergency incident (where a body was pulled from a local lake) as a training exercise. This involved staff from the hospital, ambulance service, police and fire services. Learning was taken from this and an action plan developed. Plans were in place to have additional major incident simulations every three months working with other services in the area.
- The departments business continuity plans worked in the same way as a major incident plan, with folders detailing checklists to act upon. Items within this included postal systems failure and computer failure.

Are urgent and emergency services effective? (for example, treatment is effective)

We rated effective as good because:

 Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. We saw good use of National Institute for Health and Care Excellence (NICE) guidelines and Royal College of Emergency Medicine (RCEM) standards for pathway management, including stroke and asthma.

Good

• Information about people's care and treatment was routinely monitored and action was taken to improve the effectiveness of treatment where shortfalls had been identified. The department performed well in the most recent RCEM audits and action plans to address any shortcomings were in place and progressing well to

improve. Where the department did not perform so well, for example, in the departments prophylaxis audit, we found embedded changes had been put in place to improve practice.

- Staff had the skills required to carry out their roles effectively. Since our last inspection, an education lead had been appointed, who managed training needs and development for nurses. Junior medical staff had a robust training programme while on their rotation in the emergency department. Appraisal, individual supervision and clinical supervision were used effectively within the department to support staff.
- Multidisciplinary working within the department was embedded throughout to effectively assess, plan and deliver care and treatment. We found rigorous processes in place for the management of stroke patients between the emergency department, ambulance services, radiology and the stroke team.

Evidence-based care and treatment

- Care and treatment was delivered using recognised clinical guidelines, for example, National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine's Clinical Standards for Emergency Departments. There were clear pathways, supported by checklists for the management of conditions such as stroke and sepsis. We saw evidence in patients' records that staff were familiar with these pathways and that they were followed. We observed examples of evidence based-care and practice for the treatment of asthma and stroke patients.
- The emergency department used a comprehensive audit programme to ensure that they were monitoring, reporting, and acting upon the use of evidence-based care and treatment. The programme was made up of a number of individual audits, each of which had a designated lead, start date, and report completion date. Many of these audits were linked with National Institute for Health and Care Excellence clinical guidelines or quality standards. Where non-compliance had been identified, action plans had been developed to improve practice.

Pain relief

• Patients had their pain assessed and managed promptly. In all the records we reviewed patients had an early pain score recorded and timely administration of pain relief where required. We saw examples during triage of patients being offered pain relief before moving to other areas of the department. All patients we spoke with were comfortable and told us they had been asked if they were in any pain and offered pain relief.

Nutrition and hydration

 Patients we spoke with told us they had been offered drinks and snacks where appropriate. There were regular food and drink rounds being undertaken. Drinking water was available on request once patients had been examined.

Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The trust participated in Royal College of Emergency Medicine national audits so they could benchmark their practice and performance against best practice in other emergency departments. Where short falls had been identified action plans were created. Internal re-auditing of practice was planned to ensure practice had improved where needed.
- The department took part in the royal college of emergency medicine vital signs in children audit. In the year 2015 to 2016 the department was fully compliant for standard five (a documented review by a senior doctor), was equal to the national average for standard three (the recognition of an abnormal vital sign) and standard four (documented action taken). There was an action plan created as a result of this audit which included increasing awareness, further training and the amendment of forms to improve compliance. This was due to be re-audited in two years as part of the royal colleges audit programme.
- The emergency department took part in the Royal College of Emergency Medicine audit of procedural sedation in adults in the year 2015 to 2016. The Royal College of Emergency Medicine guidance states that patients undergoing procedural sedation in the emergency department should be assessed against seven criteria relating to pre-procedural assessment, team mix and post-sedation care. The audit showed variation in practice for both the agent used and techniques, although there were no serious adverse events identified in the patients being sedated. The audit found that between 50% and 75% of patients had a pre-procedural assessment; that between 50% and 75% of patients had the right team mix present, and that less than 50% of patients had complete observations

post-procedural care. In response to these findings an action plan was developed which led to the introduction of a sedation checklist, based on the World Health Organisation Safer Surgery to reduce the risks to patients.

Prior to our last inspection the trust had taken part in other royal college of emergency medicine audits (such as the 2014 to 2015 cognitive impairment in older people, the 2014 to 2015 audit of asthma in children, the 2014 to 2015 audit of the management of the fitting child, the 2014 to 2015 audit of mental health in the emergency department and the 2014 to 2015 audit of sepsis) and we found that action plans were progressing in a timely way. Re-audit dates and leads had been identified to see if action had improved practice.

Competent staff

- Significant improvement had been made within the emergency department to ensure that staff had the skills, knowledge and experience to deliver effective care and treatment. The department had introduced a designated education facilitator role who had been pivotal in implementing a number of improvements. These included the introduction of a formal induction pack, an emergency department handbook, a minimum standards training pack and a department 'passport'.
- A rolling training programme for all emergency department staff had been introduced. Training was delivered by specialist nurses and doctors form other areas of the hospital and external speakers. Simulation training was embedded into training processes and was regularly offered to staff to build and develop skills and competence. This included training in the management of diabetic ketoacidosis in adults and management of the collapsed baby in the department. Feedback was requested from attendees on all training sessions and incorporated into future training sessions.
- Training in sepsis screening and management was regularly delivered to nursing and medical staff and where there were changes to trust policy training was delivered to bring all staff up to date with best practice. Where failures were recognised in the compliance with the sepsis protocol, additional training was delivered to improve practice.
- Learning needs of staff were identified through the use of constructive appraisals and through one to one supervision sessions. Compliance with appraisals for nursing, administrative and medical staff appraisal rates

was either on or just below the trust's 90% target. Between October 2016 and December 2016 compliance for administrative staff had improved from 60% to 90% and between April 2016 and December 2016 compliance for nursing staff had improved from 30% to 90%.

- One to one supervision sessions were actively used by staff and were encouraged during safety briefs.
 Managers could also request to have one to one meetings with staff who they were worried about.
 Managers were offered one to one session with divisional managers to support their needs. Long term agency and bank staff were also given the opportunity to have one to one sessions with managers.
- All junior doctors were allocated an educational supervisor, a clinical supervisor and a mentor, as part of their placement in the emergency department. They met once a month to discuss and review personal development plans and training needs, which was recorded within their educational supervisor report. All junior doctors were supported to take part in an audit as part of their placement and received consultant-led training sessions on a weekly basis.
- The educational facilitator regularly walked around the department and spoke with both nursing and medical staff. This gave staff an opportunity to raise concerns about variable and poor performance. Staff who were seen to be struggling were offered additional support and help through one to one sessions. Senior staff recognised the importance of using one to ones to identify "silent concerns" and to recognise where staff were struggling, even if they were not speaking out.

Multidisciplinary working

- All staff, including those from different teams and services, were involved in assessing, planning and delivering care and treatment. We found that all staff worked together to deliver care in a coordinated way.
 Staff reported good working relationships with radiology services, the mental health liaison team, the local ambulance service, the local urgent care services, and with the wards.
- There were clear and structured pathways for patients arriving at the emergency department who had a stroke. We followed a patient during this pathway and found that at all stages communication was clear. All staff (including the ambulance crew, radiographers, doctors and nurses) knew what to do as part of the pathway. When the emergency department was informed that a

potential stoke patient was on the way to the department, they called the stroke team immediately, who also informed diagnostic imaging to prepare the computed tomography (CT) scanner and reception to book them onto the computer system. As soon as the patient arrived they went to the CT scanner and onwards to a resuscitation bay where the stroke team was waiting for them. This whole process was complete within 15 minutes of the patient arriving in the department.

Seven-day services

- There was senior medical presence in the emergency department 24 hours a day, seven days a week.
 Radiology services (such as computed tomography) were also available 24 hours a day, seven days a week.
- Since the last inspection the trust had employed mental health liaison nurses to ensure that there was adequate specialist knowledge and experience 24 hours a day, seven days a week. Staff said that referral was easy and that the liaison nurses responded quickly when needed.

Access to information

- Staff had access to relevant patient information. There was an electronic patient information system which held patients' personal information, such as their next of kin and their family doctor, and details of previous attendances. For new patients this information was entered at the time of arrival. For returning patients, the information was checked and amended as necessary by the receptionist. Patient records generated for each attendance would be pre-populated with this information so that nursing staff were aware of these details when they assessed patients.
- Staff in emergency department had access to real time information systems which allowed them to view activity in the department as a whole. A large electronic "whiteboard" was located in the central coordinating hub and allowed a clear oversight of departments activity and the ability to track patients' progress, while in the department. The electronic patient record allowed the tracking of investigations and treatments while in the department. Paper records, such as observation charts were scanned by administrative staff. Discharge summaries to GPs were generated electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were required to complete a training module on consent and mental capacity. As of 22 February 2017, the trust reported the training had been completed by 97.2% of nursing staff within the unscheduled care division, which is better than the trust target of 90%. The training module had been completed by 75.0% of medical staff within urgent and emergency care, which is worse than the trust compliance target of 90%.
- Patients told us that doctors and nurses explained things to them in a way that they could understand. We observed staff asking patients' permission to undertake examinations or perform tests.

Are urgent and emergency services caring?

Outstanding

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We rated caring as outstanding because:

- Feedback from patients and their relatives was consistently positive about the way staff treated them, despite how busy the department was. People were treated with dignity, respect and kindness regardless of how busy the department was.
- We observed many occasions where staff responded compassionately when patients needed them to, particularly within the children's emergency department.
- Staff told us about an example of where they had 'gone the extra mile' to provide compassionate care to support a patient who was at the end of their life to get married in the emergency department. Staff told us how they had made sure that this was a special experience for the couple.
- All relatives we spoke with told us they felt informed and were involved in decisions about the care of their loved ones. Staff communicated with patients in a way that they could understand and worked with patients to ensure there was a shared decision-making process.
- We saw an example of a member of staff helping a patient to cope emotionally during a traumatic situation within the emergency department. Staff understood the social needs of patients and adapted their care accordingly.
Compassionate care

- The departments Friends and Family Test performance (percentage recommended) was better than the overall England performance in nine of the 12 months between January and December 2016. After October 2016, the Friends and Family Test performance had declined and in December 2016, trust performance was 82.8% compared to an England average of 86.0%.
- Staff told us about an example of where they had gone the extra mile to provide compassionate care. A patient who was at the end of their life was able to get married in the emergency department. Staff worked hard to ensure that they were given the privacy and dignity to do this and that there was adequate food and a cake for the occasion.
- We spoke with 25 patients in the department. Comments were consistently positive despite how busy the department was. Comments included: "the staff have been really good so far, I was treated with respect and compassion in all areas", "the staff have been excellent", "the staff are always nice to me".
- Additional comments included "the staff have been quite excellent, I have been treated really well. Everyone introduced themselves and I feel completely aware of what is going on", "everyone is working so hard here but I still feel that they have the time to listen to me and care for me properly". One patient said "I have been here since two this morning and have been treated brilliantly, I have had food and drink when I asked for it and was made to feel like nothing was too much trouble, I am going home soon and leaving very satisfied with how I was cared for".
- During this inspection we provided comment boxes in the department for patients and their relatives to share compliments and concerns. We received 42 completed cards, with the majority being positive. Comments included "staff were polite and friendly", "we were happy with my wife's treatment today", "staff were absolutely fantastic today with my two year old", "staff and doctors have been really nice, I was given time to explain, they listened to me", and "brilliant service and professional care both times I have come here".
- Other comments included "all staff were polite and explained what was happening. They all introduced themselves which I appreciated and chatted to you to

put you at ease", "I have received excellent service on all the occasions that I have been here" and "the staff were amazing today, put me at ease and helped me with everything".

• Call bell responses were audited monthly within the department. Between February 2015 and November 2016 the percentage of call bells answered within five minutes ranged from between 74% and 92% with the average month being between 80 and 89%.

Understanding and involvement of patients and those close to them

- We spoke with patients and their carers and relatives during the inspection. Carers and relatives we spoke with said that they had been treated well and had been offered food and drink. Carers we spoke with said that they were included as part of conversations, felt included in discussions about care. Patients also said that they felt as if they fully understood the care they were being given by everyone. One carer said "I have been completely informed of the situation and what is happening", another said "the staff have been excellent; they are kind, respectful and include me in everything".
- One relative we spoke with said "I feel the doctor was very good at informing my mother of what is going to happen moving forward. This makes me feel happy and more supported".
- Inspectors observed the triage of a child. The nurse conducting the triage was calming and engaging with both the patient and their parent, including them both in the conversation and putting them at ease. The nurse ensured that any examination done was interesting and told the parent what each device was for. The nurse made sure that the child understood their care fully. Afterwards the nurse told us "in paediatrics we have extra time to care" and "we understand it can be scary for the patient so we make the effort to make it less scary and to reassure them".
- The views and experiences of patients who were in department over 12 hours were gathered and acted on to shape and improve the service provided in the emergency department. In December 2016, 55 of the 167 patients in the department over 12 hours were interviewed. They were interviewed by a band six nurse who had the skills and experience to engage fully and answer any concerns raised. Feedback from these surveys showed that, although they were in department a long time, patients felt they were well cared for.

Feedback was positive and most patients said they were offered adequate food and drink, were kept up to date with what was going on and that staff listened to concerns and answered questions. Staff described other improvements which had been made as a result of these surveys, including having more pillows in the department and making changes to the call bell system in cubicles.

Emotional support

• We spoke with one patient who had experienced a traumatic personal issue. This patient said they were fully supported emotionally to get through it. The staff were kind to them and treated them "with the utmost dignity and respect".

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

Requires improvement

We rated responsive as requires improvement because:

- The size of the emergency department was not adequate for the volume of patients who attended. This meant that patients did not always receive care and treatment in a timely way. Since our last inspection the volume of patients seen had increased and crowding was now considered the "norm".
- The area around the nurses' and doctors' station was known colloquially as 'the corridor'. During the last inspection this area was used to accommodate patients when there were no cubicles available. During this inspection this area was used all of the time and staff told us that on numerous occasions in this area, patients were positioned two abreast. This made it difficult to care for patients in a responsive way. There were no blinds to protect patients' privacy and confidentiality and we saw observations and bloods being taken in this area.
- Flow throughout the rest of the hospital and into the community was having a significant impact on the emergency department's ability to see and treat patients. The department consistently breached

national performance targets in relation to time spent in the department. The majority of breaches of access targets were attributable to a lack of available inpatient beds.

- There was no alcohol or substance misuse team within the department which meant that vulnerable people were discharge from the service without support.
- Staff found it difficult to get hot meals for patients who had been in the department for long periods of time. In the week before the inspection five patients were in department for over 30 hours without having access to hot food.

However:

- The trust had taken a number of steps to improve patent flow. For example, the relocation and expansion of the ambulatory care unit meant that in one month over 250 patients were streamed away from the emergency department to other areas, freeing up capacity.
- We also found that a high number of patients were who streamed from triage to other services, such as the urgent care services, was increasing month on month.
- We found that the needs of people were mostly understood. The department had made adjustments for people with learning disabilities and people living with dementia, including the development of a 'dementia friendly' cubicle.
- There had been significant improvement in the management of complaints. Between January 2016 and December 2016 the average time to close a complaint had reduced from 61 days to five days.

Service planning and delivery to meet the needs of local people

- The majors' area within the emergency department was designed for 18 patients. The size of the department was not adequate for the volume of patients who attended. Crowding was considered the 'norm' which sometimes made it difficult to care for patients.
- The department was constructed as part of a private finance initiative which meant, that due to constraints with the contracts, that the size of the department could not be increased. The department was designed for 45,000 patients a year, however it was seeing over 130,000 patients each year.
- During this inspection queuing in the corridor was a regular and common occurrence and at all times there

were patients in this area. There were no curtains or blinds in this area which resulted in privacy and dignity being compromised. We saw at times that observations were taken and recorded in this area and blood tests were taken. There were also patients in gowns in the seated area which was not a dignified experience for them. We saw that some male patients were topless in this area at times and on one occasion a gentleman was exposed on a trolley. There was nowhere for relatives to sit and they were in busy areas which were used as a thoroughfare for staff. However, by being in this area patients were being observed continually by doctors and nurses around the nurses' station.

- We found that due to the close proximity of patients, private and confidential conversations (for example about medical histories) could be overheard by other patients and their relatives. One conversation about medicines took place in front of 13 other patients in the seated area in the majors' area. We observed that confidential telephone calls were taken at the nurses' station which could be overheard by patients in the corridor.
- At times of crowding, two patients were placed in some of the cubicles at the same time to free up space in the corridor and trolleys were placed alongside each other. On the first day of the inspection the department was busy and we found that staff were having to side step around trolleys due to the limited physical space between patients in the department.
- The trust had introduced many initiatives to manage flow within the confines of their department. For example, the movement of ambulatory care meant that an additional 250 patients per month went to hospital without going through the emergency department. Other initiatives were hospital wide and included direct admissions onto the medical assessment unit and wards, the introduction of consultant of the day on medical wards as an information point for staff, changes within the discharge assessment team and the development of relationships with community services. However, it was too soon to quantify the impact of these initiatives fully as they had not been fully embedded.
- Within the department there were mechanisms in place to record the numbers of patients who were streamed to their GP, urgent care services which was on site, or to the walk in centre. High numbers of patients were streamed to these services to increase capacity within the emergency department. Between December 2016 and

March 2017, 11% (13000) of patients were triaged within the department and referred to other services. The amount of patients streamed was increasing month on month.

- The department was working on a business continuity plan for crowding within the emergency department, following similar checklists to the major incident plan. Managers had identified that when there were times of crowding decisions were made based on clinical judgement rather than following criteria where all of the perceived risks have been discussed and decided upon.
- Several staff raised concerns about the inability to get hot meals within the department. This meant it was challenging to find hot food for patients who had been in the department for a long time. There were five patients the week before the inspection that had been in the department for over 30 hours without access to hot food.

Meeting people's individual needs

- The service had taken steps to support people in vulnerable circumstances. The emergency department had a 'dementia friendly' cubicle. This cubicle has green walls and pictures hung to contrast from the rest of the department. This allowed patients to find their cubicle easily. The department had a dementia champion who linked with the trust's dementia team and various charities.
- There were examples where adjustments were made for patients living with dementia and for patients with learning disabilities. Some patients were placed by the nurses' station so that staff could continually observe them for safely and provide reassurance to patients who were disorientated, anxious or agitated.
- Support was provided for people whose first language was not English. We saw posters displayed around the department publicising translation services for patients. We found on one occasion these services were used for a patient who could not speak English.
- A number of staff raised concerns that there was no alcohol or substance misuse team within the department. Following the inspection the trust informed us there was an alcohol liaison nurse within the trust, but no evidence was provided to show how they supported the emergency department. The alcohol and substance misuse service was provided by a third party provider. However, this post was vacant and was not being refilled due to contracting changes. We found that

there were patients within the department during the inspection that would have benefited from additional advice and support that this service could provide. Doctors told us that if they felt a patient required this service after discharge, they could call the third party provider and inform them of their visit to the emergency department.

Access and flow

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival. The trust consistently breached this standard between January and December 2016. Although, the standard was also breached across England overall, the trust's performance was worse than the England average in 10 of these 12 months. Between May and December 2016 there was a deteriorating trend in trust performance, from 93.4% in May 2016 to 82.0% in the December 2016. This partly coincided with a national deterioration in performance from September, but, the trust's deterioration in performance was much greater. This had worsened further between December 2016 and March 2017 when the average performance was 70.7%. The impact of the medically admitted patients had not been quantified at the time of the inspection.
- Patients should have a decision to admit or discharge made within 60 minutes. Between December 2016 and March 2017 the number of patients whose decision to admit or discharge was made within 60 minutes remained below 25% with the expectation of one week in December which was 32%. One week in January this was as low as 13%.
- Between December 2015 and November 2016 the trust's monthly median total time in A&E for all patients was consistently better than the England average.
 Performance against this metric showed an overall trend of decline over these 12 months.
- Between February 2016 and February 2017, 90 patients were declared as being '12 hour breaches' from the decision to admit until being admitted. The highest numbers of patients being '12 hours breaches' were in March (49), April (33) and December (six). This improvement was as a result of changes in the reporting system.
- The number of patient waiting longer than 12 hours who were not considered as a breach in department was

much greater. Between December 2016 and March 2017 5% of patients were in department over 12 hours. Between the same time period 25.3% of patients were in department between four and 11 hours.

- When looking at the causes of the breaches of targets within the department, the majority of these had been due to the lack of medical beds within the hospital, with very few breaches being as a result of staffing or capacity within the emergency department. Between December 2016 and March 2017 of the 5,948 breaches in the department 992 (17%) were as a result of assessment capacity within the department and only one breach was due to a delay in senior review. Of the breaches in this time period 3544 (60%) were as a result of waiting for a medical bed, and 310 (5%) were as a result of waiting for a surgical bed. The remaining 18% were due various other reasons.
- The monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was worse than the England average in six of the 12 months between December 2015 and November 2016. Following a deteriorating trend over the previous seven months, between July 2016 and November 2016 the trust's performance against this metric showed a trend of improvement, from 4.0% in July to 2.8% in November. During the inspection we saw that this had further improved further with the average percentage of patients leaving before being seen being 1.7% in March 2017.
- Of the 42 comment cards received, seven referred to the long waits to be seen and how frustrating they found it. Some respondents commented that the expectations of waiting did not match the reality and they would have liked to be updated if there was going to be a delay.

Learning from complaints and concerns

- Patients were informed as to how to make a complaint. We found complaints leaflets in the department for patients and relatives to pick up.
- The NHS Constitution gives patients and their carers the right to have complaints dealt with efficiently, be investigated and to know the outcome of the investigation. Between February 2016 and January 2017 there were 114 complaints about urgent and emergency care services. The emergency department took an average of 24 working days to investigate and close complaints; this was in line with their complaints policy, which stated that the trust had a standard 25 working

Good

day response time for complaints. Alongside these complaints the department had received 51 concerns which had been locally recorded and resolved and 51 compliments.

There had been significant improvements on the efficiency of complaints management. In January 2016 it took on average over 60 days to get a complaint resolved whereas in December 2016 this had reduced to five days.

Are urgent and emergency services well-led?

We rated well-led as good because:

- There was a clear strategy for the department which had patient safety as its top priority. The main strategic objective for the emergency department to achieve this was to consistently achieve the four and 12 hour targets. The improvement plan had well-defined objectives which were regularly reviewed. Actions engaged local commissioners, external organisations and the rest of the hospital. There were many significant actions taken to improve flow within the department, however, increasing demand on the service had minimised the impact of them.
- Governance functioned effectively within the emergency department. There was sufficient priority given to managing risks. All risks had been identified within the emergency department risk register and actions were monitored for impact.
- The leadership team was knowledgeable about the risks within the department and had the appropriate expertise and skills to fully understand the challenges and mitigate risks.
- Leaders were well respected by the staff and encouraged safe and high quality care. They treated staff with compassion and supported them so they felt valued and respected.
- Staff and patients were engaged with to improve the service. All staff were invited to attend governance days and there was regular communication through social media, emails and posters. Patients who had been

waiting in the department for over 12 hours had a post visit interview to gain their experiences. This had led to changes within the department to improve the patient's experience.

However:

• Some staff felt that the executive management team were not as engaged with staff in the department as they could be and felt that they only went to the department when it was in 'crisis'.

Leadership of service

- The leadership team within the emergency department had the skills, knowledge, experience and integrity that they needed to lead effectively. Leaders encouraged appreciative and supportive relationships among staff and understood fully the challenges to good quality care.
- The leadership team were visible and approachable and highly respected by staff in department. At the time of our inspection the nominations had been made for the annual staff excellence awards and there was an individual nomination for a member of the leadership team within the emergency department. The leadership team were described as providing "endless support to both nursing and medical staff" and as being "approachable and listens to everybody's concerns and ideas". Another member of staff said that the leadership team were "proactive".
- The leadership team felt that the trust team were engaged and had a good attitude to improvement and felt that they had been fully supported through the changes since our last inspection, both with wellbeing support and financial support. Since our last inspection two million pounds had been invested in the emergency department and we were told that there were plans in place to develop further.
- The leadership team within the emergency department was actively influencing changes in the wider healthcare system. Managers attended bi-weekly meetings with the clinical commissioning group to discuss how the department is performing and to discuss future plans.
- However, staff in the department felt that the executive team were not always visible, although they knew who they were. Some staff said that the executive team only visited the department when "something goes wrong or we are in crisis" and felt that "it would be nice to see

them at other times too". One member of staff told us they found it frustrating when trust executives walked around the department on their way home with their coats and bags.

• Some staff felt that the trust was not responding to the need for more space in the department and that ideas were not taken forward.

Vision and strategy for this service

- The department had shown continuous improvement in delivering the vision and strategy since our first comprehensive inspection. These were structured around the department's delivery board improvement plan. This plan was inclusive of urgent care services, the wider hospital and external organisations to improve emergency services in Swindon and the surrounding area and used multiple work streams throughout the entire hospital to improve performance.
- Significant changes had taken place as part of this plan which included: The relocation of the ambulatory care unit with the goal of having 30% of medical patients going through this department and reducing the demand on the emergency department. Prior to the move very few patients were admitted direct, with the majority going through the emergency department. For example, in January 2017 only 55 patients were directly admitted to the unit, with 23 being directly admitted in February 2017. This significantly increased in March 2017, with 357 patients going directly to the unit. This meant that fewer patients were going through the emergency department.
- This also included The introduction of 'consultant of the day' for acute medicine, emergency surgery and GP access to act as a point of advice and streaming for the emergency department to improve rapid access and reduce the amount of time patients are in the department.
- This also included the introduction of the discharge assessment referral team to help patients return to the community freeing up beds for emergency patients to fill.
- This also included the development of relationships with community services to prevent patients needing to go the emergency department including same day home visiting support, additional children's clinics in the community and extended GP hours in north and central Swindon.

- Senior teams within the department were looking ahead to how integration would work between the emergency department and the on-site urgent care services which had recently come under the management of the trust. Meetings commenced several weeks before the inspection to discuss with commissioners how the services would work to achieve the 'Luton and Dunstable model' as recommended by NHS England. We were also informed about plans to move the minors area to the urgent care services to increase capacity in the majors unit which would have a positive impact on crowding in the department.
- Despite all of the work which had gone into improving flow within the emergency department, many staff felt that this was overshadowed by the volume of patients attending. One member of staff said that "these initiatives relieve the pressure for only a short while".
- Staff understood their roles and responsibilities to achieving the vision and strategy at all levels within the emergency department. Staff we spoke with were dedicated to getting patient flow working and supported each other to achieve this.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the strategy and good quality care. The department held both department meetings and mortality and morbidity meetings which fed into the departments governance meeting. This in turn reported to the sub-divisional performance meeting and the unscheduled care divisional board. There were clear responsibilities for these forums and effective escalation and dissemination of information.
- Information from governance meetings was disseminated in a various different ways. Attendance was encouraged at monthly governance days and for those working clinically or not at work that day, there were email communications, interaction with a private social media group, as well as large colour posters displayed around the department.
- During our last inspection not all staff were aware of the governance days. However, we found that during this inspection all staff could discuss the governance days and what learning they took from them. Managers said that attendance at these meetings had increased over the last year from one or two staff to over thirty every time.

- The department had a risk register populated with risks which scored over 12 (a high risk). There were seven risks on the register, five of which scored 16 and over. The highest risks (which scored 20) were: inadequate capacity in the department; the timely completion of observations; and risks associated with crowding. Significant actions had taken place to resolve these, such as the relocation of ambulatory care away from the emergency department and the introduction of direct admission of medical expected patients to the medical assessment unit.
- There was a holistic understanding of performance which integrated the views of patients with safety, quality and activity information. The department had various dashboards based on quality indicators and managers could clearly demonstrate to inspectors the impact crowding had on patient experience and safety. The department linked these quality indicators with 'situation reports' to align the data with the state of the department to gain a clear and comprehensive picture why indicators were not being met. The department could clearly demonstrate the impact that crowding had on the department in terms of incident occurrence, serious incident occurrence, staff wellbeing, and friends and family results.
 - There was alignment between what was recorded on the risk register and what staff and managers told us was 'on their worry list'. Managers understood completely what their risks were, what the barriers to mitigating them and the impact they had on patient care and could confidently demonstrate evidence to support this. This confidence in understanding cascaded to staff on the ground who also understood the challenges faced by the department and knew what processes were in place to mitigate the risks.

Culture within the service

- During our last inspection we found that the culture within the service had improved and we saw further improvement at this inspection. Despite how busy the department was, staff recognised the changes that had been made and saw the improvements. Staff were particularly positive about the increase in staffing over the last two years.
- Some staff found that the speed of change within the department had affected their happiness, particularly staff asked to perform the department nurse coordinator role. Prior to our last follow-up inspection

the department had introduced the nurse in charge role to have oversight of the shift. During this inspection we found this role was fully embedded and was vital to ensuring safety of patients. The departmental leaders saw this role as pivotal to the safe running of the department and gave the ability to "step back and see the bigger picture". The leadership team recognised that the emergency nurse practitioners were not happy about this change as it pulled them away from clinical work, but recognised the impact it was having on departmental safety.

- Changes made since the last inspection were having an impact on the wellbeing of staff. It was described in an annual staff excellence award nomination that "the changes that the team have made in the last year, from implementing dedicated assessment cubicles to employing a dedicated educational supervisor have no doubt improved patient safety and staff morale".
- The emergency department was nominated for an annual staff excellence award. They were nominated by a senior member of staff and described the team as "working tirelessly under relentless amounts of pressure" and consistently putting "the care of patients first".
- Staff turnover rates in the emergency department remained high at 23.2% (compared to 20% at our last inspection).This which was over the trust's 13% target. Managers discussed that they recognised a link between the turnover of staff and the introduction of new processes and systems to improve the department as a whole.

Public and Staff engagement

- There were several different communication methods used by the leadership team to engage with staff. They found that sending emails out didn't necessarily work for them so they created a private social media group where all staff in the department could post questions, share learning and engage with senior teams and colleagues. For those not on social media the department had a folder with updates in the staff room for people to look at. Managers said that the advantage of using social media was that they could see who had and who hadn't looked at information within it and chase them up if necessary.
- To help staff through times of high workload and stress the department has employed several counsellors to spend time with staff.

Innovation, improvement and sustainability

- The department took part in many clinical trials which were under the responsibility of the emergency department trials nurse and recruited hundreds of patients a year. Trials included both international and national studies and when results were published they fed into service development and improvement. One example given was, following a trial, the department wrote into a protocol that a stroke patient could sit up further improving comfort and patient experience. As an incentive for staff to recruit patients onto trials there were prizes offered by the department for the staff who recruited the most people onto a trial.
- Senior staff told us that "three years ago we would be lucky to recruit one patient a year into a trial; we now recruit hundreds a year". Another member of staff praised the dedication of the research nurse and the impact that clinical trials had on the wellbeing and motivation of staff. One member of staff described the clinical trials nurse as "excellent and hardworking".
 - Senior managers within the department felt that the private finance initiative nature of their hospital made it difficult to improve services as they would have liked. We were given some examples where minor

improvements (such as the addition of shelves in a clinical area) were slow and expensive to complete. We were also given an example where the department had bought new monitors for the resuscitation bays but as a result of delays in getting brackets put on the walls, they could not use them.

- Sustainability was a worry of the senior team within the department who felt that despite the department being over capacity, solutions were not going to come quickly. The leadership team and the trust had regular meetings with the local clinical commissioning groups to discuss the issue. We were told that the chief executive had made the local members of parliament aware of the need for capital funding to increase the footprint of the department.
- However, the leadership team recognised that there had been a change in the trust's culture towards the department. They felt that other departments across the hospital were starting to take responsibility for flow problems which were impacting on the emergency department and that there was now a feeling that "the four hour target is a trust-wide target, not just an emergency department target".

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

Information about the service

This report relates to the inspection of medical care, including older people's care services, which is part of the unscheduled care division at Great Western Hospital. We carried out an inspection in 2015 which found some areas of the hospital required improvement. This inspection was to follow up the requirements and action taken by the trust after our last inspection.

The medicine service at the hospital provided care and treatment for six specialities; general medicine, older people's services, cardiology, gastroenterology, respiratory and clinical haematology. There were 304 inpatient beds located across 11 wards.

We visited a number of wards and departments that are part of the unscheduled care division to observe care, speak to staff and patients and review records and documentation. Areas we visited included the following wards; Dove, Falcon, Coronary Care, Mercury, Linnet acute medical unit (LAMU), endoscopy, Neptune, Saturn, Teal, Woodpecker, medical expected unit and the discharge lounge.

The trust had 41,222 medical admissions between November 2015 and October 2016. Emergency admissions accounted for 51% of the admissions, 3% were elective and 46% were day cases.

There 426.9 whole-time-equivalent nursing staff employed in the unscheduled care division in August 2016 and 22 other clinical whole time equivalent staff. We spoke with 27 patients and four relatives who were visiting the hospital, to seek their views of the service, care and treatment they had been provided with.

We spoke with 55 members of staff, including nurses, doctors, pharmacists, therapists, housekeeping and administrators, to seek their views of working at the hospital. Prior to, during and after the inspection we reviewed information and documentation provided by the trust.

Summary of findings

At the last inspection of this hospital we rated safety, effectiveness and leadership as requiring improvement. There were areas of the medical division that were not appropriately staffed and staff did not always follow safety procedures, such as those related to the control of infection and the storage of chemicals and sharps equipment. The completion of records was not consistently undertaken, including care planning and information relating to the patient's mental capacity.

At times patients experienced delays in discharge and were unable to leave hospital when they were medically fit. Senior management were not always felt to be visible. The NHS staff survey results for 2014 showed that the trust was below the national average for staff reporting good communication between senior management and staff.

We rated this service as requires improvement because:

- At times infection control was not always managed well or promoted during the provision of care and treatment.
- Not all clinical store cupboards were kept locked which meant a risk of visitors or patients accessing the areas. Clinical areas where medicines were stored were not monitored to ensure the temperature did not exceed the recommended limits.
- Patients' personal and confidential information was not stored securely in all areas. Not all documentation relating to patient care and treatment was completed in full which meant that staff were not fully informed of the actions they were to take to meet the patients care and treatment needs.
- Handovers did not consistently take place between wards and departments when transferring patients. This meant staff were not consistently provided with full and detailed information regarding the patients identified care and treatment needs.
- Patients were not consistently monitored in all departments. Staff told us that at times they were lone working in the ambulatory care department.

They added this was due to staff needing to leave the department to deliver specimens to a collection point; patients were left alone in the department which did not ensure their safety.

- The staffing establishments were not consistently met on some wards due to high numbers of vacancies. The number of nursing staff on duty did not always meet national guidelines.
- Staff within the unscheduled care division were not meeting the trust target for their mandatory training. This did not ensure staff were aware of the trust policies, procedures and systems.
- The unscheduled care division participated in a programme of local and national audits. Some areas required improvements to meet the national average. For example, the national stroke audit, the national MINAP (heart attack) audit and the national heart failure audit.
- Patients did not always receive the care they required seven days a week. For example, rehabilitation therapy at the weekends.
- Patients were able to be referred to the medical expected unit by their GP for assessment, care and treatment. At times patients had to wait for their treatment and physical tests to commence. There was no audit or monitoring to identify how long patients had to wait.
- The privacy and dignity of patients who were admitted through the medical expected unit was not always met as both male and female patients shared accommodation. This is known as a mixed sex breach. At times confidential information regarding the patients' medical condition was discussed in front of other patients. This did not ensure their privacy and dignity was fully respected.
- Whilst staff had access to translation and interpretation services, at times the patients' representatives were asked to support them. This did not ensure their confidentiality was protected and did not comply with national best practice guidelines.
- Not all staff were aware of how to access, view or input into the risk registers for their wards or departments.

However:

- Care and treatment was delivered in line with national legislation and recommendations. Staff were provided with up to date policies and procedures to inform them of the action they were required to take to meet the care needs of patients following recognised pathways. Between January and December 2016 the trust's referral to treatment time (RTT) for admitted pathways for medicine had been better than the national average. The latest figures for December 2016 showed 94% of patients were treated within 18 weeks compared to the national average of 90%.
- Staff were knowledgeable and competent to safeguard patients from abuse.
- Patients received their care and treatment from staff who were kind, empathetic and showed understanding. The feedback from patients we spoke with regarding the services provided to them was consistently positive. We saw that staff strived to respect and promote the privacy and dignity of patients in their care. Patients and their representatives were included in discussions and decisions regarding their care and treatment.
- The culture of the hospital was a positive learning environment and staff were encouraged and confident to report incidents to drive improvement.
- The trust sought feedback from patients, visitors and staff to drive improvements.
- The hospital environment generally appeared clean and hygienic.
- There were sufficient numbers of medical staff, for example junior doctors, mid-grade doctors and consultants employed to meet the needs of the patients admitted through the unscheduled care division.
- Information was shared at the start of shifts between doctors and nurses to ensure the imminent care and treatment needs of patients were met.
- Multidisciplinary team working was apparent throughout the wards and departments to ensure the care and treatment needs of patients were met in a holistic way.
- Services had been implemented and developed to meet the needs of local people. For example, the medical expected unit and ambulatory care.

- The trust had a vision and strategy for the service and the unscheduled care management team were able to inform us of a number of work streams that were ongoing to support this.
- A risk assessment system was in place to improve the quality and safety of the care provided. Governance systems were in place to ensure safe care was provided to a high standard.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- Infection control was not always managed well or promoted.
- Not all clinical store cupboards were kept locked which meant a risk of visitors or patients accessing the area.
- Clinical areas where medicines were stored were not monitored to ensure the temperature did not exceed the recommended limits.
- Some areas where medicines were stored did not have appropriate shelving to enable staff to manage effective stock rotation.
- Oxygen was stored in areas where there was not clear signage in place to alert visitors to the area.
- Patients' personal and confidential information was not always stored securely.
- Not all documentation relating to patient care and treatment was completed in full. This meant that staff were not fully informed of the action they were to take to meet the patients care and treatment needs.
- Staff were not consistently provided with a full handover for all patients transferring between wards and departments.
- Staff at times were lone working in the ambulatory care department. Due to certain care and treatment requirements patients were sometimes left alone in the department which did not ensure their safety.
- The staffing establishments were not met on some wards due to high vacancies. The number of staff on duty did not always meet national guidelines.
- Staff within the unscheduled care division were not meeting the trust target for their mandatory training.

However:

- Staff were encouraged and confident to report incidents to drive improvement.
- Most areas used by patients looked clean and hygienic.
- The medical care and treatment for patients was provided by sufficient numbers of doctors.
- Handovers took place at the start of each shift to ensure clinicians such as nurses and doctors were aware of the care and treatment needs of each patient.

• Process and systems were in place to ensure patients were safeguarded against abuse.

Incidents

- Between January and December 2016, the trust reported no incidents which were classified as Never Events for medicine. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There had been a reported never event in endoscopy in 2015, prior to our last inspection. We reviewed the investigation records and saw that a detailed investigation had taken place which had resulted in an action plan to reduce the risk of the incident reoccurring. The action plan had been implemented and closed.
- In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in medicine which met the reporting criteria set by NHS England, between January and December 2016. Of these, the most common type of incident reported was 'diagnostic incident including delay meeting SI criteria (including failure to act on test results)', which had two incidents. When compared to four other similar acute trusts, the hospital had reported far fewer serious incidents per 10,000 patient admissions.
- Staff we spoke with were confident that they were encouraged and were able to report incidents through the trust electronic reporting system. Feedback was provided to staff through email communication and at regular staff meetings. However, not all potentially serious incidents that could affect the safety of patients had been reported through this system. For example, the risk to patients being left alone in the ambulatory care department when lone working staff left the department to deliver blood samples.
- Information regarding incidents which had occurred within the trust was displayed in staff rooms to promote learning from the incidents.
- Staff gave us examples of how change had been effected following a reported incident. For example, following a patient transfer to endoscopy resulting in them missing important medication, a formalised handover sheet had been developed to identify such requirements. We also saw evidence that change had

been effected following out of date medication being given to a patient. Following a serious incident investigation after a patient fall, action had been taken to stop beds being raised above a certain height. Staff we spoke with were aware of this incident and the action taken.

- Falcon ward staff carried out a safety briefing at each handover. During this briefing staff were informed of 'hot topics' which included information following reported incidents. We observed one set of patient records which had not been completed accurately. On discussion with the ward sister we were told this would be added to the safety briefing so that staff would be reminded of the importance of accurate record keeping.
- Mortality and morbidity was monitored within the trust. Departmental mortality meetings took place at varying frequencies dependent on the speciality. There were terms of reference for these groups and the information from the groups fed into the trust mortality group meeting. Deaths were investigated and learning shared across the trust through cascading of information from these meetings.
- The trust dashboard displayed mortality and morbidity information each month showing a brief commentary to explain the mortality score. Where family members or representatives of the patient raised concerns regarding the care and treatment a full review took place. Other criteria which automatically triggered a full review were patients with learning disabilities and those who died over a weekend.

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 a provider to be open and transparent with a patient or other relevant person 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 demonstrated an understanding of the duty of candour. We were provided with examples where the duty of candour had been followed. For example, following a fall in which the patient had sustained a broken bone, there had been a full investigation and open communication with the patient. The never event reported in 2015 had been fully investigated and the duty of candour principles followed.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing patient harm and 'harm free' care. This system was used by the trust and data was collected in line with the safety thermometer methodology each month.
- Data from the patient safety thermometer showed that the trust reported 20 new pressure ulcers, 15 falls with harm and 11 new catheter urinary tract infections between January 2016 and January 2017. The prevalence rate for new pressure ulcers increased over time, rising to its highest peak in January 2017. The prevalence rate for falls with harm had been mixed over the period. The prevalence rate for new catheter urinary tract infections had been stable until September 2016, when it started to rise.
- Wards displayed information on the patient safety thermometer to inform patients and visitors of any incidents which had occurred on the ward. For example, we saw information that related to falls, pressure damage and call bell response times.
- On Dove ward the information displayed showed that every patient who was identified at risk of a fall was fully assessed using the trust falls risk assessment, within four hours of admission. The data also showed that these patients had a care plan in place to advise and guide staff on the action to take to reduce the risk of a fall.
- Staff made comments about the positive effect the trust falls lead had made on reducing the number of falls within the hospital. They were positive about the training provided to them in their wards and departments which they felt had assisted them to provide safe care and further reduce the number of falls.
- At the last inspection in 2015 we found that action had not consistently been taken to reduce the risk to patients of venous thromboembolism (VTE). Since the inspection the electronic prescribing system had been updated requiring staff to routinely complete the VTE assessment. Staff informed us this reduced the risk to patients and ensured staff completed the assessments. Patient records which we reviewed identified the VTE assessments were completed.

Cleanliness, infection control and hygiene

• All areas we visited during our inspection appeared clean, tidy and hygienic. Wards and departments were

odour free. Patients commented to us about the cleanliness of the ward they were admitted to. There was one exception to this where a relative pointed out a dusty and soiled trolley in the Medically Expected Unit (MEU).

- Visitor toilets within the hospital were clean with cleaning schedules displayed on the wall. We observed that a number of toilets we visited were up to date with the cleaning schedule. Sinks had elbow taps in place, toilets were fitted with automatic toilet flushes and there were pedal bins in place. This meant users of the facilities did not have to touch the equipment which reduced the spread of infection.
- Curtains were used in patient areas to separate bed spaces to afford privacy and dignity. We saw these were changed regularly as the date they were last changed was written on the curtains. Staff told us the housekeeping teams were responsible for this and that the changes were made every six months or more frequently when necessary. For example, when soiled or when deep cleaning a bed space.
- Equipment could easily be cleaned after use and we saw clearly visible stickers were used to identify if a piece of equipment was clean and when the cleaning had taken place.
- We saw that non-clinical equipment used for patients was able to be cleaned easily. For example the ambulatory care waiting room had wipe clean chairs.
- Staff who worked in endoscopy suite advised us that each cubicle area was cleaned between patient use and that at the end of the day the whole area was cleaned and made ready for the following day.
- We spoke with staff responsible for cleaning the endoscopes and saw this procedure followed clear guidelines which promoted the control of infection and protected patients against cross infection.
- The control of substances hazardous to health (COSHH) regulations were followed in that cleaning materials and substances were stored securely in locked cupboards. Chlorine wipes were used for cleaning equipment such as beds and commodes after use. This reduced the risk of cross infection and promoted infection control. We saw staff routinely cleaned equipment, beds and trolleys in this way after use.
- Protective personal equipment (PPE) was readily available throughout the wards and departments. We observed staff consistently wore PPE when in personal contact with patients and washed their hands

frequently. Sanitising hand gel was located throughout the wards and departments. Information was displayed encouraging staff, patients and visitors to the ward to wash and gel their hands.

- There was clear information and signs on wards and departments about infection control. For example, on side room doors regarding the precautions to take prior to entering.
- On the medical admissions unit we saw that urine had been left in two toilets following patients being asked to provide a urine sample. On one occasion urine was in a male urinal on the floor of the toilet and this was there for two hours and a bedpan was left on the toilet for one and a half hours. We also observed one patient access the toilet who then had to ask a member of staff to remove the bedpan containing urine. This did not promote the control of infection.
- We observed that staff transported urine from toilets to the sluice in bedpans without covers on. This did not promote the control of infection.

Environment and equipment

- A medical equipment management policy was available to staff which outlined the procedures for maintenance and servicing of equipment. Staff made positive comments regarding the servicing, maintenance and repair service provided.
- We noted that equipment had a date of the last service attached and saw that equipment was serviced or maintained annually. The exception to this was a blood pressure monitoring machine on ambulatory care. However, once a nurse identified this they knew immediately the action to take to ensure the machine was safe to use.
- Resuscitation equipment was located within wards and departments which contained equipment and medication for use in an emergency situation. The trolleys were secured with tamper evident tags in order to prevent unauthorised people accessing the equipment and medication. In an emergency the tags were easily broken.
- Daily and weekly checks of the emergency equipment and medicines were required to be carried out by staff and recorded within a log book. We reviewed the log books on each ward we visited. These were completed on each ward with the exception of Linnet Acute Medical Unit (LAMU) where we observed some daily checks had been missed.

- Access to the emergency equipment and medicines was compromised in the discharge lounge as the trolley which would be used was located within the nearby Betjeman clinic. This trolley was also used by the orthopaedic outpatients department. There was a risk to patients that if the emergency equipment was required it could be in use elsewhere. The trust had carried out a formal and written risk assessment for this issue which identified this as a moderate risk and which the trust had deemed an acceptable risk. There was not a grab bag available to staff in the discharge lounge. (A grab bag is a bag which contains basic emergency equipment). The resuscitation policy stated that all inpatient and outpatient areas must have access to a resuscitation trolley or grab bag. Whilst the discharge lounge did not have access to these items, the trust considered the access to the emergency equipment was in close proximity.
 - The endoscopy department had been redeveloped following an assessment by the Joint Advisory Group (JAG) which had led to the accreditation of the department being withdrawn. JAG accreditation demonstrates a hospital has the competence to deliver against national endoscopy standards and measures. Remedial work had been completed in line with the recommendations included in the report produced by JAG in October 2016. The visit to review the accreditation was to be carried out the week following our inspection. However, the outcome of the accreditation was not expected to be provided to the hospital for a number of weeks.
- Jupiter ward specialised in the care and treatment of patients living with dementia. The environment had been carefully considered to support the needs of these patients and was colour coordinated and used visual aids to orientate patients to their bed. The flooring had been changed to support patients when they were mobilising. However, this had not been introduced on other wards which also cared for patients living with dementia.
- Patients had access to showering facilities on wards. However, not all of the showers were accessible to all patients as some had a small step. Staff described how they would lift the shower chair in and then transfer the patient to chair if they were not fully mobile. This would hinder getting the patient out in an emergency or if they became unwell.

- We observed that equipment was located in rooms and cupboards within the wards and departments. These were not consistently locked. We saw that on Linnet acute medical unit (LAMU), sharp materials such as needles and blades, were accessible to patients and visitors to the ward. This did not ensure safety.
- At the last inspection we observed that sharps bins were not used in accordance with the manufacturer's guidelines which presented a potential risk to staff of needle stick injuries. At this inspection we noted that all sharps bins were being used following the manufacturers guidance, were not overfilled, shut when not being used and signed and dated when sealed ready for disposal.

Medicines

- Systems and processes were in place to promote the safe use and storage of medicines in order to keep patients safe. However, we observed that on occasions these had not always consistently followed.
- Each ward and department had medicine storage facilities to ensure the medicines were secured at all times. However, we observed that sluices on wards were not locked and we saw creams and emollients in unlocked cupboards in the sluices. This meant they were accessible to patients and visitors on the ward. We also saw in the ambulatory care unit that medicines were kept in locked cupboards in a room, shared with another department that was able to be locked with a key pad. At the time of this inspection we observed the door had been propped open. This meant patients and visitors to the ward had access.
- Controlled drugs were stored securely. Controlled drugs registers we checked were up to date and maintained appropriately. We saw on the ambulatory care unit that one controlled drug was out of date. The staff on the ward made arrangements for this to be returned to pharmacy immediately to ensure it was not used.
- We noted that there had been two incidents reported from two separate wards that an inaccurate balance of a liquid controlled drug had been recorded. Following investigation this had been attributed to a spillage of the liquid. Quills were now used to dispense liquid controlled drugs to reduce the risk of this reoccurring.
- Medicines which required cool storage were stored in refrigerators for this purpose. The temperature of the

refrigerators were checked daily and those we checked had been within normal limits. This ensured medicines were kept at an appropriate temperature for their safe use.

- We saw that on Dove ward there had been a four day gap in checking the refrigerator temperature. Staff told us this had been because the general medicines and the refrigerator were stored in a clean utility room where temperatures had reached over 30 degrees centigrade. This caused concern for the effective and safe use of the medicines and they were all, including the refrigerated medicines, returned to pharmacy for replacement. During this four day period the refrigerator was not used whilst the estate management company addressed the issue of the high temperature in the room.
- Not all of the utility rooms where medicines were stored had a room temperature monitoring system in place. This did not enable staff to be certain that medicines were stored as directed by the manufacturers. Medication storage rooms were observed to be particularly hot and whilst not all medication required refrigerated storage it did require storage at room temperature. As there was no monitoring of the room temperature there was a risk that medication was stored at temperatures which exceeded the recommendations made by the manufacturers.
- The ambulatory care unit had recently been opened.
 The medication storage in this unit was cluttered which increased the risk of error from not being able to find medicines or rotating stock appropriately. The nurse practitioner advised that shelving within the cupboard was required to enable proper access to the medicines.
 A request had been made and accepted but had not been actioned at the time of our inspection.
- A medicine safety meeting took place within the trust every two months and was attended by clinicians from the unscheduled care division. This enabled systems and processes to be reviewed and information shared regarding legislation and best practice updates.
- We observed nursing staff administering medicines to patients. We saw staff wore a badge which informed patients, visitors and other staff they were in the process of administering medicines to reduce being interrupted. Medicines were administered safely.
- Piped oxygen was accessible in wards and departments, with the exception of the discharge lounge where oxygen was available only in cylinders. Wards and

departments had a supply of portable oxygen cylinders for use in an emergency. We consistently identified that oxygen was stored in areas where there was no signage to alert people to its presence.

- Fluids for intravenous use were stored in locked cupboards.
- Wards and departments were supported by the pharmacy department to obtain stocks of medicines.
- Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications. The trust carried out audits of the medicine reconciliation process. The Linnet acute medical unit (LAMU) had the lowest medicine reconciliation rate. The matron had an awareness of increasing medicine errors on the unit and had entered this on the risk register in February 2017. An action plan was in place to reduce the risk to patients. This action was joint working with pharmacy and LAMU to complete a business case for increased pharmacy support on the unit. In addition a control had been put into place for the pharmacy department to support LAMU with additional resources in the interim.. Examples of errors had included: one patient had gone home with another patient's medicine and another patient's own medicines were not checked within 48 hours of admission. This had led to confusion with accurate prescribing of medicines while in hospital.

Records

- Each ward and department had secure storage facilities for medical records. However, not all of the trolleys were locked and therefore notes containing personal and confidential information were accessible to patients and visitors to the wards.
- We reviewed 16 sets of patient medical and nursing records across the medical wards and departments. Medical records were clear and detailed care and treatment plans were in place. Nursing records contained information regarding identified risks to the patient during care and treatment, care planning and a record of the care and treatment provided. We saw disparity in the completion of the nursing records, with some care plans personalised to promote individualised care and others that had not been amended or

completed in full. This did not provide staff with detailed information on the action they were required to take to meet the individual and at times specialised care needs of the patient.

- We observed the food intake chart for one patient. Their nutritional risk assessment stated that they had a compromised swallow and were required to be provided with a pureed diet. The food intake chart indicated that they had been provided with toast and/or bread. This increased the risk from choking for this patient. We discussed this with the ward sister who told us the recording was inaccurate and the patient would not have been given this type of food. Detail of this error was to be added to safety briefing so that staff would be informed of importance of accurate recording at handover.
- Wound care plans were in place when necessary which were detailed and informative. We saw the care plan specified the size and position of the wound, the dressing to be used and when the wound required checking and redressing.
- Risk assessments were completed regarding moving and handling, falls, nutrition, pressure damage and cannula checks. A cannula is a tube that can be inserted into a vein for the insertion of fluids. However, staff had identified that one patient identified had a poor nutritional intake but no nutritional risk assessment had been completed to fully assess the risk. This meant that the care plan did not provide sufficiently detailed information on the action staff were required to take to ensure the patient's nutritional intake was satisfactory.
 Electronic records were maintained by staff of the care and treatment and investigative tests carried out for patients. The computers were password protected and screens were positioned so that patient confidentiality was respected.
- Patient observation charts, fluid charts, food intake charts and detail of care rounding were positioned at the patient's bedside for ease of use. These records were completed and up to date. However, staff commented to us that the care rounding tool was not appropriate for the level of care some patients received. The care rounding form provided space to record care every two hours but staff commented that many patients receive care more frequently and that this was sometimes not recorded due to the time factor involved in recording electronically or within the care log.

Safeguarding

- There were reliable systems, process and practices in place to keep people safeguarded from abuse. We saw the Safeguarding Adults at Risk Trust Strategy 2016-2021 and Safeguarding Adults at Risk Policy. Policies were in line with relevant legislation, for example, The Care Act, (2014) and the Mental Capacity Act (2005) and developed in partnership with the Local Safeguarding Adults Board.
- Safeguarding training was mandatory for all staff and was required to be updated every three years. The trust set a target of 80% compliance for Safeguarding Adults at Risk training levels 1 and 2. For Safeguarding Adults at Risk level 1 training the target was met with 90.5% of staff having received training. The compliance target for level 1 child protection training was 95%. The compliance target for child protection training levels 2 and 3 was 90%. However, only 50.9% of staff were up to date with Safeguarding Adults at Risk level 2 training. This training had been implemented for the first time in November 2016 which could explain the low compliance at the time. A training strategy called the 'The Golden Thread' had been introduced which ensured that safeguarding was also included as a slide in all training given to staff be this clinical or otherwise and there were opportunities for bespoke training for staff to be provided.
- Information was communicated to staff and patients around safeguarding issues via notice boards in the hospital. Staff had access to referral forms and referral checklists in relation to safeguarding adults via the trust intranet page. The trust had established a central point for referring safeguarding issues and to access support. This aligned process allowed for quality assurance of safeguarding referrals to take place without delaying the process of raising a safeguarding issue with the appropriate local authority.
- Implementation of safety systems, processes and practices were monitored and improved when required. The trust had established an annual audit programme to monitor the number and type of safeguarding alerts raised. The programme, completed in September 2016, highlighted that overall compliance with safeguarding practice had risen from 71% to 91% with safeguarding alerts increasing by 15%. This would indicate an improved reporting culture within the trust. Learning

from the audit was cascaded to staff via the Safeguarding Operational Group meetings, which were attended by senior nursing staff, and also raised to board meetings.

- Staff informed us that they were aware of who to contact if they needed guidance around safeguarding issues and felt confident they knew how to respond to concerns of abuse or neglect. Staff gave us examples of where they had raised safeguarding alerts and where they had worked with local authorities in regards to safeguarding adults. We were also told of examples where safeguarding information was passed on to care providers appropriately when an individual was discharged from a ward.
- We saw on some wards, for example Kingfisher ward, that flow charts were displayed as a visual reminder for staff on how to respond to suspected safeguarding issues and make appropriate referrals.
- The trust provided staff with detailed policies and procedures to support them when a patient or colleague experienced domestic violence. The trust had worked with an external organisation to promote the protection of women against domestic abuse. We saw there were posters advertising the support in the women's toilets. This showed the trust had considered the appropriate positioning of the information to enable women to access the information confidentially should they need to.
- The trust liaised with partner organisations and attended local safeguarding adult's boards within the region. Representatives from the trust attended local multi agency risk assessment conferences (MARAC). These are meetings where information is shared about the highest risk domestic abuse cases, between relevant professionals. For example, the police, child protection and health services. Liaison with the police regarding child sex exploitation (CSE) and people trafficking also occurred.

Mandatory training

• The trust required staff to complete a programme of mandatory training. The training included a corporate induction, adult and paediatric basic life support, safeguarding vulnerable adults and children, infection prevention and control, dementia awareness, fire safety awareness, health and safety, manual handling theory and national early warning scoring system. A nationally recognised early warning system known as the national early warning score (NEWS) was used in the hospital to alert staff to the deteriorating patient. Scores are obtained based on physiological measurements.

- The trust set a target of 80% of staff to complete basic life support training for both adults and children. Data provided evidenced that 78.9% of staff were up to date with adult basic life support and 63.2% of staff were up to date with paediatric basic life support. The basic life support training for both adults and children also covered defibrillation. As the trust target was not met, this did not ensure that all staff would be confident or competent to respond to an emergency situation.
- An overall 60.8% of staff were up to date with training in the national early warning scoring system, against the target of 80%. 75.4% of registered nursing and 64.7% of health care assistants were up to date with the training. Among medical and dental staff only 25.6% were up to date with this module. Allied health professionals were the only staff group that were compliant with the training target (90.4% had completed the training). This did not ensure that staff were knowledgeable about the system and meant there was a risk that the deteriorating patient would not be recognised and escalated appropriately.
- The trust set a target of 80% for its health and safety training module, which included major incident training. (The module also includes accident reporting and minor incident investigation.) As of 20 January 2017, 91.1% of staff in medicine were up to date with this training course, and the target was therefore met.
- Staff we spoke with confirmed they were provided with time to do their mandatory training and senior staff monitored and encouraged this to happen.
- There had been a change to the environment of the endoscopy department in that building work had taken place to alter the environment. There had been no fire drill training within the department between December 2016 and February 2017. Staff compliance with fire safety awareness training did not meet the trust target as 78.8% of staff had completed this against the trust target of 80%. We were told this would be actioned by the sister in charge of the department.

Assessing and responding to patient risk

• Nursing staff completed risk assessments for patients and developed management plans to inform staff of the action to take to reduce the identified risk.

- The trust used the National Early Warning Score (NEWS) system for monitoring and identifying the deteriorating patient by carrying out physical observations.
- We looked at the nursing records for 16 patients and saw that the NEWS charts had been completed correctly. The NEWS scores and when necessary the patient were escalated to the medical staff appropriately. Guidance was provided on the chart itself of when a score indicated the need to escalate the patient.
- The endoscopy department carried out safety briefings prior to and after procedures. The world health organisation (WHO) five steps to safer surgery surgical checklist was completed before, during and after each procedure for each patient. This is a safety checklist to increase the safety of patients undergoing surgery. We reviewed the audits carried out in the department to ensure staff complied with the completion of the checklist. Records of the outcome of audits showed that in January 2016 one checklist did not have a patient identifier. An action plan was put into place to reduce the risk of this reoccurring. The action plan was followed up at the time of the next audit.
- The endoscopy department held a team briefing at the start of each shift to review the content of the planned patient list and ensure there was sufficient staff and equipment to complete the list.
- Patients attending the Linnet acute medical unit (LAMU) were assessed by nursing and medical staff. The initial assessment highlighted patients who were at risk from sepsis and identified the care and treatment pathway for these patients. Sepsis is a life threatening condition that arises when the body's response to infection injures its own tissues and organs. Other wards and departments followed this pathway should a patient develop sepsis following admission. On Kingfisher ward we saw that information was provided for staff on a noticeboard to alert them to the possibility of sepsis developing in a patient and clear guidelines of the pathway and treatment were displayed.
- A policy and procedure was in place regarding the care and treatment of patients who had an intra-aortic balloon pump in use. These patients required one to one nursing care. Staff we spoke with were aware of this policy and told us additional staff were consistently provided when this need arose. The intra-aortic balloon pump is a mechanical device that increases oxygen to the heart and increases cardiac output.

- We attended a multi-disciplinary team meeting on the Linnet acute medical unit (LAMU). Staff at this meeting highlighted a lack of formality in the handover process of patients moving to and from the LAMU to other wards and how that handover occurred. Examples were given regarding four recently transferred patients specifically: staff had received a detailed handover for two patients but not for the other two. Staff added a handover was formally carried out if the patient was unwell or there was a requirement for immediate care and treatment.
- GPs were able to refer patients to the medical expected unit. During weekday working hours the GP telephoned either the ambulatory care consultant or the GP based in the unit. At weekends and out of working hours the telephone calls were received by the on call medical registrar. Medical staff informed us that there was not a formal system for identifying the arrival of the patient to them. Nursing staff received the patient into the unit and carried out baseline observations. Nurses we spoke with told us they then advised the medical staff, if they were on the ward, that the patient had arrived or updated the electronic log of patients on the unit. This ran the risk of patients not being highlighted promptly for initial triage and management of time critical conditions.
- Concerns were raised by staff who worked in ambulatory care. The ambulatory care unit was expected to close at 8pm, which was the time the nursing staff ended the shift. However, there were occasions where beds were not available in the hospital before 8pm, which meant staff were required to remain on duty with the patient. Staff told us the shift had on occasions extended to 10.30pm and that staff regularly stayed until 9pm. Patients were at times left alone in the department. For example, the ambulatory care unit did not have a system to send off blood samples and the staff transported these to the surgical admissions unit. When staff were lone working this meant there was no one in the department to monitor and observe patients. We were told this had been reported to senior staff through emails but not through the hospitals formal incident reporting system. Following our inspection the trust provided further information regarding this, which confirmed there had been no formally reported incidents of staff staying until 10.30pm. However, they did recognise staff occasionally worked until 9pm or "slightly later". The trust told us that in order to mitigate the risk of the unit staying open

later than planned, admissions were not accepted after 6pm and that any nursing staff staying on were supported by the unit's doctors, GP or consultants, which ensured there was no lone working taking place. The trust had a policy and procedure to guide and inform staff of the care for patients who required non-invasive ventilation (NIV). However, this did not identify when patients would require additional nursing care or one to one care. NIV refers to the administration of ventilator support without using an invasive artificial airway (endotracheal tube). Saturn ward provided care and treatment for patients requiring NIV. We were told there was no system to formally measure the acuity of patients' care needs. We requested documentation regarding the numbers of patients requiring NIV and when one to one care had been required and arranged but this information was not recorded. We saw that patients requiring NIV were located throughout the ward and allocated to nursing staff within the ratio of one to eight. The trust could not provide an audit trail regarding the times level 2 care was needed. Level 1 care is determined as a ward patient needing support from a critical care team input and level 2 as a patient having higher dependency care needs.

Nursing staffing

- The trust used the Safer Nursing Care Tool and collected data twice a year to plan staffing levels and skill mix on the wards. The safer staffing tool was used in conjunction with national guidance and clinical review.
- Staff raised concerns regarding the acuity levels of patients on the ward. We were told across many wards and departments that the complexity of patient need was not reflected in the staffing levels and skill mix. Staff on surgical wards where medical outlying patients were admitted commented that the care needs of patients with medical conditions often required additional nursing and therapist care and treatment. They added that the staffing levels and skill mix were not always adjusted to achieve this.
- Staffing levels varied depending on the speciality ward or department. Staffing in the coronary care unit was planned using an acuity dependency tool which reflected the higher level of patient complexity on this ward. This was reflected in the trained nurse to four patient's ratio. On the respiratory ward we found that a number of patients were treated with non-invasive ventilation (NIV) which was an additional care and

treatment requirement. However, these patients were not placed together in a high dependency bay but located throughout the ward and cared for as part of the nurse to eight patient ratio. The British Thoracic Society guidance recommends that there should be provision beyond normal ward ratio for patients who are treated with NIV.

- As of December 2016, the trust reported a vacancy rate of 8.7% for nursing staff in medicine. This was higher than the trust target of 8%.
- Between January and December 2016, the trust reported a turnover rate of 17.4% in medicine. This was higher than the trust target of 13%.
- The highest turnover rate was on Teal ward, where 12 nursing staff left against an average of 39 in post over the 12 months (30.8%). This was followed by Woodpecker Ward (11 leavers against an average of 41 in post, 26.8%) and the acute medical unit (23 leavers against an average of 92.5 in post, 24.9%). All three also had high vacancy rates: 8.9%, 10.4% and 12.1%, respectively.
- The highest vacancy rate was in gastroenterology specialist nurses (1.3 out of 3.3 WTE posts vacant, 38.8%) and Jupiter Ward (6.9 out of 44 WTE posts vacant, 15.7%).
- The trust was actively recruiting registered nurses but had experienced difficulty with this. A number of nurses had been recruited but were yet to commence employment which left vacancies and gaps in duty rotas at the time of our inspection.
- A programme of recruitment for registered nurses had been carried out and a number of international staff recruited into the hospital. Staff reported that the international staff were working towards their English speaking exams and some were working as supernumerary until such time as they could register in the UK.
- A number of student nurses had been recruited to commence employment once they completed their training and qualified as registered nurses. These were not due to complete their training until August 2017.
- The Linnet acute medical unit (LAMU) had a staffing establishment of 35 registered nurses. Out of the 35 there were 14 vacancies. These were planned to be filled by seven foreign nationals who had yet to pass their English test and seven student nurses due to start in

August. Teal ward had nine whole time equivalent vacancies for registered nurses. Five of the vacancies were planned to be filled by nurses who were currently students or internationally recruited nurses.

- At the time of our inspection, ward staff were carrying out additional shifts and bank and agency usage was seen on all wards and departments.
- The highest bank and agency usage was on Teal ward, where usage was over 20% in every month, and on Woodpecker ward, where usage was over 20% in all months except June and July 2016.
- Between January and December 2016, the trust reported a sickness rate of 5.0% in medicine. This was higher than the trust target of 3.5%. The sickness level was worst during the winter months: 6.5% in January 2016, 6.4% in November 2016 and 6.0% in December. Between February and October it varied between 3.7% (August) and 5.5% (April). We were told that back to work interviews were carried out to ensure staff had the support they required following a period of illness.

Medical staffing

- Arrangements for medical staffing kept patients safe. As of December 2016, the trust reported a vacancy rate of 0.6% in medicine which was lower than the trust target of 8%. Between January and December 2016, the trust reported a turnover rate of medical staff of 6.1% in medicine which was lower than the trust target of 13%. For the same time period, the trust reported a sickness rate of 1.4% in medicine. This was lower than the trust rate of 3.5%.
- Between April 2015 and March 2016, locum doctor usage was consistently lower than 20% for all but two reporting units. The exceptions were acute medicine, which reported usage of 20% in April 2015 for the winter pressure ward. The latter relied entirely on agency and locum medical staff between October 2015 and March 2016.
- There were consultant physicians (those trained in general medicine) available at all times. Until 8pm the consultants had a presence in the hospital and after this time were available by an on call rota. Medical and nursing staff we spoke with were positive about this system; they told us there were never any problems accessing consultants when needed. We were told that often consultants remained in the hospital later than 8pm and were helpful and responsive to requests for support.

- On the medical assessment unit we saw consultants carrying out ward rounds and supporting the junior doctors. Each day medical cover was provided for patients in the acute medical unit and across the medical wards and departments. Doctors working on the acute medical unit that we spoke with told us that the medical staffing cover was excellent with seven to eight doctors working on the unit during the day and four at night.
- Divisional leads we spoke with were proud of the junior doctor complement over the weekend. Junior doctors were assigned to specific wards at weekends with supervision provided by senior doctors and consultants. A handover took place on Saturday morning and this was where the junior doctors were assigned to the wards.
- We spoke with five junior doctors who all told us there were sufficient numbers of doctors over the seven days to provide safe and effective care for patients. They said they were supported by senior medical staff, including registrars and consultants to provide care and treatment for patients. We were provided with examples of the approachability and support from consultants. For example, one junior doctor told us how a consultant had provided them with assistance when they were concerned about a patient on the coronary care unit. They added the consultant was not the named consultant for the patient but happened to be in the unit at the time and offered help and support. This was valued by the junior doctor.
- A consultant and a team of junior doctors were appointed on a locum basis to provide and coordinate the care and treatment of medical outlier patients. A medical outlier patient is one who is not on a general or speciality medical ward during their admission. We saw there were medical outliers on three surgical wards or departments. The medical team visited them each day from Monday to Friday and a weekend plan was put into place for their care and treatment at the weekend. Should they require medical attention over the weekend the on call medical teams were contacted. Staff reported this system worked well and they had no concerns regarding who to contact. A registrar was due to start working with the outlying patient team at the end of March 2017.
- Medical teams attended handovers at the start and finish of shifts to ensure oncoming medical staff were made aware of the care and treatment needs of patients

in the hospital. For example, medical staff on the acute medical unit met each morning and evening on the unit and the medical outlying patient team met in the surgical admissions unit each weekday.

• On Saturn, the respiratory ward, medics followed a set board round SORT (sick, out today, rest of patients, to come in) and at weekends SON (sick, out today, new patient).

Major incident awareness and training

- The trust had a major incident plan in place which detailed the actions to take should there be any incident that interrupted the service delivery and also the action to take if there was an increase in demand on beds.
- Site management meetings took place four times each day at which the availability of beds was reviewed. At the site management meetings contingency plans were reviewed regarding the pressure on beds and when necessary the trust escalation policy and procedures were followed.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- The unscheduled care division participated in a programme of local and national audits. Some areas required improvements to meet the national average.
- For example, the hospital achieved the lowest rating of grade E in the national stroke audit. The national MINAP (heart attack) audit and the national heart failure audit also identified some areas that required improvement.
- Patients did not always receive the care they required seven days a week. For example, rehabilitation therapy at the weekends for patients who had experienced a stroke.

However:

- Policies and procedures were in place to guide and inform staff on delivering care and treatment in accordance with national legislation and recommendations.
- The nutritional needs of patients were assessed and actions put into place to ensure they were met.

- The patients had a lower than expected risk of readmission at the hospital when compared to the national average.
- Patients were cared for by competent staff who were provided with regular appraisals and role specific training.
- Patients received care and treatment from clinicians from different disciplines who worked together to co-ordinate care. Multi-disciplinary team working was apparent across the wards and departments.
- Patients' consent to care and treatment was sought in line with national legislation and guidance.

Evidence-based care and treatment

- Staff were provided with policies and procedures which had been developed to reflect best practice and evidence based guidelines. The hospital had developed care pathways based on national guidance and recommendations. This ensured patients received effective, timely care and treatment.
- We observed the care and treatment for one patient with pneumonia was in accordance with the British Thoracic Society guidelines.
- The Linnet acute medical unit (LAMU) followed guidelines published by the National Institute for Health and Care Excellence (NICE) when providing care and treatment for patients who presented with chest pain.
- The NICE guidelines (10) relating to short term management and aggressions within mental health had been implemented to support staff when caring for patients or dealing with visitors.
- A policy and procedure was in place to alert staff to recognising and appropriately managing suspected domestic abuse. This was reflective of the relevant NICE guidelines. (50)
- Patient care followed Royal College of Physicians guidelines for patients with neutropenic sepsis. This is a life threatening complication of anti-cancer treatment; the term is used to describe a significant inflammatory response to a presumed bacterial infection in a person with or without fever.
- However, the NICE stroke guidelines were not fully met as not all patients received 45 minutes of therapy for five out of seven days. The ward sister was aware of this and informed us of a planned business case that was being prepared for presentation to the trust board.
- A programme of local audit took place within endoscopy suite. There was a member of staff employed

on the bank who took responsibility for this. The audits took place to inform the JAG (Joint Advisory Group) accreditation procedure. At the time of our inspection the trust were awaiting a further visit from the JAG to follow up recommendations they had made regarding the environment. It was planned to review the endoscopy operational policy and procedure to ensure it was reflective of the most up to date national guidelines and recommendations.

Pain relief

- Staff assessed the pain patients experienced regularly and managed it promptly. We observed nurses asking patients about their pain and offering analgesia when necessary.
- The NEWS charts referenced a nationally recognised pain assessment scoring tool for assessing pain for patients with a cognitive impairment. We saw these had been completed appropriately.
- In the care log booklets there were care plans completed regarding the pain experienced by the patient. Not all of these were completed in the records we reviewed. For example, we saw a care log which detailed the pain that the patient experienced and the action staff could take to relieve this pain. The patient had communication difficulties and despite staff reporting that they were unsettled, fidgety and vocal there was no record to show that pain relieving action had been taken.
- A pain management team was in operation in the hospital and responded to requests from staff to support patients with complex pain issues. Staff we spoke with made positive comments about the team and assistance they had received to care for patients' pain issues.

Nutrition and hydration

• Patients who were admitted during the week following a stroke had their swallowing reflex assessed by a speech and language therapist (SALT). Nursing staff on the acute stroke unit and in the emergency department (ED) had received training to enable them to carry out an initial swallowing reflex assessment. This enabled decisions to be made promptly as to whether patients were able to take oral fluids and nutrition. For patients who did not have a satisfactory swallowing reflex, hydration was provided intravenously or subcutaneously. Over a weekend, if the nurses'

assessment indicated an impaired swallowing reflex a nasogastric tube (NGT) would be fitted and feed by NGT could be started following the trusts emergency regime until seen by the SALT.

- Patients who accessed the discharge lounge were provided with soup and sandwiches if they were in the department over the lunchtime period. Staff we spoke with expressed concerns that there was limited access to a hot meal should patients request this. The trust provided further information following the inspection which informed us that a total of five hot meals per day were available to patients in the discharge lounge. Data collected throughout January to March 2017 between two and nine meals had been requested each month.
- We observed that patients who were admitted to the ambulatory care unit had access to water, tea and coffee and could help themselves. Packed lunches were also provided for patients if they were on the unit for a long period of time.
- The dementia care ward had recently carried out a trial of finger foods for patients on the ward. For example, one patient who lived with dementia constantly walked and therefore was losing weight as they were not able to sit long enough to eat a meal. A trial of colourful small pieces of 'finger food' which could be eaten while walking around had been carried out and deemed a success. The patient's relatives were very pleased to see them eating more.

Patient outcomes

- The trust took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade E in the latest audit period which was from April 2016 to June 2016. The trust saw the most improvement in 'domain 1: scanning' achieving A for both patient and team centred performance. The trust also saw improvement in five patient centred domains and six team centred domains.
- All hospitals in England that treat heart attack patients submit data to Myocardial Ischaemia National Audit Project (MINAP) by hospital site (as opposed to trust). Between April 2014 and March 2015, 41.9% of non-ST-elevation myocardial infarction (nSTEMI) patients were admitted to a cardiac unit or ward at Great Western and 91.6% were seen by a cardiologist or member of the team, compared to the England averages of 55% and 95.1% respectively. The proportion of nSTEMI patients who were referred for or had

angiography at Great Western was 99.6% compared to an England average of 79%. Although the trust saw improvements for all three metrics when compared to their results in the 2013/14 audit, they performed worse than the overall England results for two of the three outcomes.

- The trust took part in the 2015 National Diabetes Inpatient Audit. They scored better than the England average in 12 metrics and worse than the England average in five metrics.
- The trust's results in the 2016 Heart Failure Audit were worse than the England and Wales average for three of the four standards relating to in-hospital care. The fourth standard 'received echo' was similar to the average. Great Western's results were better than the average for three of the seven standards relating to discharge. The remaining four standards were worse than the average, in particular the standard 'referral to heart failure nurse to follow up (%)' scored particularly low.
- The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 58.4%, which was worse than the audit minimum standard of 90%. The 2015 figure was 90.7%. The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 16%. The 2015 figure was 21.1%. The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 54.1%, this is significantly worse than the national level. The 2015 figure was 63.4%. The proportion of patients with SCLC receiving chemotherapy was 62.5%; this is not significantly different from the national level. The 2015 figure was 71.4%. The one year relative survival rate for Great Western is 27.3%. The trust had taken action to address the findings from these audits by increasing outpatient capacity and consultant locums to provide a more prompt service.
- Between October 2015 and September 2016, patients at Great Western had a lower than expected risk of readmission for non-elective admissions and a higher than expected risk for elective admissions when compared to the England average. Elective Clinical Haematology had the highest relative risk of readmission.
- Between October 2015 and September 2016 the average length of stay for medical elective patients at Great

Western was 2.9 days, which is lower than England average of 4.1 days. For medical non-elective patients, the average length of stay was 5.8 days, which is lower than England average of 6.7 days.

• We asked clinical staff to show us the policy or procedure for the decision making process for when patients should be admitted to the coronary care unit. We were told the decision was made by the doctor who made the decision to admit the patient. We observed that one patient had attended the hospital with chest pain but they had not been admitted to the coronary care unit. Another doctor advised us there was such a policy and procedure but they were unable to find it on the intranet. This did not ensure that care and treatment pathways for patients attending the hospital with chest pain were consistent. The trust informed us following the inspection that the 'suspected cardiac chest pain protocol' was used to treat patients with cardiac sounding chest pain. This protocol consisted of three pathways based on the patients clinical presentation and was available on the trust intranet.

Competent staff

- Staff received regular appraisals. The percentage of staff receiving an appraisal was higher than the trust target. Between January and December 2016, 90.8% of registered nursing staff and 94.3% of unregistered nursing staff in medicine had received an appraisal. In both cases this was higher than the trust target of 80%. Over the same period, 83.3% of medical staff within medicine at the trust had received an appraisal. Again this was higher than the trust target of 80%.
- Additional role specific training was available for staff. We saw information on Dove ward which showed 80-85% of staff had completed role specific training during October to January 2016 and 90-92% of staff February to March 2016.
- Staff who worked on the acute stroke unit completed specialist training four times a year. The stroke specialist nurses provided training for nursing staff who worked in other wards and departments to enable them to react promptly if a patient on their ward experienced a stroke.
- The trust provided role specific training regarding non-invasive ventilation (NIV) management for registered nurses who worked on the respiratory ward. The trust informed us there was no formal study day for this and all training took place on the ward with new staff. We were told by the trust that all registered nurses

on the ward had completed this. Staff were provided with information regarding the care and treatment of NIV management in a policy and procedure. In addition staff were able to attend the advanced respiratory care (ARC) course which included non-invasive ventilation training.

- Registered nurses who worked on Saturn ward acute medicine specialising in chronic respiratory conditions, were provided with tracheostomy care training. The trust informed us that 75% of registered nurses had completed this training. This meant that not all registered nurses on the ward were trained and competent to deliver care and treatment to meet all of the needs of patients. However, we were told by staff that there was always a member of staff on duty on each shift who had completed this training.
- Staff we spoke with confirmed they were encouraged and supported to achieve clinical and professional development by attending training.
- We spoke with one health care assistant who made positive comments about the support they received from the ward sister to develop their skills and competencies.
- The training academy displayed information for staff to access continuous professional development modules in specialised areas of care. For example, Fundamental Acute Stroke and Treatment Course, Physical Assessment and Clinical Examination (PACE) course 2017 and Specialist Care of the Older Person Essentials Course.
- Support classes were available for international staff who were required to complete the The International English Language Testing System (IELTS).
- Staff made positive comments about a closed social media group which had been set up by their ward manager. This was an information sharing group which could only be accessed by nominated people to ensure privacy of conversations and information. Relevant information regarding training was shared on this site and staff were positive about the ease of access to this information.
- Registered nurses were supported to revalidate. This is a process which requires registered nurses to revalidate their registration with their professional body the Nursing and Midwifery Council (NMC) every three years. Training sessions were available to support nurses through this process.

Multidisciplinary working

- There was clear evidence of multi-disciplinary team working within and between wards and departments. Staff demonstrated respect for colleagues and we saw communication between different disciplines was effective.
- We observed ward rounds taking place that were attended by a multi-disciplinary team. For example, consultants, doctors, nurses and therapists. This enabled a team discussion about the patients care and treatment which was clearly documented in the patients' medical records.
- Staff reported that the critical care outreach team were supportive and provided a prompt and efficient service for patients who deteriorated on the wards.
- The respiratory nurses were part of an integrated team providing support, care and treatment to patients who lived in their own homes and the community staff.
- A multi-disciplinary team responded promptly when a patient experienced a fall. This team was led by a geriatrician and included nurses and therapists. This was part of the hospital's incident management and review process, known as 'SWARM'.
- We attended a multidisciplinary team meeting on the Linnet acute medical unit (LAMU) which was attended by consultants, doctors, nursing staff and therapists. This provided good communication and sharing of information to ensure the patient received appropriate care and treatment. We also observed multi-disciplinary team working on Neptune ward for a patient who had complex care needs and required a long term care package. The patients' needs were clearly identified and discussed and included reference to deprivation of liberties and potential safeguarding issues. This showed that a holistic approach was carried out to ensure the safety and wellbeing of the patient.
- The acute stroke unit held a multi-disciplinary team meeting twice a week to review care, treatment and discharge plans for each patient.
- The electronic whiteboard provided clear information of which clinicians had been involved in the patients care and when referrals to other disciplines had been made.

Seven-day services

• There was a consultant presence in the hospital seven days a week. The patient care and treatment pathways were reviewed daily by medical staff. Junior doctors had

access to an on call consultant rota for evenings and at night. All medical and nursing staff were confident that the consultants responded promptly when advice or support was required.

- The discharge lounge was open on Monday to Fridays from 8am to 8pm. A trial was being carried out to include Saturday mornings.
- The trans-ischemic attack (TIA) clinic was held each day led by a consultant. This meant patients were seen promptly and appropriate care and treatment provided.
- There was a lack of therapy staff available over the weekends on the acute stroke unit. This meant patients did not have access to physiotherapists, occupational therapists or speech and language therapists. This meant the patient's rehabilitation programme was less intense at the weekend and relied on the nursing staff to deliver. Should a patient require acute physiotherapy treatment such as for a chest infection, the ward staff could access the on call physiotherapist.
- Nurse specialists were available seven days a week to provide specialist input into patient care.
- Ward staff had access to mental health services for patients. The telephone contact details were available in wards and departments which identified the service operated during weekdays, with an emergency on call service at weekends.
- The tissue viability service was available five days per week. Staff reported the tissue viability nurses were prompt to respond to referrals and were visible across the wards and departments.
- The ambulatory care unit was open from 8am to 8pm on weekdays, assessing medical patients.
- The medical expected unit was open seven days a week over the 24 hour period to accept referrals from GPs.

Access to information

- Staff had access to patient information to enable them to deliver effective care and treatment.
- Electronic patient records were maintained and available at all times. The health records department scanned the results of tests and investigations onto the health records.
- Paper clinical records were stored securely in a locked records room and when requested staff took records to the wards and departments. The medical records staff

worked during the week on Mondays to Fridays. Out of hours, emergency department staff had access to the medical records store should paper records be required for a particular patient.

- A tracking system was in place so that records were easily traced and located when required.
- The electronic patient records system alerted staff to an individual's specific needs. For example icons were used to recognise patients who were living with dementia, learning disabilities, those at risk of falling or patients who required end of life care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff we spoke with were knowledgeable about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- As of 20 January 2017, 82.7% of staff were up to date with the trust's training module "consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding training". The trust was therefore compliant with its target for 80% of staff to have completed this module.
- We saw capacity was assessed and where patients were deemed not to have capacity to make decisions the appropriate process had been followed to safeguard them.
- Deprivations of Liberty authorisation had been sought when necessary to keep patients safe. These had been reported as incidents as detailed in the standard operating procedures.
- Patients who chose to discharge themselves from the ward against medical advice were requested to complete a self-discharge form to show they had been provided with information regarding the dangers of this and that they chose to ignore medical advice and leave anyway.
- The endoscopy department audited patient records to ensure that patient consent took place outside of the procedure room. This was to ensure that the national Global Rating scale standard was complied with which is part of the JAG accreditation criteria. The outcomes of audits we reviewed showed this happened for all of the patients.

Are medical care services caring?



We rated caring as good because:

- Feedback from patients and their representatives was positive.
- Patients were treated by kind and caring staff who were helpful and supportive.
- The privacy and dignity of patients was respected and promoted in most areas.
- Patients and their representatives were involved in the planning of their care and were provided with sufficient information to make informed decisions.

However:

• The privacy and dignity of patients in the medical expected unit was not consistently promoted.

Compassionate care

- We spoke with 31 patients and relatives during our inspection to seek their views of the service provided to them. All of the patients we spoke with made positive comments about the kind and caring staff. Specific comments included: "the staff have been so caring and understanding, I couldn't wish for better care", "the staff are kind, caring and passionate", "the staff are very considerate with their time and give me help when I need it" and "everyone at this hospital is excellent, they are a real credit to the NHS".
- We observed staff spending time with patients and their relatives and that they were polite, kind and caring. We observed staff crouching down to patients in wheelchairs and chairs so that they were at the same level and making eye contact when holding conversations.
- It was apparent from conversations, which we overheard, on the elderly care wards that staff had taken time to get to know and understand their patients. We saw preferred names were used as requested by patients.
- We observed the care provided to one patient who was disorientated and showing evidence of some confusion at being on the ward. Staff walked around the ward with the patient at their pace, offering reassurance and support as they went.

- We observed that on all wards and departments there were thank you cards and letters from previous patients expressing their gratitude for the care provided.
- Relatives of one patient who had been admitted to the coronary care unit had nominated a health care assistant for a staff award. They commented that nothing was too much trouble and the health care assistant always kept their relative smiling and happy at a time when he was unwell. They added that in their family's eyes he was an 'unsung hero'.
- The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements were needed. The Friends and Family Test response rate for medicine at Great Western was 16% which was worse than the England average of 25% between January and December 2016. The trust response rate was particularly low, dropping below 10%, in April, September and October 2016. The ambulatory care unit had the highest response rate at 51% and scored 100% six times over the 12 month period. The Coronary Care Unit displayed January 2017 Friends and Family Test results on the ward, which showed a response rate of 40%.
- Most reporting units scored over 80% in every month. There were three exceptions. Jupiter and Saturn wards both scored 75% in January 2016, but scored over 80% otherwise, where data were available.
- Wards displayed the Friends and Family Test results on notice boards to enable patients and visitors to review patient satisfaction.
- The heart function inpatient service requested patients to complete satisfaction surveys regarding the care and treatment they received. The survey covering 2016-2017 had been completed by 76 patients, all of whom made positive comments about the service. Specific comments included: "very helpful and reassuring to me in my anxious condition", "they are all loving and caring" and "the friendly and nice attitude are a comfort to me".
- Staff spoke proudly of the service provided by their wards and departments and of the caring service provided by colleagues. We were provided with examples, such as staff purchasing a patient a birthday cake for a patient who had been unable to return home to celebrate a milestone birthday. We also heard how staff had arranged and organised for a patient's dog to be brought to the ward to spend time with the patient.

• The privacy and dignity of patients in the medical expected unit was compromised as we observed that their medical history was discussed with them in a corridor in front of other patients.

Understanding and involvement of patients and those close to them

- We consistently saw staff were supportive and included patients and their representatives in their care and treatment plans.
- Patients told us they felt involved in their care and had received information regarding the care and treatment they required.
- We were told by two relatives that they and the patient had been provided with sufficient information to make decisions about the care and treatment plan discussed with them. One patient said "they [the staff] took time to answer my questions despite being so busy". Another told us "the staff always make time to explain things to me".
- We observed staff provided support to patients living with dementia and supported their relatives. For example, one patient was distressed and we saw a member of staff walking around the ward with the patient, calmly chatting with them. Later we saw their relative having a conversation with the staff member who was explaining the incident to them and how the patient was being supported with their distress.
- Visitors were encouraged to attend the wards and departments. We saw that visitors who could not attend during recognised visiting hours were enabled to visit when convenient to them.
- The heart function inpatient service patient satisfaction surveys consistently showed that patients felt they were provided with sufficient information regarding their condition. For example: "told what heart failure meant which put me at ease and less frightened when explained", "understanding the heart function and causes of illness" and "documentation explained".
- The hospital had a staff recognition award scheme in place and patients and relatives were able to nominate staff for an award. We saw some of the nominations that had been put forward. Patients and relatives had been positive about the support and involvement in their care and treatment whilst at the hospital. For example, one relative made positive comments about the kind and compassionate end of life care their mother received on a medical ward. They mentioned how the staff, and

particularly one member of staff, enabled the family to spend precious time with their mother and provided them with full explanations of her care and treatment requirements.

Emotional support

- Clinical nurse specialists supported patients and ward staff regarding medical conditions such as diabetes and stroke.
- There were volunteers working within some of the elderly care wards. We observed one volunteer on Jupiter ward spending time talking to patients and providing a manicure and hand massage. Staff told us this helped relax and support some patients who were living with dementia.
- On Dove ward we saw that visiting times were open. This enabled patients to receive the support of their friends and loved ones when needed.
- Staff were aware of the need for privacy when delivering distressing information regarding care, treatment and prognosis. The ambulatory care centre did not have the facility to hold private conversations and had made arrangements for the use of a private room in urgent care services for this purpose.
- Chaplaincy support was available within the hospital from the Chaplain and a support team.
- A multi-faith room was available for prayer and accessible to patients and visitors to the hospital.

Are medical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Patients were able to be referred to the medical expected unit by their GP for assessment, care and treatment. At times patients had to wait for their treatment and physical tests to commence. There was no audit or monitoring to identify how long patients had to wait.
- The privacy and dignity of patients who were admitted through the medical expected unit was not always met as both male and female patients shared accommodation. This is known as a mixed sex breach.
- Patients' discharges were sometimes delayed while they waited for their medicines to take home and a discharge letter for their GP.

- Whilst staff had access to translation and interpretation services, at times the patients representatives were asked to support them. This did not ensure their confidentiality was protected.
- People did not always receive a response to their complaint within the timescales identified in the trust policy and procedure.

However:

- Services had been implemented and developed to meet the needs of local people. For example the medical expected unit and ambulatory care.
- The hospital held regular meetings and managed the flow of patients through the hospital. This helped patients to receive the care and treatment they required.
- Referral to treatment times at the hospital, when considering admitted pathways for medicine, were better than the national average. This meant that patients did not wait as long for their treatment as in other parts of England.
- Patients who required care and treatment for medical needs were sometimes admitted to wards and departments outside of the medical division. A team of doctors provided regular care and treatment to these patients to ensure their care was co-ordinated and appropriate for their needs.

Service planning and delivery to meet the needs of local people

- The hospital had developed services to enable local people to access care and treatment in a way which met their needs.
- The ambulatory care centre enabled patients to attend the hospital for care and treatment without the need to be admitted for an overnight stay. For example, for intravenous (IV) antibiotics, blood transfusions or ascitic drainage (draining fluid build-up). GPs were able to refer patients directly to the department which prevented the patient having to wait for assessment in the emergency department.
- The numbers of patients attending the ambulatory care centre had increased over the past year. Staff commented that they regularly saw up to 40 patients per day. They told us that there used to be instances where patients who were planned to come in to have specific treatments for example, fluid drainage were turned away due to capacity issues. Staff added this was

due to the unit being used as overnight accommodation for patients who required admission. The trust had addressed this by no longer using the unit for accommodating patients overnight.

- A transient ischaemic attack (TIA) clinic had been implemented which enabled patients a follow up or assessment service when a TIA had occurred or was suspected. A TIA is caused by a temporary disruption in the blood supply to part of the brain. This enabled patients to be treated without admission. Staff told us that should a patient require admission following attendance at the clinic this would be arranged through the acute stroke unit. The clinic was in operation seven days a week with consultant and nurse led care.
- A medically expected unit had opened two weeks prior to our inspection. The unit enabled GPs to directly refer patients for assessment, care and treatment without the need for them to attend the emergency department.
- The discharge lounge was open Monday to Friday and Saturday mornings, to receive patients who were medically fit and due to be discharged from the hospital. The discharge lounge enabled patients to wait for medicines or information in a comfortable seated environment whilst providing beds on wards for new patients to be admitted. There were also two beds available in the lounge for patients who were not able to sit out in a chair, however, see comments on this under caring. .

Access and flow

- The flow of patients through the hospital was managed by the site managers and through a series of bed and site management meetings held throughout the day. Representatives from all wards and departments were requested to attend these meetings although we observed that this did not consistently happen due to pressures of work in the clinical areas.
- Site management meetings took place a minimum of three times a day. At a time of escalation when the number of patients attending the hospital was high the frequency of the meetings was increased. There was a proforma for the content of the meeting which was followed each time. The meeting reviewed the flow of patients through the hospital, focussing on the number of patients predicted to attend the hospital either through the scheduled or unscheduled route. Patients who were known as medical outliers were discussed

and the ward they had been admitted to recorded. A medical outlier is a patient who was not on a general or specialist medical ward due to the lack of available or appropriate bed.

- Between September 2015 and August 2016, 42% of patients did not move wards during their admission, and 58% moved once or more. When the assessment areas were included, the number of patients moving two or more times was 26% compared to 16% for the previous 12 month period. This reflected the increase in patients being admitted to the hospital against the number of discharges each day.
- Between January and December 2016 the trust's referral to treatment time (RTT) for admitted pathways for medicine had been better than the England overall performance. The figures for December 2016 showed 94% of this group of patients were treated within 18 weeks versus the England average of 90%. The trust's performance had remained stable across the period. Within the unscheduled care division we saw that the hospital performed better for RTT within cardiology, gastroenterology and thoracic medicine. Data from March 2017 showed that all specialities were exceeding the 92% incomplete performance target, as well as performing above the national average, with General Medicine at 98.0%, Rheumatology at 95.5% and Neurology at 96.8%.
- The endoscopy department was meeting targets for waiting lists. When patients were delayed access to treatment due to the waiting list, additional lists were planned and carried out at the weekend. Lists were in place on Mondays to Saturdays and additional lists included on Sundays when required.
- The medical expected unit (MEU) accepted patients referred by their GP for assessment and necessary care and treatment. This was a short stay area where patients were then admitted to either the medical admissions unit or another medical ward. The unit comprised of two bays and a side room. The waiting area was in a corridor outside the bays. Staff told us that at times patients waited for up to five hours to be assessed and/or receive care and treatment. There was no formal monitoring or auditing of the times patients waited to see the doctor or be allocated a bed when needed. During our inspection we observed that the ward was full and had no available beds but were expecting seven GP referrals.

- The Linnet acute medical unit (LAMU) received referrals from ED, ambulatory care and MEU. A standard operating procedure identified processes to follow to promote the onward flow of patients in readiness for new arrivals. A trust target of six patients to be moved to base wards by 8am and a further five by 11am had been set. However, staff told us this was often difficult to achieve due to lack of available beds. We observed the MAU coordinator moving beds and forward planning to provide capacity for expected patients.
- The TIA clinic admitted patients who required further care and treatment to the acute stroke unit when there was an available bed. Staff told us that at times the four hour target could not be met due to the unavailability of beds. Staff on the acute stroke unit told us that they often cared for medical patients who had not had a stroke due to the lack of availability of beds elsewhere in the hospital. However, they added that should a patient who had had a stroke require a bed they were supported by the hospital site management team to move patients in order to accommodate the patient appropriately. During our inspection there were five patients on the ward who had not experienced a stroke.
- There was a locum consultant who had responsibility for the care of medical outliers in the hospital. The consultant was supported by a team of junior doctors who worked Mondays to Fridays and saw outlying patients each day.
- We reviewed the medical records of seven patients with medical care and treatment needs who had been admitted to surgical speciality wards due to a lack of medical beds. We saw they were seen each day by medical staff with a weekend treatment plan clearly identified.
- Discharge planning was evident within medical and nursing notes from an early stage following the patient's admission to hospital.
- Staff identified patients who were likely to require social care support following discharge from hospital and a referral was carried out as soon as possible, usually within 24 hours of the patient's arrival on the ward. However, staff reported that assessments for long term care placements were complex and issues regarding funding and availability of nursing, residential and domiciliary care impacted on the timeliness of the discharge of patients.

- Nursing staff informed us that despite a focus on achieving as many discharges as possible each day to promote the flow of patients through the hospital, they were able to halt discharges at any stage if the patient was not clinically fit.
- Staff we spoke with were empowered to raise concerns and told us that despite constant pressures on beds, they always had the ability to not discharge if there were clinical concerns regarding the patient.
- During our visit to the discharge lounge we observed that patients were frustrated waiting for their medication to take home and discharge letter.
 Observation and discussion with staff identified a lack of communication as to when drugs were ready and could be collected from pharmacy. This occurred three times while we were in the discharge lounge.
- The trust had not reported any mixed sex breaches. However, we observed that in the medically expected unit male and female patients were allocated bed/ trolley spaces in the same four bedded bay.

Meeting people's individual needs

- Staff were provided with guidelines, policies and procedures to meet the additional needs of patients attending the hospital.
- A learning disabilities forum met four times a year. The forum consisted of health professionals and people living with a learning disability. Patient stories were shared and care and practice within the hospital reviewed with an aim to ensure patients received the care and support they needed.
- The electronic patient system had an alert system embedded which identified to staff patients who required additional support such as those requiring support due to their dementia or a learning disability.
- Wards had nominated staff who were known as champions and provided a lead for dementia care. This enabled them to undertake additional training and attend meetings to cascade information to their colleagues.
- Information leaflets were available throughout the wards and departments to provide written information for patients and their representatives on specific conditions and illnesses.
- Patients who had experienced a stroke were admitted to the acute stroke unit whenever possible; therapy staff provided an intensive rehabilitation service to promote recovery. However, patients were not able to receive the

care and treatment from physiotherapists, occupational therapists (OT) and speech and language therapists at the weekend as these services were provided Monday to Friday only. We were provided with examples from the staff of where this had delayed the discharge of patients. For example, when a patient required an occupational therapy assessment such as regarding their mobility on stairs at the weekend. This had been recognised as an issue by the senior ward manager who informed of us of a business plan which was being developed at the time of our inspection to raise this with the unscheduled care management team.

- Staff on the wards which accepted medical outliers told us that at times there was insufficient OT and physiotherapy support to assist with their ongoing medical care needs.
- Staff had access to a telephone translation and interpretation service which staff had used and found helpful in the past. We were also told that a translation book was available within the hospital which enabled staff to access commonly used phrases in many languages. Staff commented that there was also information on how to pronounce the words which they had found helpful.
- Two members of staff we spoke with told us if a patient had a family member with them they would be asked to translate and interpret for the patient. This did not comply with national best practice guidelines or ensure the patients confidentiality and staff could not be sure they consented to this happening if they were unable to communicate with the patient.
- The medical wards and departments we visited, with the exception of the medical expected unit, placed patients in single sex accommodation. The Department of Health issues clear guidelines on the criteria when patients can be in mixed sex accommodation. The medical expected department did not meet this criteria and we saw that on two occasion's patients of both sexes were in a four bed bay. The staff said this was while they were being assessed to establish if they required an admission to hospital. However, this was a breach of the mixed sex accommodation guidelines and did not meet individual patient's needs.
- We observed relatives and waiting rooms in departments and wards contained magazines for people to occupy themselves when waiting for appointments or visiting relatives.

- Wards that provided medical care for older patients had a variety of equipment to enable patients to engage in meaningful activities. For example, age appropriate colouring books, jigsaws, books, magazines and games such as cards and dominos. Jupiter ward had a team of volunteers who regularly attended the ward and communicated with and engaged in activities with patients. We were also told about regular musical events that took place on the ward with visiting musicians.
 - Teal ward had recently purchased a digital reminiscence technology system. This enabled patients to have a personalised profile on line which included for example, their favourite music, television and poems. This had been funded through charitable donations. The ward had obtained one mobile and one large screen for patients to use and early reports were favourable.
- Kingfisher ward had monitored the call bell response times and found that 89% of call bells had been answered within five minutes against a trust target of 95%. An additional health care assistant had been placed on night duty to improve the response times. Data would be collected as part of the safety thermometer to establish if the target had been reached.
- Two patients commented that they would have liked to have access to the internet by a Wi-Fi system whilst they were inpatients. The trust informed us that Wi-Fi was available to purchase, for all patients and visitors at all times and with access to 15 minutes of free Wi-Fi per day. For patients accessing the cancer and renal services, who often spend long periods of time in the hospital, the Wi-Fi access is free at all times.

Learning from complaints and concerns

- Between February 2016 and January 2017 the trust received 274 complaints about medicine. Of these 245 were closed as of 30 January 2017, leaving 29 open. The trust took a mean average of 33.7 working days to investigate and close complaints. The trust complaints policy states that complaints should normally be responded to within 25 working days. This meant people did not always receive a timely response to their complaint.
- However, there were 26 closed complaints for medicine where the closed date was not recorded, despite an

outcome for the complaint being recorded. This did not enable the trust to accurately monitor the number of complaints which were responded to in accordance with the trust policy.

- The associate medical director for unscheduled care was aware of and involved with complaints relating to the division. We discussed the complaints process with the director who told us the trust have found complaints were getting more detailed and challenging to investigate, which meant the response times could be delayed.
- An electronic complaints log was in operation within the trust which recorded all complaints made and the associated actions. We reviewed a number of complaints investigation and responses which had been received within the medical division. We saw these had been thoroughly investigated and feedback provided to the complainant.
- Gastroenterology received the largest number of complaints of any medical specialty: 41 (15.0% of all complaints). This was followed by geriatric medicine (29 or 10.6%) and neurology (23 or 8.4%). It should be noted that only 52.6% of complaints about medicine could be coded to a specialty.
- The most common subject complained about was "clinical treatment" (90 complaints or 32.8%). This was followed by "communications" (49 or 17.9%) and "admissions, discharge and transfers" (39 or 14.2%).
- Staff told us there had been a focus on meeting with or speaking with complainants rather than relying on written communication. For example, we were given an example of a situation where a ward sister had met with the complainant following the initial complaint being received and then kept the complainant updated with telephone calls.
- The trust took action following a complaint to reduce the risk of the same issue affecting other patients. For example:
- Following incidents where patients had been given air as opposed to oxygen the air outlets had been capped across the wards and departments.
- Formal handover sheets had been implemented for patients going to endoscopy following a complaint regarding a patient missing essential medication.

Are medical care services well-led?

Good

We rated well-led as good because:

- The trust had a vision and strategy for the service and the unscheduled care management team were able to inform us of a number of work streams that were ongoing to support this.
- Staff were proud to work at the hospital and spoke of a positive culture and strong leadership that was visible throughout the wards and departments.
- A risk assessment system was in place to improve the quality and safety of the care provided.
- Governance systems were in place to ensure safe care was provided to a high standard.
- The trust shared information with the staff and sought their feedback through the staff survey. Staff spoke of a listening culture within the trust and felt able to raise concerns or suggestions to the unscheduled care management team.
- Feedback from patients and their representatives was sought and action taken to address any issues raised.

However:

• Not all staff were aware of how to access, view or input into the risk registers for their wards or departments.

Vision and strategy for this service

- The trust had developed an integrated business plan which incorporated the unscheduled care division. This set out the vision and strategic priorities for 2016-2020. The trust aimed to work with their partners in health and social care, delivering personalised, accessible and integrated services for local people including any visit to hospital.
- The medical divisional senior management team articulated there were a number of work streams ongoing to achieve the vision and strategy.
- A focus was being made regarding seven day services across the medical division and a business case had been presented to the trust board to increase seven day services available.
- Not all staff we spoke with who worked in the unscheduled care division were aware of the vision and strategy.

• The trust had developed values for the staff to work towards. These were known as the STAR values and stood for service, teamwork, ambition and respect. Staff we spoke with were aware of the values and we saw information displayed to remind staff throughout the hospital.

Governance, risk management and quality measurement

- The safeguarding adults at risk forum reviewed systems and processes in place, such as staff training and policies, to ensure patients were protected from the risk of abuse. Members of the forum were allocated specific items to follow up and action. For example, the low numbers of medical staff achieving safeguarding training.
- The trust had developed a new risk reporting matrix that was displayed on the trust electronic dashboard. We were told by senior managers that all staff could access the risk register relevant to their place of work. Staff that we spoke with did not demonstrate a knowledge or understanding of how this system worked. The trust informed us that the risk register was located on the intranet and was able to be filtered to each department and service. Training was available for staff who were required to add or manage risks using the risk register.
- Each ward and department had an electronic risk register which informed the unscheduled care divisions risk register. The senior management team reviewed all high risks and were able to share with us actions taken to address the risks. For example, there was only one respiratory physiologist across the trust. This had been recorded as a risk and the action to recruit additional consultant had been taken. There were concerns identified regarding the nursing vacancies in the trust and a recruitment drive had been undertaken which included recruiting staff from overseas. Medical locums were in post to ensure sufficient medical cover was available over seven days.
- The unscheduled care division held a monthly meeting at which governance; performance and risk issues were discussed. Following this meeting an action log was circulated which identified who was responsible for actioning items. The action logs identified when the previous actions had been completed and closed. The

meeting was attended by the divisional directors and clinical leads for wards and departments. The outcomes from the meeting were reported to the executive committee of the trust.

- The trust supported the quality improvement team to visit a trust which had been awarded 'outstanding' in their CQC inspection. This was to enable staff to review other systems and practices and bring back to their hospital to drive improvement.
- The trust had a mortality group chaired by a doctor from the unscheduled care division. The trust wide group identified mortality alerts, reviewed relative risk alerts and Dr Foster patient safety indicators. Dr Foster intelligence is a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public. Themes and trends were identified at this group and action taken to promote patient safety and reporting. For example, a review had taken place of the reporting of deaths and a system was put into place to ensure the coding was correct.
- The trust were one of six trusts involved in a national work stream to review mortality recording processes.
 This had included national training, monthly teleconferences and face to face meetings every three months. As a result of this pilot the trust had developed their mortality data base to reflect the national reporting process.
- The mortality group reported to the patient quality committee every month which was attended by the medical director and the chief nurse. Information from this was fed into the governance committee and the trust board.

Leadership of service

- The medical wards and departments came under the divisional group of 'unscheduled care'. A clear management structure was in place within the medical division with leadership provided by ward sisters, ward managers, matrons, the divisional director of nursing, associate medical director and a divisional director.
- Staff we spoke with were positive about the local leadership on their wards. Staff said they were supported, had access to senior staff at all times and found they were approachable and visible on the wards.
- Management meetings took place regularly within the unscheduled care division to review services and improve them. For example, the newly implemented

medically expected unit (MEU) had been discussed at a number of meetings which had resulted in actions to improve the service whilst it was embedding. Staff told us they were able to identify and raise suggestions which would help streamline the service and that they felt listened to.

- The coronary care unit had positive comments to make regarding the support from the unscheduled care management team. Staff said they were able to raise issues or concerns and were listened to and action taken when necessary.
- Ward and departmental sisters attended a monthly divisional meeting to review systems and practices and disseminate new information. The meetings were attended by senior managers from the unscheduled care division who we were told were proactive in responding to suggested changes and improvements.
- Staff were enabled to nominate colleagues for the . 'outstanding leader of the year' award. We saw that a number of ward sisters had been nominated for this year's awards and staff had given reasons for the nominations. These included; 'always putting in more than 100% into [their] role and more. The most inspirational leader I have had the pleasure of working with', 'they help everybody, manages our team brilliantly', 'they are an inspirational and brilliant role model for the team. I personally have witnessed and learnt from [their) professionalism when dealing with clinical and managerial situations'. Staff had also nominated matrons for the same award and examples were given of matrons who worked with staff clinically on the wards, supporting and offering guidance to staff. Staff described this as leading by example in a positive way.

Culture within the service

- Staff we spoke with were proud to work at the hospital and made positive comments about their colleagues.
- We saw there was a culture of kindness between the staff and towards patients and their representatives.
- Staff valued the ward sisters and managers working alongside them on the ward, promoting team working and setting high standards of care. Ward sisters and managers praised the resilience and commitment of the staff on the wards and spoke of caring, patient focused environments due to the actions of the staff.
- Staff were supported to develop their skills and knowledge through accessible training. There were

posters on the wall in the training academy which showed a wide ranging programme of additional training for staff to attend. This demonstrated a culture of learning and development.

• We were told there was a long list of student nurses who had requested a placement on the critical care unit due to the supportive and positive learning environment.

Public engagement

- The learning disability forum met four times a year and included people who lived with a learning disability. Feedback was obtained from patients and their carers who attended the hospital with a learning disability. An action plan was in place for the forum with entries dated, responsibility named and dated of when the action to be completed. We saw that the forum had been instrumental in the raising awareness and implementation of the hospital passport which supported people with a learning disability attending hospital and sharing pertinent information.
- The hospital had a good relationship with voluntary workers. We saw volunteers working on the wards and departments supporting patients and staff. There were also many examples where patients, carers and charities had worked with the hospital to raise or provide funds to improve services.
- Feedback from patients and their representatives was important to the hospital who used this to drive improvement and patient satisfaction. Patients were encouraged to raise concerns with staff when they occurred. Friends and family test surveys were available on wards and patients were asked to complete these. We saw the results were displayed for patients and visitors to the ward to view.

Staff engagement

- 43% of staff completed the staff survey in 2015. The survey asked staff to respond to questions regarding their views of working for the trust. Compared to the 2014 survey the staff responses showed improvement in 18 areas, worse in one area and no significant difference in the other 41 comparable areas
- The trust was viewed as a listening trust with staff ideas considered and sought. We saw an MEU sheet with suggestions to improve the newly implemented service
- We saw that the hospital recognised staff performance and achievement. There was an annual awards

ceremony in which individual and teams of staff were recognised. Staff were enabled to nominate colleagues for a variety of awards, such as outstanding leader of the year and innovation in practice award.

- A monthly celebration took place recognising the individual staff or teams who had demonstrated the trust STAR values.
- The unscheduled care division produced a newsletter every two months. This was sent to staff by email and also paper copies were available within wards and departments. The purpose of the newsletter was to highlight to staff what was happening in the division. We saw the most recently published newsletter available to staff. This contained a review of recent incidents, audits and complaints. The newsletter contained information for staff on the outcomes and learning that had come out of these processes.
- The trust provided information to staff in a monthly newsletter which was available on the intranet and also in paper copies around the hospital. We saw the January 2017 newsletter which included advice for staff on preparing for this inspection, supporting patients to leave hospital, support available to staff, development of new and existing services and changes to policies and procedures.

Innovation, improvement and sustainability

- The trust had recognised, from previous reported serious incidents that there had been a failure in consistency to recognise and take appropriate action to escalate the deteriorating patient appropriately. An exercise and ongoing programme of training had been implemented across the unscheduled care division using a simulation suite within the academy. This had enabled staff to complete role specific training in a simulated task or environment to improve technical and non-technical skills, focus on patient safety and optimised team performance. Staff we spoke with were positive about the training they had received using this method.
- The cardiology department inserted the first four lead pacemaker for a patient in the world. The medical staff were monitoring the patient's recovery and rehabilitation as part of an international research project to assess the advantages of the new technology.
- The trust launched an initiative known as '500 lives' which aimed to save an extra 500 lives over five years through the provision of safe, high quality care and

treatment. The trust's commitment to safety was recognised by an external national provider of healthcare intelligence when it was nominated for a top hospitals award in the category of patient safety.

 A GP was employed in ambulatory care four days a week. The purpose of this new position was to improve communication with GPs to ensure basic tests had been completed prior to the patient attending the ambulatory care unit. It was anticipated that this would help to increase the flow of patients through the department and prevent patients attending the unit unnecessarily. The trust had introduced acute neurology clinics, located close to the short stay/ambulatory care unit, for patients who attended the acute medical unit and would have needed to be admitted in the past for further opinions and tests. These patients could now be discharged with an appointment, either the following day or the day after. This initiative had led to a significant number of admissions being avoided and provided a positive experience for patients.
Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Surgery services forms part of the Planned Care division which also includes critical care services and pain services.

The theatre department at Great Western Hospital has 15 theatres of which seven have laminar flow which provide a clinically appropriate environment for major joint and implant surgery. Two theatres are allocated for emergency and trauma patients. An out of hours emergency theatre is staffed 24 hours a day. The department has two separate recovery areas with a total of 18 adult beds, four paediatric bays and an isolation area for patients who require care and treatment away from other patients. There is also a theatre admission lounge for elective orthopaedic patients.

There are six surgical wards within the hospital: surgical admissions unit, Trauma, Aldbourne, Ampney, Meldon & Shalbourne. Shalbourne is a private ward which is also used for NHS patients during periods of escalation. In total there were 124 inpatient surgical beds.

The surgical assessment unit provides assessment to emergency patients. Patients are referred into the unit by their GP or were admitted through the emergency department.

The day surgery unit, which has 14 patient trolley beds, has been used as an escalation ward for over a year. A standard operating procedure has been written to clearly identify the day case ward as an escalation ward, and a business case has been agreed to convert the unit to a permanent ward. Recruitment was in process at the time of our inspection. The trust had 27,910 surgical admissions between November 2015 and October 2016. Emergency admissions accounted for 10,516 (37.6%), 13,025 (46.7%) were day case admissions, and the remaining 4,369 (15.7%) were elective admissions. Operations are performed for both inpatients and day case patients. Specialisms included: general surgery; urology; gynaecology; ophthalmics; and trauma and orthopaedics.

During the inspection we spoke to 29 members of staff, 14 patients and three careers. We also looked at 25 sets of patient records.

Summary of findings

We rated this service as requires improvement because:

- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again.
- Due to pressure for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients.
- Elective operations were being cancelled due to the pressure on the beds within the trust, and surgical wards were being used to accommodate medical patients.
- The electronic prescribing and medication administration system could not always be used effectively as it relied on access to the hospital's Wi-Fi, and this could lead to delays in the administration of pain relief to patients.
- Mandatory training compliance required improvement, particularly in basic life support and dementia awareness.
- Some patients' dignity was compromised by a lack of toilet facilities in the surgical assessment unit and theatre recovery.
- Complaints were not always dealt with within 25 working days as per the hospital policy.

However:

- The service encouraged openness and transparency from staff with incident reporting, and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- Staff could demonstrate the patient outcomes were improving.
- The trauma unit had used innovative ideas to improve nutrition and hydration for patients.
- Patients living with dementia were well cared for on surgical wards.
- There were improved governance arrangements across the surgical service, with a holistic view of care and performance across surgical services.

Although there are no changes to our ratings for surgical services since our last inspections we did find areas of

improvement. This included improved reporting of incidents, and a more cohesive clinical governance structure to support the delivery of the Planned Care strategy.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again.
- There were periods of understaffing on the surgical wards and operating theatres, where the required levels of nurses, set by the trust, were not met.
- Mandatory training compliance levels for all staff were not meeting the trust's target, and were well below target in some areas. This included level two safeguarding of vulnerable adults training where only 50% of nursing staff had completed the training and 42% of medical staff against a hospital target of 80%.
- Due to pressure for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients.
- There was a risk to patient safety post-operatively because of the closure of one of the theatre recovery areas in periods of escalation which led to a longer route from theatre to recovery
- There were some very long delays over a number of months, in issuing electronic discharge summaries from the surgical assessment unit.

However:

- Incident reporting was good, and lessons learned from incidents were shared with staff across surgical service and more widely across the hospital.
- Wards and theatres were visibly clean.
- Patients care records and surgical records were accurate and legible, and stored safely.

Incidents

 Information on safety performance showed evidence of lessons being learned and shared from incidents. The department kept an action log of learning from incidents. The log included missing instruments, recovery issues, staff injuries, sharps injuries, and theatre list errors. We saw that actions required were noted as well as action taken following incidents. We saw that incidents were discussed with staff at the Planned Care clinical governance half day. Minutes showed that lessons learned were discussed, such as following a patient fall it had been agreed that patients that had multiple falls should have hourly care rounds.

- Staff were open and transparent about reporting incidents and there were systems in place to make sure that incidents were reported and investigated. All staff we spoke to said they would have no hesitation in reporting incidents to managers and knew how to report them through the electronic system. However, in the Shalbourne Suite team meeting minutes it was noted that some staff do not enter incidents on the reporting system, despite encouragement by management. Staff were encouraged to attend the training sessions available to increase their confidence to report incidents. An incident management policy was available to all staff which outlined what to do in the event of a serious incident and outlined the root cause analysis process for staff to follow.
- Electronic systems were used to report all incidents and clinical managers reviewed each incident and investigated where necessary. All incidents were discussed at monthly divisional board meetings, team meetings and at the half day governance meetings. Staff had access to this information through the trust-wide governance dashboard. Learning from incidents was cascaded to staff through divisional bimonthly newsletters and joint meetings. Staff told us that they were provided with feedback on incidents and they were well supported when incidents occurred. The top three themes for incidents were categorised as: treatment/procedure; slips, trips and falls; and infrastructure, including staffing, facilities and environment.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event has the potential to cause serious patient harm or death and are reported even if no harm has been caused. Between 1st January 2016 and 31st December 2016, the trust reported two Never Events for Surgery under the category of Surgical/Invasive procedure. The first was in February 2016 an involved a retained foreign object post-procedure; strands of gauze were cemented to the tip of the femur during a hip joint operation. The second was in March 2016 and involved the wrong implant/prosthesis being used; a patient received the incorrect lens during a cataract procedure. We saw

comprehensive root cause analysis had been undertaken for both never events, which included detection of the incident, care and service delivery problems, root causes, lessons learned and a post-investigation risk assessment. Duty of candour arrangements were documented including: notifying the patients of the problems as soon as possible after the event, sharing the final report with the patients, and inviting the patients to attend the hospital to discuss the outcome of the review.

- Lessons are shared within and beyond the affected team. At the planned care clinical governance half day learning from both never events were discussed as well as learning from events and serious incidents from other departments within the hospital. This included examples of where the national early warning score (NEWS) escalation processes had not been followed; and where falls assessments were not reviewed following transfer of a patient.
- Surgery reported and acted on serious incidents in line with the Serious Incident Framework 2015. Between the 1 January 2016 and 31 December 2016 the department reported the two never events, as described above as serious incident which met the reporting criteria set by NHS England.
- SWARMs were held following any serious incident. A SWARM is a gathering of appropriate staff to determine the cause of the incident, openly discuss it, consider how it can be corrected, and decide on and undertake appropriate actions quickly. All the staff we spoke to about SWARMS told us that these were good forums, where people could speak up openly, and worked really well.
- Surgical mortality and morbidity reviews were used to improve the service. Mortality and morbidity reviews are used within the NHS to monitor the quality of inpatient care, to review deaths as part of professional learning, and provide hospital management with assurance that patients are not dying as a consequence of unsafe clinical practice. The hospital used the national framework to undertake mortality and morbidity meetings. We saw that structured data collection was undertaken, meetings were held when appropriate, and areas of good practice were identified as well as any key recommendations or improvements that are required. Agreed actions would include the name of the person responsible and deadline dates.

Duty of Candour

- People were told when they were affected by something that goes wrong, given an apology and informed of any actions taken as a result. Staff we spoke with were aware of the duty of candour and demonstrated good understanding of their responsibilities under this legislation. 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. Serious incident reports showed that this requirement had always been considered and applied when required.
- Staff at all levels were able to describe what the duty of candour involved and the actions required, and were aware of the hospital guidance regarding duty of candour and how to access this. We saw evidence during our inspection of good clinical engagement, and clinicians would offer to meet with families when things had gone wrong.

Safety thermometer

- The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harm and reducing or eliminating their occurrence. Data from the Patient Safety Thermometer showed that the hospital reported 41 new pressure ulcers, 26 falls with harm and 39 new catheter urinary tract infections between January 2016 and January 2017.
- The surgery inpatient areas had a variable picture of avoidable patient harm. The number of falls was variable month on month. In the surgery wards, including the Shalbourne Suite, there had been six falls with harm from January 2016 to January 2017. The incidence of pressure ulcers was variable, with 19 identified over the same time period, ranging from none to three pressure ulcers identified per month. There were public displays of the results of avoidable patient harm data on the wards. The wards were open about

their patient care data, and displayed when they had last treated a patient with a hospital-acquired pressure ulcer, a patient had a fall with harm, or had a catheter urinary tract infection.

 All adult should be assessed for venous thromboembolism (VTE) risk on admission to hospital so that appropriate preventative treatment can be given to improve outcomes. Hospital-wide data shows that 99.3% of adults receive an assessment for VTE, which is above the target of 95%, and the national average of 96%.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from healthcare-associated infections. Between January and December 2016, there was one incident of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA) across the hospital.
- There were 20 incidents of Clostridium Difficile between January 2016 and December 2016 of which two were identified in the surgical wards. Prevalence of C. Difficile was lower than the overall England prevalence in all months except May and December 2016, when there was a notable spike in prevalence. There were no clear trends in prevalence. There were no related identifiable reasons for these increases.
- There were 17 incidences of methicillin-sensitive Staphylococcus aureus (MSSA). Prevalence of MSSA showed an overall increase over the year. Prevalence was lower than the England average up until May 2016 however from June 2016 onwards prevalence was higher than the overall England prevalence in all but two months (August and October).
- An IP&C audit & surveillance nurse conducted regular additional patient equipment audits and discussed cleaning with managers to raise awareness on the wards
- Wards and theatres we visited on our inspection were visibly clean. Corridors in both areas were free of clutter which facilitated the safe transport and movement of patients and staff.
- Reliable systems were in place to prevent and protect people from a healthcare associated infection. In theatres National Institute for Health and Care Excellence guidance on the prevention and treatment of surgical site infections were followed. This included guidance on the preoperative phase on showering, hair removal, patients theatre wear, staff theatre wear, staff leaving the operating area, nasal decontamination,

bowel preparation, hand jewellery, artificial nails and nail polish. However, we saw that some theatre staff were breaching aspects of staff theatre wear in that masks were not being disposed of on leaving theatre, but being worn around necks in theatre corridors.

- Guidance was followed on the intraoperative phase and postoperative phase, including hand decontamination, incise drapes, sterile gowns, gloves, antiseptic skins preparation. There were no surgical site infections for surgical repair of neck of femur between April and June 2016. This was better than the national average of 1.4%.
- Staff on the wards decontaminated their hands in line with the World Health Organisation five moments for hand hygiene and National Institute for Health and Care Excellence (NICE) guidance before and after delivering patient care or being in contact with a patient. All staff we saw were bare below the elbows, and we saw staff washing their hands before and after patient contact and when in contact with patient surroundings. Staff we spoke to understood the importance of good hand hygiene.
- Hand hygiene practice was audited every six months. Results within surgery showed between 98% and 100% compliance every month from April to December 2016. To increase the awareness of hand hygiene to staff an infection control light box which uses ultraviolet light to demonstrate if hands have been washed effectively hands was used by staff on clinical governance days.
- There was an accredited hospital sterilisation and decontamination unit (HSDU) who were responsible for cleaning surgical equipment. The unit operated from 7am to 11pm Monday to Friday and 9am to 5pm on the weekends. There was a 24-hour on call service.

Environment and equipment

- Facilities and premises within wards were designed in a way that kept people safe. All equipment we looked at had been checked, tested and dated in line with hospital policy. Safety testing had been carried out on equipment to ensure they were safe to use. We saw that equipment maintenance logs were up-to-date for all surgical wards, including annual servicing.
- The design and layout of some aspects of theatres and recovery was identified as a patient safety risk. Theatre staff and management raised concerns because of the long route between the two areas during a diversion put in place when a recovery area was being used for temporary beds for step down care during periods of

escalation. Potential risks identified include poor patient experience and care, limited access to patient toilet and showering facilities, and increased staff costs. To reduce some of the risks for patients care commodes were made available for patients, and agency staff had been brought in to improve levels of care. Additional monitoring equipment was available for patients from theatres which enabled staff to monitor them during transfer. Where there are theatre lists for paediatric patients, the patients are moved closer to the main recovery unit.

- The equipment used in theatres had been checked, tested and dated and service logs were up-to-date. A procurement contract was in place to ensure that equipment was maintained and replaced as required, and the theatre staff and management told us that this worked well.
- We saw that clinical waste was well managed. Single use equipment were disposed of in sharp instrument bins or clinical waste bins. Nursing staff told us they were emptied on a regular basis.
- The maintenance and use of equipment kept people safe. All equipment conformed to relevant safety standards and were regularly serviced in line with trust policies. Theatre staff used the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines for checking anaesthetic equipment and checklists, and the Royal College of Surgeons (RCS) Good Surgical Practice 2014 which gives a baseline of clear and assessable standards for individual surgeons and their practice. We reviewed some check sheets and found that equipment was checked in line with these standards.
- Resuscitation equipment was available and fit for purpose and checked in line with professional standards on daily basis. Resuscitation trolleys were easily accessible to staff in all wards and in theatres, anaesthetic rooms and recovery. There was evidence of regular checks to ensure trolleys were appropriately equipped. Trolleys were sealed with tamper evident tags to ensure that they were tamper-proof.

Medicines

• Arrangements for managing medicines, medical gases and contrast media mitigated the risk of harm to patients. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines.

- The hospital had implemented electronic prescribing and medicine administration to sustain patient safety whilst undertaking medicines administration. This system supported excellent record keeping of administered drugs and reduced risks by reporting any missed doses, contraindications of drugs and provided a comprehensive audit trail, therefore meeting the Nursing and Midwifery Council's administration of medicines standards. All nurses, including agency staff, have to complete an e-learning course and obtain a pass rate of 100% before being able to use the system.
- There were consistent recording of patient allergies in patient records and on the electronic prescribing and medication system. Allergies were a mandatory field within the system, which could then alert staff if medication should not be given to a patient.
- Nursing staff were aware of policies on administration of controlled drugs as stated by the Nursing and Midwifery Council – Standards for Medicines Management. We saw that controlled drugs were stored in locked cupboards. We also saw that the controlled drugs register was checked in anaesthetic and recovery rooms in accordance with legal and professional regulations.
- Local microbiology protocols were available to staff for the administration of antibiotics, and prescribers were using them. The hospital had noted that there was higher than expected use of intravenous (IV) antibiotics on Meldon ward, and staff were working with the pharmacy to reduce this. This was on the Planned Care division's risk register as there was a risk that delayed or missed intravenous medication due to the large number of patients requiring IV medication on the ward and the rime it took to prepare and administer the medication.
- Medicines which required refrigeration were stored in a locked fridge, with daily temperature checks carried out. Ward staff stored medicines at recommended temperatures, monitored refrigerator and room temperatures, and took advice from pharmacy when temperatures were outside recommended ranges.

Records

- Most people's individual care records were written and managed in a way that kept people safe. Records we saw were accurate, complete, legible, up-to-date and stored securely.
- A redesigned nursing assessment and care planning documentation had been introduced and staff we spoke to told us that this had improved the way they worked,

through colour coding documents to make them patient friendly and easier to complete, pulling risk assessment and care plans together. All care records we looked at on wards during our inspection were fully completed, and risks identified and included in nursing care plans.

- We checked 10 sets of patients' individual records (nursing and medical) on surgical wards and all were legible, accurate complete and up-to-date. We checked a range of information including pressure ulcer assessment charts, observation charts for the national early warning score (NEWS), malnutrition universal screening tool (MUST) food chart and care plans. Information was clear, concise and care plans were up-to-date.
- We also checked 5 sets of patients' individual records (nursing and medical) on the day surgery unit. The new nursing assessment and care planning tool was not used on the day surgery unit. We found these notes were not uniform and it was not always easy to find information within them. Staff told us that records were not always easily available when treating patients. Nursing staff told us that most notes were scanned and available through the patient administration system. However one patient had been on the unit for nine days, and the staff had no original notes for the period the patient was on the ward.
- Patient's individual care records were stored securely in lockable dedicated trolleys. Electronic records were accessed by nursing staff with passwords.
- Surgeons' records were accurate, comprehensive, legible and contemporaneous. We reviewed ten sets of surgical records and saw that were written in line with the Royal College of Surgeons Good Surgical Practice guidance.
- We saw that records included comprehensive information from the patients' pre-operative assessments. This included gaining consent, capacity assessments, falls risks or mobility concerns, current medications, allergies and dietary requirements.
- In the surgical assessment unit there were some delays in sending electronic discharge summaries to GPs.
 Incident reports in May 2016 had shown there were over 100 summaries that had not been electronically sent.
 This continued to increase to over 300 in August 2016, over 500 in September 2016, and over 700 in October 2017. This issue had been added to the risk register.
 Patients and GPs were contacted by telephone and

given an apology for the delays. There has been a change in policy to change from electronic discharge summaries, which were felt to be not appropriate in the surgical assessment unit, to letter. This was agreed with GPs. The service is now focusing on clearing the backlog, but recognised that there 'was still a way to go' to achieve this.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements. All staff we spoke with understood their roles and responsibilities. A member of staff on the day surgery unit (escalation ward) gave us a good example of a case identified on the unit. They were able to quickly find the information they needed on the intranet, and follow the appropriate procedure in line with the safeguarding flow chart. We were told that this member of staff was able to go home after a shift and not worry about the patient because they knew they had followed procedures. This member of staff also received constructive feedback within a couple of days of reporting the concern from the safeguarding lead for the hospital.
- The hospital set a target of 80% for completion of safeguarding vulnerable adults training. Data provided to us in February 2017 showed 90% of nurses and 81% of medical staff had completed level one training. However, for the level two safeguarding of vulnerable adults training only 57% of nursing staff had completed the training and 42% of medical staff. This meant that opportunities to identify safeguarding concerns may have been missed.

Mandatory training

A programme of mandatory and statutory training was provided to all staff which included infection prevention and control, basic life support, equality and diversity awareness, manual handling and information governance. The trust set a target of 80% for most of the mandatory training. However, there were a high number of areas where hospital targets had not been met. Within surgery, for nursing staff this included referral to treatment level 1 (57%); adult basic life support (78%); paediatric basic life support (63%); and national early warning scoring system (71%). For medical staff training compliance was very low in some areas. These included: adult basic life support (66%); paediatric life support

(45%); end of life care level 2 (66%); fire safety awareness (60%); Mental Health Act (62%); national early warning scoring system (34%); and referral to treatment level 1 (35%).

- Training on information governance and record keeping introduction and refresher courses had a target of 95%.
 98% of nursing staff had completed the induction course, but only 81% had completed the refresher course. For medical staff, only 88% had completed the induction course, and 74% had completed the refresher course.
- Pilot sepsis training was rolled out to Meldon Ward from July 2016, and by the time of our inspection 94% of Meldon staff had been trained using guidance form the National Institute for Health and Care Excellence (NICE) and UK Sepsis Trust's red flag sepsis guidance. This exceeded the hospital target of 90%. We saw evidence that some staff from other surgical wards had a training session with the acute sepsis and kidney injury team, completed a training module or attended the annual World Sepsis Day event. Training all staff to screen for sepsis using the trust tool is an objective for 2017/18.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for surgical patients, and risk management plans were developed in line with national guidance.
- The hospital had established quality improvement groups to address five key safety priorities: sepsis; falls prevention; rescuing of deteriorating patients; acute kidney injury; and pressure ulcer prevention. Between October and December 2016, the hospital's dedicated sepsis team gave lifesaving treatment to 287 patients, with 87% going on to survive the diagnosis. The latest performance is attributable to the introduction of the new Acute Sepsis and Kidney (ASK) team who provide medics with practical support and expert advice on treating the life threatening condition.
 - There was a hospital wide policy for the detection of the deteriorating patient and a clearly documented response. The service used National Early Warning Scores (NEWS) which standardises the assessment patients so acute illness can be identified and there care escalated if they deteriorate. This information was audited every three months. The latest available data published in October 2016 showed that NEWS had been completed within the last 24 hours for patients on all surgical wards 40% had not been calculated correctly

on the trauma unit (two records in five). Recommendations included ward managers discussing with their teams and identify and address locally any training needs.

- The hospital used the World Health Organisation's checklist for all surgery including cataract surgery. We saw that this was comprehensive and well documented, with awareness of surgeons and anaesthetists not to be complacent about undertaking this thoroughly. Local audits confirmed that 100% of surgical patients had a WHO checklist completed between August and November 2016. However, within main theatres 52% of records checked showed that the WHO checklist had not been completed accurately over this period. Following this audit the checklist was amended to remove the debrief element so it was completed at the end of each list, rather than each procedure. It was also amended to require a name as well as a signature.
- National Safety Standards for Invasive Procedures (NatSSIPs) set out the key steps necessary to deliver safe care for patients undergoing invasive procedures. The NatSSIPs were published by NHS England in 2015 to support organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. The NatSSIPs covered all invasive procedures including those performed outside of the operating department. All departments within the hospital had been asked to self-assess themselves against the national safety standards by December 2016. Both main theatres and the day surgery unit were rated green and had commenced improvement activities. This work was underpinned by human factors training which was due to be rolled out to all staff from April 2017.
- All patients, on admission, received an assessment of venous thromboembolism (VTE) and bleeding risks using the clinical risk assessment criteria described in the national tool outlined by NICE – QS3, Venous Thromboembolism in adults: reducing the risk in hospital.
- The Sepsis 6 is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. We saw that Sepsis 6 pathway was used for all patients with a clinical suspicion of infection or deteriorating patient on arrival in the hospital or wards. More than 77 per cent of patients with sepsis in the last

three months of 2016 benefited from the Sepsis Six - a set of globally recognised medical interventions designed to put the brakes on sepsis before it really takes hold.

- Arrangements were in place in cases of life threatening haemorrhage, including the availability of blood for transfusion, access to emergency equipment, such as sutures and packs. There was also a designated emergency theatre that was available 24 hours a day with adequate staffing. The anaesthetics team also provided a 24 hour on call service.
- The rate and level of harm from falls across the hospital was the top reported incident type resulting in harm to patients. On average124 falls were reported each month. Sensor chair mats were introduced on the trauma unit to alert staff to patients who had got out the chair. Staff were also alerted to patients who were at a higher risk of falling by the use of red walking frames. An audit showed that staff responded more quickly to these patients and that the number of falls had reduced, but acknowledged that a longer trial period was required.
- The day surgery unit issued patients with a leaflet which for patients which outlined who to contact if they experienced any problems. This included a contact numbers covering 24 hours a day, seven days a week.
- Ampney ward had introduced monthly safety briefings which were shared with all staff. These were high level reminders for staff of relevant issues, such as completing the incident reporting system, or informing the site manager when beds become available, or documenting NEWS scores accurately at every set of observations.

Nursing staffing

- Nurse staffing levels and skill mix was planned and reviewed. To plan nurse staffing the hospital uses the Safer Nursing Care Tool in conjunction with national guidance. In December 2016 there were 440 full time equivalent nursing and midwifery staff in post, representing 94% of the planned establishment.
- Between January 2016 and December 2016, the trust reported a vacancy rate of 2.1% in surgery, a turnover rate of 13.5% and a sickness rate of 4.8%. Managers had assessed the reasons for high turnover rates, and recognised that a number of nurses left the hospital once their training had been completed to work elsewhere. As a result the service is looking for ways to improve staff retention, such as a development

programme for band 5 nurses who wished to progress toward a band 6 post. Managers also told us that sickness policies were not being followed, but that this has now changed, and with good support from occupation health sickness levels are now improving by supporting staff back to work.

- Staff retention in theatres was improving. The service is training band 5 theatre nurses so they can work in other areas, such as recovery and anaesthesia, this was allowing staff to stay in the department but experience other areas of practice.
- Between April 2015 and March 2016, the trust reported an average bank and agency usage rate of 12.1% in Surgery. There was one ward, Ampney ward, which had consistently higher usage of bank and agency staff than other wards. On Ampney ward we found four nurses being overseen by agency nurses who were in charge on a regular basis on night shifts. The nurses told us that they did not always feel supported, as agency staff do not have access to electronic systems which could lead to communication problems such as completion of handover notes, investigation reports and results being delayed.
- Agency nurses were managed well. A comprehensive induction included how to access advice and help, use of emergency equipment. In theatres we saw that there was an induction package and sign off process so that managers could be assure that agency staff were skilled to deliver the care required.
- The day surgery unit being run as an escalation ward had led to increased use of agency staff during 2016/17.
- Arrangements for handovers and shift changes ensured people were kept safe. We saw a comprehensive hand over between day and night shift staff on the trauma unit. Comprehensive discussions were had about all patients on the unit including patients with deprivation of liberty safeguards in place, infection control, risks, dietary requirements and mobility/falls risks. Patients who could be moved if necessary due to escalation procedures were also discussed for patients who were medically fit. An agency nurse who refused to attend the handover meeting because they didn't want to work on the trauma unit was sent home.
- We undertook an evening visit as part of our unannounced visit. The hospital's rostering system had

'gone down' on the morning of our visit and staff had not been able to access rostering systems all day. When we arrived we found the site manager was going to every area of the hospital to ensure safe staffing levels.

Surgical staffing

- Surgical staffing levels and skill mix was planned and reviewed so that people received safe care and treatment at all times in line with guidance.
- Between 1st October 2016 and 31st October 2016 there were proportionally less senior staff and more junior (foundation year one and two) staff working at the trust when compared with the England average.
- Between January and December 2016, the hospital reported a vacancy rate of 1.2% in surgical staffing, and a turnover rate of 6.5% in surgical staffing.
- Between April 2015 and March 2016, the trust reported low use of bank and locum staff with no bank and locum usage for 11 out of the 12 months.
- There was surgical and anaesthetic cover 24 hours a day, seven days a week. A senior house officer and registrar were on call at all times. A consultant on call was in residence from 8.00am to 8.00pm, and then could be contacted by phone from 8.00pm to 8.00am. Nursing staff told us that surgical staff responded promptly to on call requests.
- However, a risk had been identified in February 2017 of inadequate anaesthetic on call cover, due to a gap in trainee anaesthetist provision from the Deanery. The potential consequence was an increase in locum spend, poor utilisation of theatre sessions and loss of revenue. Rotas had been reviewed to minimise the risk by identifying consultants responsible for covering shortfalls.
- Nursing staff we met said they felt well supported by the surgical teams. Although some of the wards did not have doctors based there, we were told they came quickly when requested. When we visited the hospital we observed doctors reviewing patients and coming onto wards when requested by nursing staff.

Major incident awareness and training

- Potential risks were taken into account when planning services, such as seasonal fluctuations, the impact of adverse weather and disruption to staffing
- The trust set a target of 80% for its health and safety training module, which includes major incident training. (The module also includes accident reporting and minor

incident investigation.) As of 20 January 2017, 87.5% of staff in Surgery were up to date with this training course, although a breakdown of this information by staff groups showed that only 73% of allied health professionals had completed this training module.

• The trust provided us with an incident response plan (July 2014) which set out the processes for responding to a range of incidents, including major incidents which cause or have the potential to cause severe disruption to the service and/or serious threat to the health of the community. There were a series of action cards for each service and roles within that service. This included the surgical assessment unit, day surgery unit, theatres and actions for the clinical site managers. The plan covered both in hours and out of hours. Major incident training was carried out within theatres, including the relocation of critical care service into theatres. Staff reported that this had worked well, and that they felt confident that they knew how to access information should a major incident occur.

Are surgery services effective?

Good

We rated effective as good because:

- Staff were using national guidance to improve the outcomes for patients. Outcomes for patients with a hip fracture or who required an emergency laparotomy had improved
- There was good multidisciplinary working across all staff groups to make sure patients care was coordinated.
- Seven-day cover was provided by physiotherapy, pharmacy, mental health liaison and key diagnostic service.
- The trauma unit had used innovative ideas to improve nutrition and hydration for patients.
- Staff had access to training that was appropriate to their role.

Evidence-based care and treatment

• Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice. Relevant and current evidence-based guidance, standards, best practice and legislation were used to develop how

services, care and treatment were delivered. This included guidance from NICE and professional associations such as the Royal College of Anaesthetists, the Royal College of Nursing, and the Association of Perioperative Practice. For example, theatre staff were involved in the audit of perioperative anaphylaxis to improve outcomes for patients. Staff also told us about the falls and fragility fracture audit, results had been shared at the trauma and orthopaedics clinical governance group and audit meetings.

Staff were not always executing the sepsis pathway in a timely way. Between January and March 2017 six patients had been identified as having sepsis, and all six had been screened using an appropriate tool. However, only four of these patients received intravenous antibiotics within 90 minutes and had a review of their antibiotics by day three following sepsis identification. At the time of our inspection sepsis screening as part of the escalation process for patients with a NEWS score of more than 5 was underway.

- Surgical staff were engaged in NCEPOD data collection and reporting. They used this to monitor their services against best practice and benchmark their outcomes. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. There was also a designated emergency theatre that was available 24 hours a day with adequate staffing.
- The surgical teams were involved in a wide range of clinical audits including mandatory audits, mortality reviews, Dr Foster investigations, complaints, areas of local concern, improving efficiency and as part of the clinical governance plan. The surgical audit programme included: morbidity and mortality reviews; national severe trauma audit; surgical assessment unit waiting time and flow audit; annual sharps reporting audit; and an audit on the quality of medicines discharge information sent to GPs.
- Adults receiving intravenous (IV) fluid therapy were cared for by healthcare professionals competent in assessing patients' fluid and electrolyte needs, prescribing and administering IV fluids, and monitoring patient experience.

- Patients had access to the nutrition and dietetic team, who could provide appropriate advice and guidance to staff and patients in order to improve health for various conditions at different stages of disease and recovery.
- Patients were not discriminated against on ground including age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief, or sexual orientation when making care and treatment decisions. The Equality Delivery System (EDS) is a tool which helps NHS organisations to ensure that all services being provided and the working conditions of staff meet the requirements of the Equality Act 2010. The hospital's latest assessment against the goals shows that they have improved patient access and experience through its interpreting services, Healthwatch reports and in training in dignity.
- The rights of people subject to the Mental Health Act (MHA) were protected and staff had regard to the MHA Code of Practice. A trust wide mental health liaison team had been established and provided a service 24 hours a day seven days a week.

Pain relief

- Staff assessed and managed patients' pain by using the recognised Abbey Pain Assessment Scale tool. This tool was specifically helpful for patients with cognitive impairment who may not be able to express how they felt. It involved checking if a patient was showing signs of pain from facial expressions, if they cried out, whether they were anxious or withdrawn, and physiological symptoms such as a temperature or pulse outside of normal limits. These areas were scored and actions taken if the tool showed any evidence the patient was in pain.
- Pain relief on the wards was well managed and staff responded quickly to patients requesting pain relief. During the inspection we were shown the electronic prescribing and medicine administration system to keep patients safe from harm by ensuring that drugs could be administered appropriately. Staff used a 'tablet' to enter prescribed drugs before they were administered to ensure that there were no contraindications and that the drug could be safely given to the patient.

Nutrition and hydration

• Patients' nutrition and hydration needs were assessed and met. We saw that a healthcare assistant on the trauma unit had created a picture menu which showed

photographs of all food options that the hospital provided. This could be used for non-verbal patients or patients with learning disabilities so they could more easily identify what food they would like at mealtimes. This had been hugely successful on the ward and at the time of the inspection this was being rolled out across the hospital.

- On the trauma ward, as part of the Scaling Up project, nutritional support was provided by a healthcare assistant who had responsibility to provide nutritional assistance to support healthy eating to all patients following a fractured neck of femur. The aim was to provide good nutrition at the heart of any recovery plan, ensure that elderly patients, some of whom may lack the capacity to ask for food when hungry, get the essential nourishment needed to stay healthy in hospital. This project has been rolled out to all patients within the trauma unit.
- As part of the nursing inpatient admission documentation all patients should be screened using the Malnutrition Universal Screening Tool (MUST) a validated nutrition screening tool which identifies patients who were malnourished or at risk of malnutrition. We saw that this had been completed in all of the patients' records that we looked at.
- We saw patients were being appropriately starved before surgery and assessed. If a patient was operated on in an emergency situation, their response to the risk of nausea and vomiting was managed in theatre and recovery either with appropriate medicines or close monitoring.

Patient outcomes

- Information about the outcomes of patients care and treatment was routinely collected and monitored. We reviewed outcomes for bowel cancer, oesophago-gastric cancer, emergency laparotomy, and hip fractures.
- In the 2016 Bowel Cancer Audit, 85% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national average (69%). The 90-day post-operative mortality rate was 0.9% which was within the expected range. The two-year post-operative mortality rate was 16.8%; the 30-day unplanned readmission rate was 11.0%; and the 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 40.0% both of which

fall within the expected range. This showed improvements on the audit undertaken in 2015, however the percentage of eligible cases submitted to the audit decreased from 96.8% in 2015 to 82% in 2016.

- In the 2016 Oesophago-Gastric Cancer National Audit, poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing. The 90-day post-operative mortality rate was 0.0%, which was within the expected range. The 2014 rate was 0%. The proportion of patients treated with curative intent in the Strategic Clinical Network was 54.4%, significantly higher than the national aggregate, but is in the top 25% compared to other providers. This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.
- In the 2016 National Emergency Laparotomy Audit (NELA), the hospital achieved an amber rating for the proportion of cases with pre-operative documentation of risk of death. It achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames; the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre; and the crude proportion of highest-risk cases admitted to critical care post-operatively. The risk-adjusted 30-day mortality for the hospital was within expected range. As part of the Emergency Laparotomy Collaborative staff have improved sepsis recognition on the surgical assessment unit; improved preoperative risk scoring to guide management, set target times to get to theatre, and improved consultant surgeon and anaesthetist presence in theatre throughout the operation. Mortality rates improved and were consistently below the national average (11%), and from July to September 2016 had reduced to 3.6%
- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 8.5% which was in expected limits. This was an improvement from 2015 (11.5%). The proportion of patients having surgery on the day of or day after admission was 81%, which does not meet the national aspirational standard of 85%, but is in the top 25% compared to other providers. The perioperative

medical assessment rate was 96%, which does not meet the national aspirational standard of 100%, but is also in the top 25% compared to other providers. The proportion of patients not developing pressure ulcers was 97.1%, which falls in the middle 50% of trusts. The overall length of stay was 16.4 days, which falls in the middle 50% of trusts.

- The hospital had joined a national project known as HIPQIP Scaling Up, one of six trusts in the UK meeting regularly to share improvement stories and ideas to reduce mortality rates amongst hip fracture patients. This includes increasing nutritional support, operating within 36 hours of the fracture occurring, improving mobility, and improving the patient experience by involving patients in their care, and following up with questionnaires. A regular hip fracture multidisciplinary team meeting was instated and representatives from all involved specialties met monthly to check on progress and drive quality improvement projects forwards. This has resulted in: improved numbers of patients receiving good pain relief in the emergency department; an updated fractured neck of femur proforma which included guidance on sepsis and acute kidney injury care bundles; and increased mobilisation of patients from physiotherapy staff on the day of surgery or day one postoperatively. The actions have contributed to improved mortality rates, and staff expect to see further improvements being introduced as the Scaling Up project continues.
- Patients with a fractured neck of femur were provided with an intermediate level of care for where they had requirements somewhere between that of the surgical ward and the intensive care unit three days post-operatively, and had access to orthogeriatrician. Staff spoke very positively about the orthogeriatrician service, who could provide a comprehensive geriatric assessment, assessment of co-morbidities, and provide specialised post-operative care.
- Between October 2015 and September 2016, patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England averages.
- The hospital had mixed outcomes in the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016. PROMS assessed the quality of care delivered to NHS patients from the patient perspective following hip and knee replacements and varicose veins. Hip replacement indicators showed more

patients' health worsening than the England averages, and the rest were in line with the England averages. Varicose vein indicators showed fewer patients' health improving and fewer patients' health worsening than the England averages.

Competent staff

- Surgical staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis.
- As of December 2016, 85.3% of staff within Surgery at the trust had received an appraisal compared to a trust target of 80%.
- Learning needs of staff were identified at annual appraisals, but staff told us that they could approach their line managers for support if they felt it was required. Staff in the surgical assessment unit told us they were encouraged and given opportunities to develop.
- Staff had appropriate training to meet their learning needs. During our inspection we saw theatre staff undertaking on line training and saw a lecture to trainee operating department practitioners on the subject of medicines.
- Recovery unit staff had lead roles in diabetes, dementia, blood, infection control, control of substances hazard to health (COSHH), bereavement, wound care and pain control. These staff told us that they enjoyed having lead responsibilities and opportunities for continuous learning.
- The hospital had introduced a development programme called 'Drive to Develop' for band 5 nurses who wished to progress toward a band 6 post. The programme aimed to develop and enhance the management and leadership capabilities and confidence of band 5 nurses. It included essential operational knowledge and skills, strategic leadership skills and personal and professional development to support a future pipeline of dynamic, supportive, innovative ward sisters and charge nurses. Nurses spoke very positively about this opportunity.

Multidisciplinary working

• All necessary staff, including those in different teams, and services were involved in assessing, planning and delivering people's care and treatment. We saw a daily

team 'huddle' with good communication between all staff involved and good multidisciplinary team working. Patients were involved in these discussions which were professional and friendly.

- Staff worked together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or services, including referral, discharge and transition. We saw that there was good team working between nursing staff and physiotherapy, with patients receiving pain relief up to 30 minutes before physiotherapy.
- We observed 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 and took part as required.
- All patients receive prompt screening when escalated for sepsis by the critical care outreach team. Outreach services supported acutely and critically ill patients in surgical wards 24 hours a day, seven days a week. This included support staff to detect early deterioration in a patient's condition and provide timely review and request admission to the critical care unit if required.
- We observed physiotherapists and occupational therapists working with patients on the surgical wards and they liaised with the nursing staff and medical teams who were involved in the patients care.
- To assist the staff on the surgery wards a discharge team was available for patients who had complex needs and required detailed planning before they could be discharged. They provided support for the ward staff, for example, they would liaise with external professionals, including care homes. We observed this team on the surgery wards during our inspection and at the daily site meetings.

Seven-day services

- All emergency admissions were seen and had a thorough clinical assessment by a suitable consultant as soon as possible and within 14 hours from the time of arrival at the hospital. Consultant cover was available seven days a week and ward rounds were undertaken by the consultant and senior house officers each day.
- The anaesthetic team provided a 24 hour service. There was an anaesthetic clinical lead to promote and support anaesthetic staff, and an on call anaesthetic team member available for the emergency department. However, a risk had been identified in February 2017 of inadequate anaesthetic on call cover, due to a gap in

trainee anaesthetist provision from the Deanery. The potential consequence was an increase in locum spend, poor utilisation of theatre sessions and loss of revenue. Rotas had been reviewed to minimise the risk by identifying consultants responsible for covering shortfalls.

- Patients had access to physiotherapy and occupational therapy during the week and at the weekend and access to interventional radiotherapy and therapeutic endoscopy 24 hours a day, seven days per week.
- There were arrangements for pharmacist cover across the whole week. Pharmacists attended wards on weekdays and there was an on-call pharmacist out of hours and at weekends.
- There was access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making, including imaging and x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) echocardiogram, endoscopy, bronchoscopy and pathology. These services were available within 12 hours for urgent patients and within 24 hours for non-urgent patients in line with current guidance.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included care and risk assessment, comprehensive care plans which contained a narrative about each patient, case notes and test results.
- Large electronic whiteboards were used in each ward we visited, which gave parameters for flow and planning. Patient information was anonymised. These provided clear information of which clinicians were involved in each patients' care, referral information, expected discharge dates, and other patients information which allowed clinical staff to oversee patients in each area.
- Discharge summaries for older people with complex needs were comprehensive and included reasons for admission to hospital, investigations done and the results, changes to medication, plan for follow up and important information that would aid community management, such as pressure risk and weight.

- When patients moved between teams and services, including at referral, discharge and transition, all the information need for their ongoing care was mostly shared appropriately, in a timely way and in line with relevant protocols.
- However, electronic discharge summaries for the surgical assessment unit were not always completed in a timely way that kept patients safe. A new proforma has been introduced which should improve timeliness of discharge information communicated to GPs. However, at the time of our inspection there was still a backlog of discharge summaries to be sent out.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Health Capacity Act 2005. A new consent form for patients who lacked capacity was introduced in August 2016. An audit of these forms was undertaken in January 2017, and showed 40% compliance. Awareness of the results was raised with the patient quality committee.
- The risk of invalid consent was on the hospital's risk register.
- Anaesthetists sought consent for anaesthesia from patients prior to surgery, and discussed the benefits and risks as part of the pre-operative assessment. Patients also received a leaflet about general anaesthesia prior to their surgery.
- On wards and within theatres we saw communication boards displaying information to care for vulnerable patients, including patients with learning disabilities, deprivation of liberty safeguards, Mental Health Act, and patients living with dementia. Contact details of who to go to for advice and support were displayed.
- The hospital reported that as of February 2017 the Mental Capacity Act (MCA) training has been completed by 91% of surgical nurses but only 62% of surgical doctors (against a hospital target of 80%.
- Deprivation of Liberty Safeguarding training had been completed by 90% of nursing staff and 79% of surgical doctors, against a hospital target of 80%.

Are surgery services caring?



We rated caring as good because:

- Comments received from patients were consistently positive.
- Patients told us that they were actively involved in their care.
- There was access to emotional support, including a psychiatric liaison nurse.

However:

• Some patients' dignity was compromised by a lack of toilet facilities in the surgical assessment unit and theatre recovery.

Compassionate care

- Staff understood and respected people's personal, cultural and religious needs, and took those into account when planning care.
- We spoke with 29 patients and 14 relatives and reviewed 13 comments cards. All feedback was positive in relation to the way patients were treated by staff. Comments included: "The staff listen to me and explain things for me"; "It's really lovely here"; "I feel involved. The doctors have given me loads of information"; "They did what they could to manage my pain"; "It's easy to visit here"; "Staff are attentive and work hard. It takes several minutes to answer the call bell at night"; "Staff explain what they are doing, and are very helpful. I asked about pain management and physiotherapy, and I was seen quickly. I have been prepped to go home"; "The food was really good"; "I have nothing but praise for the staff working at the day surgery unit. They were supportive, friendly with the right amount of teasing and banter to make my son's whole time easy"; "I could not fault of any of the staff. Everyone was helpful + polite. Everything was explained several times. The operation and aftercare was exceptional. I would recommend the hospital to everyone"; "Everything v. good. Caring, cheerful staff. Things explained clearly. Staff v. caring and understanding. Precautions taken (my blood pressure was a little high so I had an ECG). I particularly valued not being hurried. Everything clean and hygienic. Plenty of toilets (!) Treat with dignity and respect, comfortable. I worried needlessly!! Reassuring staff."

- 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 a patient who was having a local anaesthetic procedure who was treated with dignity, respect and compassion. The procedure was well explained by the surgeons, and told what to expect and what to do prior to and after surgery.
- We saw theatre nurses being supportive to patients in recovery. One patient was unable to be discharged to the ward as there was no available bed to suit the patient. Recovery staff found a private area within recovery and relatives were able to visit and stay with the patient.
- Staff showed an encouraging, sensitive and supportive attitude to people who used their service and to those close to them. Patients and their families told us that they felt involved in their care.
- We saw that staff respected confidentiality. In both theatres and wards there were areas where clinicians could have private conversations with patients, their families and carers.
- Carers were issued with a carer's passport, which enabled them to access free parking and meals vouchers. Reclining chairs were also available for carers to use when staying with patients.
- The Friends and Family Test response rate for Surgery at the trust was 14% which was worse than the England average of 29% between January 2016 and December 2016. The percentage of respondents who said they would recommend the service was consistently higher than 80% for all five reporting units in surgery. The lowest scores were for the surgical assessment unit, which recorded scores of below 90% in four of the six months where data were available. In February 2017 the service had introduced a system to identify patients who were expected to be discharged the following day and to ensure that they were given a Friends and Family card to complete the day before discharge.

Understanding and involvement of patients and those close to them

 Staff communicated with people so that they understood their care, treatment or condition. Patients we spoke with said they were informed about their care and that their relatives were included in discussions.
 One patient said "everything was explained several times"; another patient said "all the staff nurses doctors and the anaesthetist were exceptionally helpful and knowledgeable despite a deal of pain this was dealt with promptly and with sincere care and attention." We were also told by one patient that their partner had been actively involved in their care while in hospital so they wold be more confident to care for the patient when they returned home.

- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included access to translation services. Managers also used staff within their units (wards and theatres), who could speak other languages to talk to patients.
- Staff ensured that patients and those close to them were able to find further information or ask questions about their care and treatment. Patient leaflets were available on all wards we visited so patients could access information about their condition, treatment and support services. Display boards on wards were comprehensive and up-to-date.

Emotional support

- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and physically. Patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief personal hygiene and anxiety.
- Staff understood the impact that person centred care had on the wellbeing of the patient and those close to them both emotionally and socially. Staff could describe the importance of offering emotional support and could give examples of the positive impact it had on patients. Staff told us that they had access to a psychiatric liaison nurse who could support patients. Patients that we spoke with in theatres and on the wards all reported how they had been supported emotionally during their inpatient stay. One patient told us they had received excellent care and were well prepped to return home. Several patients commented on how well their pain relief was managed.

Are surgery services responsive?

Requires improvement

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We rated responsive as requires improvement because:

- Due to pressure for beds and the demand on services, some patients had to use facilities and premises that were not always appropriate for inpatients.
- Discharge processes were not always effective.
- For the period January December 2016 the trust cancelled a total of 768 surgical procedures, similar to the England average.
- Complaints were not always dealt with within 25 working days as per the hospital policy. Although some complaints were granted a further 20 days because of the complexity 16% of complaints took more than 40 days to close.

However:

- The average length of stay was for non-elective patients was better than the England average.
- Most patients who had their operations cancelled on the day of surgery were re-booked within the 28-day timescale
- Patients living with dementia were well supported on surgical wards.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. However, leaders and managers understood that the local area has a fast growing local population, with new housing developments being built, with lower than average access to primary care. This was having an impact on delayed transfers of care.
- As part of service planning due to winter pressures and the increase demand on beds surgical wards were being used for medical patients. This had an impact on the number of elective operations that could be undertaken. The day surgery unit and recovery areas within theatres were only used for surgical patients. The surgical assessment unit was used for medical patients during periods of escalation. The hospital had risk assessed the day case unit and identified actions to reduce risks to patients being treated in this area.

Despite some work being undertaken in these areas, such as a shower built within the day surgery unit and trolley beds being available within the surgical assessment unit these areas were not fit for purpose. Patients in the day surgery unit highly praised the attitude and dedication of nursing staff but expressed concerns at the facilities, such as broken chairs for visitors.

- Strict admission criteria to the day surgery unit ward in periods of escalation had been established. Criteria included: over 18 years old only; medically stable; no complex care required; independently mobile; estimated discharge date within 48 hours; and surgical post-operative short stay patients. However, it was clear that these were breached on a regular basis, as we met patients who had been on the unit for three or four days.
- The day surgery unit was equipped for eight patients, but incident reporting showed that on occasion up to 20 patients were placed on the unit. This had led to staff shortages, and single sex breaches. Further investigation identified that there has been seven weeks where breaches had occurred, and in one week there had been 50 breaches.
- Between October 2015 and September 2016 the average length of stay for surgical elective patients at the trust was 3.2 days, this was better than the England average of 3.3 days. For surgical non-elective patients, the average length of stay was 3.3 days, this was better than the England average of 5.1 days.

Access and flow

- A lack of care provision in the community contributed to some patients experiencing a delay in being discharged from hospital. Admissions outweighed discharges, which affected patient flow and experience. The average number of medically fit patients ready of discharge but unable to leave the hospitals due to delays in community care reached its highest number in January 2017, with over 90 patients against a target of 35 across the hospital.
- The Planned Care division were failing to deliver the national performance required for referral to treatment standards, leading to patients waiting longer for treatment. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
- Between April 2016 and March 2017 the trust's referral to treatment time (RTT) for incomplete pathways showed

an improvement, with six months of the year being above the national target. The specialties where referral to treatment times (RTT) were below the national average were: general surgery which achieved 81.9% against a national average of 87.3%; and ophthalmology which achieved 87.2% against a national average of 91.4%. However, other specialties were above the national average for referral to treatment times, including urology; trauma and orthopaedics; ears, nose and throat; oral surgery; and plastic surgery. The day surgery unit has been used as an escalation ward for over a year. The hospital had clear patient acuity guidelines to determine who could be admitted to these wards. However, it was clear that these guidelines were regularly breached and that the unit was frequently in excess of its maximum patient intake of eight patients, and that this resulted in barriers to patient flow from the recovery area to the unit and wards. On the day of our inspection we found that nine of the 11 patients on the escalation ward were emergency admissions. Nurses told us that the 'matron of the day' would visit the unit regularly and they were comfortable with raising any concerns.

- Theatre utilisation decreased slightly in January 2017. This was affected by the number of 'on the day' cancellations due to bed escalation issues.
- Bed shortages across the hospital were identified as the most significant factor in cancellations on the day for surgery (39% of total reportable cancellations). The other high contributor was a lack of theatre time (12%), which is also indicative of flow issues between theatre, recovery and the day surgery unit, and wards.
- Discharges were organised through daily multidisciplinary meetings including complex discharges. All senior managers on duty attended the daily site meetings to improve patient flow and improve delayed discharges of care. We found on the day of inspection that there were 90 patients across the hospital who were medically fit for discharge. We were told that the hospital were looking at alternative solutions such as treatment escalation plans, hospital at home care and virtual wards to help facilitate discharges for these patients.
- Daily system wide telephone calls took place to review patient discharges, these were called 'Gold calls'. This involved a clinical commissioning group executive as chair and executive officers from the hospital and partner organisations to discuss the hospitals current

position, patients who were medically fit for discharge, potential discharges identified, identification of bed deficit and to discuss and agree actions to manage capacity across the region. However in February 2017 it had been agreed that this system had not been as effective as it could be. Changes made include suggestions from the emergency department delivery board, ensuring correct decision makers are on the call, and understanding the capacity within other organisations to support the hospital, plus the commissioning and spot purchasing of any additional capacity is now an expected outcome of the gold calls.

- A patient outlier team had been established to ensure outlying patients were reviewed by medical teams from their specialty on a daily basis. Outlying patients are those patients who are an in-patient in the hospital but not located on the most appropriate ward for their condition. However at the time of our inspection it was noted that the locum doctor who was part of the team was not available, and this left the team short staffed.
- Issues for discharging patients included patient transport. We saw that transport did not always turn up on time for patients, and in some cases did not turn up at all. The contract was measured against whether a patient was booked for transport, not whether that booking had gone ahead at the agreed time and the patient's discharge transport journey had taken pace. This resulted in a lack of oversight and effective contract monitoring to ensure patients were discharged in the most effective way.
- Theatre staff prioritised care and treatment for people with the most urgent needs. Surgical team briefings in theatres involved all required key staff, and prioritisation of patients was undertaken between the multidisciplinary team including with the operating surgeons.
- Readmissions of patients as an emergency within 30 days of discharge was 11% which was higher than the target of 7.1% for the period between October 2015 and September 2016. Cancellations on the day of surgery were 0.9% which was higher than the target of 0.8%. However, of those people who were cancelled, only 2.5% did not have their procedure rebooked within 28 days which was better than the target of 5%.
- Cancelled operations as a percentage of elective admissions were similar to the England average. For the period January December 2016 the trust cancelled a total of 768 surgical procedures. Of the 768 cancellations

2.7% were not rebooked and treated within 28 days. Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short notice cancellations.

- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. Last minute cancellations were explained to patients and they were supported to access care and treatment again as soon as possible. For example, we found that if admitted patients had their operations cancelled, a senior manager would meet with the patient to inform them of the cancellation. They would also be prepared with a list of alternatives dates so that the patient could be rescheduled at that point.
- A clinical annual leave policy was updated in 2016/17 so that clinicians need to give eight weeks' notice for annual leave. This has allowed the service to plan better and drive up booking in advance criteria.

Meeting people's individual needs

- The surgical services took account of peoples different needs including those in vulnerable circumstances.
- We saw that patients living with dementia were well supported in all wards we visited. We saw a good understanding of how to support people living with dementia on the trauma unit where staff had developed many new ideas to support patients living with dementia, including a box of tactile objects and objects that they could look at to 'remember days gone past'. A member of staff had also created a picture menu that showed photographs of the meal and food options, to help people decide what they wanted to eat. The unit is also planning to purchase equipment to enable patients to listen to music and old movies.
- Patients had access to specialist nurses, including the specialist pain nurse, breast care nurse specialist, and the diabetes specialist nurse.
- We saw that waiting areas had well deigned notice boards and a wide range of leaflets that patients and their carers could access.

- Within theatres recliners were available for carers, and carers were also encouraged to come into recovery, where appropriate, to support the patient post-operatively.
- Translation services for people with visual or hearing impairments were available to staff and had been well used. Staff told us they could also access translators who were able to visit the unit if required.
- Staff told us that they had good access to a psychiatric liaison nurse who could support patients.
- A shower had been installed in the day surgery unit as this was effectively permanently used as a ward. This had improved the experience for patients staying on the unit.
- A trust wide mental health liaison team had been established and provided a service 24 hours a day seven days a week. We saw that the team were responsive to requests for support from staff on the surgical assessment unit.
- The hospital had a chaplaincy centre which was approved by the Swindon Interfaith group when the hospital was designed. The chaplaincy service was available 24 hours a day, seven days a week.
- From 1st August 2016 onwards, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services. The hospital had a learning disability forum who were responsible for the implementation of the Standard. A library of 'easy to read' documents were being produced across the hospital for people with a learning disability and their carers.
- In the surgical assessment unit we found that there was no access to toilet facilities without leaving the unit and a lack of toilets in the theatre recovery area. This meant that some patients had to use commodes in close proximity to other patients which compromised their dignity.

Learning from complaints and concerns

• Patients and their families and carers who we spoke to were aware about how they could make a complaint or raise concerns. They told us that they would feel comfortable to do so. Patients and their families and

carers were treated compassionately and given the help and support they needed to make a complaint. Outcomes of complaints were explained appropriately to individuals. There was transparency and openness about how complaints and concerns were dealt with.

- Complaints were handled confidentially, with a regular update for the complainant and formal records were kept. The hospital's patient safety and quality governance dashboard contained a set of metrics that looked at complaints, compliments, incidents, pressure ulcers, falls and medication errors. This data was collected and shared at various meetings including divisional, ward leader and clinical governance meetings.
- Lessons learned from concerns and complaints were shared and action taken to improve quality of care. Lessons were also shared with other wards and departments. We saw that an anonymised complaint letter was made available to staff on the trauma unit, and that all staff were asked to sign that they had read it and the actions in place to ensure the issue did not happen again.
 - Complaints were not always dealt within the hospitals agreed timeframe. Between February 2016 and January 2017 there were 303 complaints about surgery, 129 (42%) were about clinical treatment, and 13 of these complaints alleged that poor care caused moderate to severe harm. Of these 80 were upheld and 121 were partially upheld, with the rest either not upheld, rejected or no case to answer. The trust took an average of 27.5 working days to investigate and close complaints. The trust acknowledged that some complaints require longer to thoroughly conclude the investigation and provide a full response, and therefore an extension of a further 20 days can be granted to complete an investigation. Nevertheless 49 complaints took over 40 days to close.
- Themes of complaints were identified with one common theme being communication. In response to this theme feedback had been provided to the general surgery team that they needed to be more realistic and communicate more clearly with patients about the discharge process. As a result it was advised that conversations about discharge should be recorded in patient notes.

Are surgery services well-led?



We rated well-led as requires improvement because:

- Most staff we spoke with told us that senior leaders were not visible, and that attempts to engage with staff did not feel heartfelt.
- We found that there were areas of concern with a lack of management oversight and mitigations.
- Actions identified to mitigate risks on the risk register did not always lead to negation of those risks.

However:

- Across the wards and the theatre departments there was a clear vision and a set of values, with quality and safety being the top priority. Managers and clinicians told us that they been involved in the business planning process.
- There was an effective governance framework to support the delivery of the strategy and good quality care. The performance dashboard provided a holistic view of performance across surgery and Planned Care.

Leadership and culture within the service

- Leaders of the service had the skills, knowledge, experience and integrity that they needed, both when they were appointed and on an ongoing basis. Leaders and managers had access to, and attended, the hospital's leadership development programme, which included medical staff leadership and NHS leadership academy programmes.
- Leaders and senior managers of the service had the capacity, capability and experience to lead effectively. The hospital had a system of gold and silver senior managers who would be on duty to make high level decisions on a daily basis. Senior managers were gold level and made high level decisions and service managers were silver. There is also an on-call Executive and on-call manager system to support out of hours. All senior managers on duty attended the daily site meetings to improve patient flow and improve delayed discharges of care. This system was in place 24 hours a day, seven days per week through the use of a designated gold and silver manager on-call / on site.
- Staff told us that ward leaders and theatre managers were supportive and valued their staff. We were told that

they had an open door policy and that they were able to have open discussions with their line managers. Staff told us that managers had high standards and expected good practice and that staff wanted to do their best. Staff told us that they enjoyed working for the trust and that they could talk to their immediate managers if they had any concerns and that they would be listened to.

- Staff told us that senior managers within the service and executives across the hospital were not always visible and approachable. We were told senior staff used 'hot desks' in different wards and departments every Friday to be more accessible to staff. However, staff told us they would be based in an office, and were therefore not visible. Senior managers and executives sent thank you emails to staff recognising their hard work. However, some staff felt that these were not personalised, and therefore did not feel heartfelt.
- However, senior leaders told us that they knew the staff on the ground, understood their concerns well and thought that staff were comfortable to speak up.
- Action was taken to address behaviours and performance that was not consistent with the vision and values, regardless of seniority. We were given good examples of effective performance management of staff, with staff given additional training and support.

Vision and strategy for this service

- There was a clear vision and set of values, with quality and safety the top priority. The strategic vision for the service was "to provide high quality emergency and elective care with timely access to our services ensuring that patients receive the care appropriate to their needs in a safe, quality and consistent way."
- The priorities for Planned Care, which includes surgery, were: living within agreed budgets and delivering agreed targets in line with the transformation programme; doing it safely and supporting the 500 extra lives saved initiative; delivering emergency department and referral to treatment in a sustainable and affordable way; and focus on integration, improve pathway to help manage demand, focussing on Swindon and Wiltshire.
- Managers told us that they had been part of the business planning process for 2017/18. They had developed local business plans with input from clinical teams which had then fed into the Planned Care division plan. Priorities for theatre services in 2017/18 included a stock management system, an update

preoperative and theatre management system. Managers were confident that these could be achieved and would lead to cost savings and efficiencies in the services they provided.

• Staff we spoke to understood the vision and values of the hospital. However, they expressed concern at being able to deliver the strategy, given the projected population growth of the region with reduced resources and recruitment problems.

Governance, risk management and quality measurement

- An effective governance structure was in place to support the delivery of the strategy and good quality care, which integrated with the hospital's structure and functions. A trust-wide patients safety and quality governance dashboard has been introduce and is available to all staff. We saw a holistic understanding of performance which integrates the views of people with safety, quality, and activity information. The dashboard contained a range of clinical governance information, data and analysis, as well as links to additional data sources and other dashboards, such as safeguarding, WHO checklist, infection prevention and control and incident data. Data was updated on a weekly basis, where possible. The information could be filtered to divisions, departments and by timeframe. Key themes and risk areas were easily identified, as well as performance over time so managers can see where indicators are improving or decreasing.
- The governance framework and management systems were regularly reviewed and improved, and we saw that plans were underway for a new performance dashboard which would incorporate training videos and would be more interactive.
- The Planned Care division had held five governance half days during the year to increase staff engagement. Staff and managers expressed that this was a useful way to share good practice, update staff on performance, and discuss the quality of care being delivered.
- The surgical service had a risk register which included, for example, patient harm due to inadequate staffing levels for long stay patients whilst the day surgery unit was used as an escalation ward. Other risks included the World Health Organisation protocol not being followed due to documentation issues, and the impact on patient safety; inadequate anaesthetic on call cover; and risk of delayed or missed intravenous medication on Meldon

ward. We saw some alignment between what staff and management told us was on their 'worry list' and the recorded risks. We noted that the issue of electronic discharge letters was reported several times over a five month period, and the issue was escalating. Senior members of staff and managers told us that this was a risk. This was not on the departments risk register.

- We also identified a number risks during our inspections that were not on the risk register, such as non-completion of mandatory training.
- We reviewed a variety of departmental meeting minutes such as the anaesthetic governance meetings, trauma and orthopaedics clinical governance meetings, planned care nurse meetings, and ward meetings. We noted that there were generally good levels of attendance. Minutes of these meetings were not always well documented; however this had recently improved as the governance team had implemented a new template which helped staff to cover all topics and define actions that needed to be escalated. The new template helped staff to capture actions required with a named responsible person and a date by which the action should be achieved. It also helped staff to review previously agreed actions. Meetings were structured under hospital-wide agreed headings, such as 'team focus'; 'responsiveness'; 'staff feedback'; and 'well led'. Good practice guidance for team meetings were also attached to the minutes.

Public and staff engagement

- Within surgery a quarterly newsletter has been produced called 'Surgical Snippets', introduced in January 2016, which provided useful divisional and trust wide information for staff. This included updates on policies and guidelines, recent training sessions, and learning from incidents. It also provides lighter news such as 'star of the month', and staff told us that this was helpful for sharing information
- The hospital had implemented a staff excellence awards and patients' choice awards programme. At the time of our inspection we were given 26 nomination forms for staff excellence awards who worked within surgical areas and eight nominations for surgical staff for the patients' choice awards. Categories included: working together; innovation in practice; outstanding leader of the year; making a difference behind the scenes; team of

the year; and outstanding contribution for safety and quality. Staff we spoke to were delighted about being able to nominate colleagues and be recognised for the work that they did.

• The latest available staff survey results from 2015 showed that across the hospital there were high engagement scores which were above the national average. Seventy-one percent of staff across the hospital stated that they were able to contribute towards improvements at work (which aligned with the national average). The results which scored better than the national averages were: staff motivation at work, fairness and effectiveness of procedures for reporting errors, near misses and incidents. However, 35% of staff across the hospital stated that they had experienced harassment, bullying or abuse from patients, relatives or the public (compared to 27% nationally), and 79% stated that they had worked extra hours (compared to 72% nationally).

Innovation, improvement and sustainability

- A theatre utilisation programme identified cost improvements of £0.5 million in 2016/17. This had been achieved through an increase in patient throughput, starting theatre lists on time, theatre utilisation programme, and reducing late finishes. This has also lead to an increase in morale. The theatre utilisation project has projected further savings of £0.5 million for 2017/18. The bulk of the 2017/18 savings will relate to bringing back in house surgical services which were outsourced to private hospitals in 2016/17 and previous years.
- The programme also highlighted the Association of Anaesthetists of Great Britain and Ireland recommendation that all-day theatre lists should be used with the same theatre team, including surgeon and anaesthetist to improve theatre efficiency. However, the annual job planning process for surgeons at the hospital, where an agreement is made to between surgeons and management to focus on outcomes that benefit patients had been already been completed. Nevertheless, some surgeons were volunteering to undertake all day lists in theatre that could help prevent the build-up or patients towards the end of each day.
- We saw that innovation was encouraged. A healthcare assistant on the trauma unit had created a picture menu which showed photographs of all food options that the hospital provided. This could be used for non-verbal

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patients or patients with learning disabilities so they could more easily identify what food they would like at mealtimes. This had been hugely successful on the ward and at the time of the inspection this was being rolled out across the hospital.

Staff in the surgical assessment unit have designed a new triage framework which included standard against which they could be measured against, and improve patients safety and experience. This included changing the layout of the department to improve patient flow and increase nursing visibility. The unit demonstrated improved triage times with 86% of patients now triaged within agreed timescales, compared to 60% the previous year. The unit has not received a complaint regarding waiting times since the introduction of the new system which had also been an improvement.

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

Information about the service

Great Western Hospital provides care for adult patients who require intensive care (described as level three care) or high dependency care (described as level two care). The unit also admitted some children for stabilisation and onward transfer to a paediatric unit. This service will be reported separately in the children's and young people's report.

In the period from April 2016 to December 2016, the intensive care unit admitted 251 patients to the intensive care beds and 513 patients for high dependency care, which equates to around 900 patients each year. The unit had 12 beds and all were located within individual rooms. Patients are admitted to the intensive care unit as admissions from the emergency department, after emergency surgery or as planned admissions for patients having complex and high-risk surgery.

Critical care provides an outreach team to assess deteriorating and acutely ill adult patients on the general wards throughout the hospital.

We inspected the critical care unit on Tuesday 21 February, Wednesday 22 February and Thursday 23 February, followed by an unannounced visit on 3 April 2017. We spoke with 27 members of staff of varying seniority including medical staff, nursing staff, physiotherapists, pharmacists, dietitian and housekeeping staff. We spoke with some patients and their relatives. We observed care interventions, checked the clinical environment and reviewed patient records.

Prior to and after the inspection we reviewed information and data including data submitted to the Intensive Care National Audit and Research Centre. We looked at information requested and sent to us by the organisation, which included audit results, minutes of meetings, organisational policies, incidents, complaints and feedback.

We previously inspected this critical care unit in October 2015. We rated the service as 'requires improvement' overall. Effective, caring and responsive domains were rated as 'good'. Safety and the well-led domain were rated as 'requires improvement'.

Summary of findings

We rated this service as good because:

- There was a good incident reporting culture, learning was identified and staff received feedback from incidents.
- There were safe nursing and medical staffing levels to deliver effective care and treatment.
- The service provided care and treatment in line with evidence-based guidance.
- There were experienced nursing and medical staff who received annual appraisals and were supported with training and professional development.
- The service monitored patient outcomes and these were good when compared nationally and to other similar units.
- Staff cared for patients with compassion and kindness. Staff treated patients with respect and dignity at all times.
- The provision of the service met the needs of most people.
- Patients' individual needs were met wherever possible.
- There were clear governance and risk management processes.
- There was strong leadership and teamwork.

However:

- There was only one junior doctor in the unit at night, when standards recommended a unit of this size should be covered by two at all times.
- Junior medical staff were not all 'airway competent' with skills in advanced airway techniques.
- Provision for therapy services did not meet national guidelines. There was not sufficient physiotherapy and dietitian support, and limited support from other therapies.
- Patients were not provided with a rehabilitation 'prescription' when they left the unit.
- There was a high level of delayed discharges for patients. However, this did not result in any significant delays in admitting new patients.
- Patients were sometimes transferred to general wards at night, which was not optimal for their care.

Are critical care services safe?

Requires improvement

We rated safe as requires improvement because:

- There was only one junior doctor in the unit at night, when standards recommended a unit of this size should be covered by two at all times.
- Junior medical staff were not all 'airway competent' with skills in advanced airway techniques.
- Patients were not provided with a rehabilitation 'prescription' when they left the unit.
- There was a lack of accountability for demonstrating lessons had been learned and embedded when patients died.
- There were some gaps in daily checks of equipment, including emergency equipment trolleys and fridge temperatures and the fridge used to house medicines could not be locked.
- Patients' allergies were not always documented and staff did not always sign when they administered flushes of central venous lines.
- Patients' medical records were not always stored securely.

However:

- There was a good incident reporting culture, learning was identified and staff received feedback from incidents.
- Records were written and managed in a manner that kept patients safe.
- There were safe nursing and medical staffing levels to deliver effective care and treatment.
- Staff assessed patients and responded to changes in their condition.
- There were effective processes for handovers when clinical staff changed shifts.

Incidents

• The critical care unit reported no never events between January 2016 and December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how

to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- There was a good incident reporting culture. In accordance with the NHS serious incident framework (2015), the trust reported two serious incidents in critical care between January 2016 and December 2016. We reviewed the investigation report for one of these incidents (the other was still being investigated) and found a thorough investigation had taken place. The investigation highlighted areas of learning and these were shared with staff. Staff discussed incidents in staff meetings as a regular agenda item. The unit had a folder with incident investigation reports that staff were required to read, and sign to say they had done so.
- Staff reported incidents on an electronic system, which was straightforward to use. Most incidents reported in the year from March 2015 (98%) were near misses or caused no or minimum harm to patients. The incidents indicated that staff did categorise a number as near misses where appropriate. There was a wide range of incidents suggesting staff were proactive in their reporting.
- There was a regular review of mortality and morbidity (M&M), but a lack of evidence of accountability to show lessons were learned and actions taken when something needed to change. Investigations relating to M&M had recently changed. The service now used a 'structured judgement review' to improve mortality case note reviews, as recommended by the Royal College of Physicians (2016). Minutes of meetings were taken and shared with relevant people. However, the quality of the minutes was not sufficient to ensure people who were not present would gain useful information about cases discussed. There was discussion and consideration of failures of care. However, learning points and actions, and who was responsible for delivering them, were not written down in any detail or as evidence of improving care.

Duty of Candour

• Staff were aware of the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We reviewed one investigation where duty of candour applied as a patient had suffered harm. There was evidence within the investigation report, although it was not referred to as duty of candour, that the patient and their family had been kept informed. The investigation report had been shared with the patient. This demonstrated openness and transparency when something went wrong, and a recognition that the patient and their family required support.

• Staff received training in the duty of candour, although not all nursing staff were up-to-date. The compliance among nursing staff in the unit was 72% against a target of 80%. Medical staff had achieved compliance of 81%, which was just above the target required.

Safety thermometer

- Safety performance on the unit was good. The service used a tool known as a 'patient safety thermometer' to record certain incidents of avoidable patient harm. Staff collected data providing a snapshot of any avoidable patient harm on one specific day each month. Between January 2016 and February 2017, there was 100% harm-free care on these specific days. There had been no new pressure ulcers (grade three and four), no falls with harm and no new catheter-related urinary tract infections. The unit openly displayed this information for patients and visitors.
- There were a low number of patient falls, none of which had caused harm. The service reported six patient falls in the critical care unit between March 2016 and December 2016. Investigations into these incidents raised concerns about the effectiveness of falls' risk assessments. There were also concerns about the ability of staff to observe patients nursed in single rooms when nurses were supporting more than one patient. Following the investigations, staff ensured there was sufficient support for any patients at risks of falls at all times. Healthcare assistants also provided patients with care activities, observation and support for those at risk of falling.
- There was a low number of unit-acquired pressure ulcers. The service reported 25 incidents related to wounds or pressure ulcers between January 2016 and December 2016. The majority of these (13) were identified when patients were admitted to the unit with

pressure ulcers acquired elsewhere. Three developed because of airway devices causing irritation to patients' skin. These were investigated and the outcomes were shared with staff to increase awareness of the risks of airway devices causing pressure damage.

Cleanliness, infection control and hygiene

- The environment was visibly clean and tidy. Members of the housekeeping department told us all patient rooms were cleaned once a day. They would be cleaned more frequently if there were any identified infection risks. There was a laminated card in patient rooms to show staff when the room had been cleaned. However, there were no charts demonstrating when other rooms, including toilets and visitor visiting areas, were cleaned.
- Most patient equipment on the unit was visibly clean and well maintained. There was one commode, which was not fit for purpose as the lid covering was damaged and efficient cleaning could not be ensured. The wheels were not clean as there was dust/dirt accumulated within the wheel capsule, which meant there might be an infection risk when using the commodes for different patients. We informed the senior nurse and the matron and the commode was replaced at the time of our inspection.
- The unit was checked each day for cleanliness, although not all the checklists were completed. The nurse in charge was responsible for completing an 'are your patients safe and in a clean ward' checklist everyday by 10am. This included checks to ensure the unit was visibly clean. Checks were made of commodes, and the effectiveness of damp and high-level dusting. We reviewed the checklists and found it was only partly completed or not completed on seven days in February 2017 and on five days between 1 and 20 March 2017. Nurses looking after patients completed safety checks three times a day and this included damp dusting of patient equipment.
- We checked different areas of the unit and found dust on ventilators in a storeroom. Storerooms were generally full of equipment, which had to be moved to enable effective cleaning of the floor. In one storeroom, we found a mattress being stored on the floor, which made cleaning of the floor difficult. However, we did not see any visible dust or dirt on the floors or in difficult to reach places.
- There were good results from cleaning audits. Cleaning by housekeeping staff included areas such as floors,

high and low dusting in the unit, patient rooms, and bathrooms. Results were between 92% and 100% for the period of April 2016 to February 2017. Results for the audits for those areas clinical staff were responsible for cleaning, such as patient equipment, were between 89% and 100% between May 2016 and February 2017.

- We observed mostly good infection control and prevention practices. Staff washed their hands or used hand-sanitiser when required. Each patient room had a hand basin for staff to wash their hands before and after patient contact. There was access to gloves and aprons outside all rooms to protect staff and reduce the risk of spreading infection. However, there was some inconsistency in the practice around isolation procedures. One patient was being nursed in isolation for a potential airborne infection. Infection control procedures required staff to wear a mask while awaiting pathology results to state if the patient was infectious. We observed how staff did not consistently wear masks, and the door to the room was not always closed. The patient's family were not instructed to wear any protective clothing, such as gloves and aprons, when visiting the patient. When we asked staff about this they told us they were awaiting confirmation that the patient was not infectious.
- Care practices provided good infection prevention and control. The service audited compliance with care practices (known as care bundles) to reduce the risk of infections. Audits included looking at care to reduce ventilated-associated pneumonia (VAP), care of central venous catheters, hand hygiene, and care of peripheral venous catheters. The audit results from April 2016 to January 2017 demonstrated a compliance rate of 95% or more in five care bundles out of nine. Compliance in the remaining four measures was 89-95%. The one area with a lack of consistent data was the audit of central venous catheters. Data had been collected but not submitted for four out of ten months.
- The unit had a good safety record for hospital-acquired infections. There had been no methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and no incidences of Clostridium Difficile in 2016 or 2017 at the time of our inspection.
- The unit had facilities for nursing patients with suspected or confirmed infections, although these did not entirely meet recommended requirements. All patients on the unit were nursed in single rooms and two had air change facilities. This was a system that

allowed air to flow into the room, but not escape from the room and be vented externally. However, these rooms did not have enclosed gowning and hand washing areas on entry, which meant there were not full isolation facilities.

 Not all curtains on the unit were disposable as per national recommendations. The unit had fabric curtains at the internal windows in patients' rooms and within the clinical area. The curtains were changed every six months or sooner if visibly dirty, or the room had been occupied by a patient with an infection. We reviewed the Department of Health: Health Building Note 04-02: Critical Care Units (2013) section 6.13, which states curtains should be easily movable and disposable. This meant the unit was not following national guidance.

Environment and equipment

- The environment was fit for purpose, although, as an older unit did not meet all the recommendations for modern units. However, the service recognised they did not meet some of the recommendations within the Health Building Note 04-02 for Critical Care (Department of Health, 2013). This was because the unit was built in 2003, and the most recent recommended guidance had been introduced in 2013. This had been entered on the critical care risk register as a moderate risk and was in line with recommendations by the Faculty of Intensive Care Medicine Core Standard 3.1 (FICM, 2013). The care environment met the majority of recommendations except: Each bed space did not have the recommended number of electrical sockets, although there were 24 from a recommended 28. However, there was no evidence of this leading to any safety incidents.
- The height of the ceilings did not meet specifications so beds were not able to have overhead electric hoists. However, a mobile hoist was used to safely transfer appropriate patients. The unit had sufficient space to safely treat patients. There were eight single rooms for intensive care patients and four slightly smaller single rooms for patients requiring high dependency care. The single rooms had enough space to ensure five members of staff could work safely, as recommended by the Health Building Note 04-02. Each room had essential equipment and met the Health Building Note recommendations to care for patients who were seriously ill or with life threatening conditions.

- Equipment was regularly serviced, but some essential equipment was coming to the end of its serviceable life. All eight ventilators (breathing machines for patients) were now over ten years old. The ventilators had been regularly serviced and maintained in their lifetime; however the manufacturer would not service or maintain the ventilators from 2018. This had been entered on the service's risk register and options were being explored to replace them. There was no spare ventilator should there be more than eight patients requiring invasive ventilator support. There were two transfer ventilators that could be used, and provision to hire ventilators should this be needed. Following the inspection, we were informed that new ventilators are on the 2018/19 capital replacement scheme. This means the unit will be able to replace all ventilators before the contract is terminated.
- There was suitable emergency equipment, although • some routines checks had occasionally not been carried out. The unit had a resuscitation trolley for adults and another for children. There was also a 'difficult airways trolley' for dealing with emergency procedures involving a patient's airway. The resuscitation trolleys were tamper evident, and restocked after each use. We checked the expiry dates of the contents, which were all in date. However, the trolleys were not always checked, as they were required to be, each day. There were also two airway tubes on the difficult airways trolley with damaged packaging. When we pointed this out, the matron immediately replaced these. We checked 'transfer bags' (bags with essential equipment used when transferring patients to other departments or other hospitals). These had been checked daily. They did not contain any drugs and medical staff would bring a dedicated drug bag when transferring patients. This drug bag was regularly checked. There was a trolley with equipment specifically available to staff when a child was admitted. Records showed this trolley was checked every week and after being used.
- There were effective processes for managing and disposing of clinical waste. Each room had clinical waste bins, and bins for disposal of sharp instruments. The bins were not overfilled, which avoided staff or others injuring themselves. The dirty utility room had sufficient space and was kept tidy to avoid accidents or spillages. There was one macerator unit to dispose of used disposable bedpans.

• The unit was kept secure. Access was permitted by staff checking visitors using CCTV. The entrance led directly into the relatives' waiting area, which contained a telephone visitors could use to contact staff. Staff ensured that colleagues looking after patients were informed when relatives had arrived. Relatives told us they did not wait long before they were able to visit the patient.

Medicines

- Arrangements for the management of medicines kept patients safe. Medicines were stored in a central clinical area. Medicines and intravenous fluids were stored in locked cupboards with keypads in line with national guidance. Intravenous fluids with additives such as potassium were stored in a different storage area behind a keypad secured door. However, this door was open when we first arrived on the unit, so could have allowed unauthorised access. Patient's own medicines were stored in keypad lockable drawers in the individual patient rooms. Medicines and fluids we checked were in date.
- Opened liquid medicines were labelled to ensure they were used or disposed of before they expired. The pharmacy dispensed liquid medicines with stickers for staff to record the date it was opened and the date it expired. This is due to most liquid medicines having a limited lifetime once they are opened. Those we checked all had the dates recorded and they were within their expiry date.
- Management of controlled drugs were in line with the trust's policy. We did a spot check and confirmed the stock recorded was correct. As required, records confirmed that drugs were signed for by two registered nurses when these were administered and when adding drugs into stock.
- The medicine fridge did not have sufficient security, although temperatures were checked to ensure medicines were stored in line with recommendations. Medicines requiring refrigeration were stored in a fridge in the middle of the unit, which was clearly visible for all staff. However, the fridge was not locked or lockable. Although this had been risk assessed and was included in the trust's medicines control and administration policy (2015), this does not meet legal requirements. Staff were required to check and record the fridge temperature daily. We checked a range of records to confirm these checks were carried out, and found that

the fridge temperature had been checked as required. None of the recorded temperatures fell outside of accepted values. There were instructions for staff of what to do if they did.

- Medical gases, such as oxygen, were mostly stored safely, although some empty cylinders were not stored in accordance with policy. A number of small empty cylinders were stored on the floor underneath a shelf in the main central area of the unit. Full cylinders were stored in designated racking to prevent them falling. Empty cylinders were stored in a plastic box on the floor beside the racking system ready to be removed. However, four empty cylinders were standing next to the plastic box, although when this was pointed out, they were removed by staff. This did not meet the trust's 'medical gas cylinder (handling, storage and use)' policy (2014). It was noted this policy was overdue for review (due August 2016).
- There was safe prescribing of medicines. We reviewed four prescription charts and saw medicines were correctly prescribed, signed and dated. The records were legible and clear. Antibiotics were prescribed correctly. They had a start and stop date, and a designated requirement to be reviewed at a certain date. They were reviewed by the medical staff in line with recommendations (National Institute for Health and Care Excellence: Quality standard 61, 2014). A microbiologist visited the unit twice a week to review patients and prescribing, and was available for advice at other times as required. There was an open culture around reporting medicines' incidents on the unit. The service had reported 18 incidents between January 2016 and December 2016. Incidents had been reviewed and learning shared with staff through an internal report and a clinical information book.
- Prescription charts included venous thromboembolism (VTE) assessment and these were completed consistently. All prescriptions were legible, signed and dated. There was a signature sample list for prescribing doctors to ensure accountability for prescriptions. When medicines were not administered, there was a reason documented in line with the trust's guidelines.
- There was input to patient care from a pharmacist. They
 visited the unit every day during the week, and took part
 in the multidisciplinary ward round in the morning.
 Pharmacist assistants checked and restocked storage of
 medicines on the unit every week.

 Medicines administration in critical care was transferred from a manual to an electronic system when patients were discharged to a ward. When a patient was ready to be transferred medical staff updated the electronic prescribing and medicine administration system used elsewhere in the hospital. There were plans to introduce the electronic system within the critical care unit in the near future to save duplication and possible errors.

Records

- Patients' individual care records were mostly stored in a way that maintained patients' confidentiality. Patient care records were in paper format and kept in designated holders marked 'confidential'. They were stored outside each patient's room, and within sight of all staff. These folders held the patient records for the current admission. Old notes were kept in a closed trolley in the middle of the unit, although this was not locked. There had been one incident regarding security of patient records. The incident was investigated and learning identified to avoid any recurrence. If staff had concerns about the security of notes, they stored them in a trolley placed centrally in the unit rather than unsecured outside a patient's room.
- Patients' records were well managed and completed. We reviewed four patient records. The records included information about why the patient was referred to critical care, and admission information by medical staff. The admission information covered, for example, mental health conditions, any concerns about mental capacity, and an infection control risk assessment. Each record had a three-day personalised care plan, which included risk assessments for pressure ulcers, nutrition, pain, and personal hygiene. There were separate documents for the monitoring of patients' arterial, peripheral and central venous lines. Staff completed patient care records in a timely manner, and they were legible and signed.
- In most cases, the decision time to admit patients was documented. In accordance with policy, medical staff discussed all referrals with the consultant intensivist on duty. They documented when patients were referred, and the admission time to the critical care unit in most records. However as this was not consistently done it was not always possible to know if patients were admitted within the standard of four hours from decision to admit.

• The unit was carrying out a regular audit of patient records, which demonstrated an improving picture. In 2016, the unit had achieved 81% compliance, which was improved from 2015 where it had achieved just 62%. Areas that required improvement included 'entries having a legible printed designation' (of the person making the entry, for example, 'nurse') and 'entries having a legible printed name' (the name of the person making the entry in 'print' and in addition to the signature). In a more recent set of audits, there were themes for low compliance including 'all signatures recorded', and stickers with patients' date of birth not used on every page. The audit also showed the drug allergies were not always recorded sufficiently and flushes for central venous lines were not always signed for. This information was shared via a display in the staff room to raise awareness.

Safeguarding

- Most staff were up-to-date with their safeguarding mandatory training. The trust provided training in both safeguarding vulnerable adults and children at levels one and two, dependent upon staff roles. Training compliance for nursing staff in critical care was:
- Child safeguarding level one: for nurses, 94.2% and for medical staff, 100% had completed the course against a trust target of 95%.
- Child safeguarding level two: for nurses, 82.6% and for medical staff, 87.5% had completed the course against a trust target of 90%.
- Safeguarding vulnerable adults' level one, including learning disability awareness: for nurses, 87% and for medical staff, 100% had completed the course against a trust target of 80%.
- Safeguarding vulnerable adults' level two: for nurses, 32.4% had updated the course against a trust target of 80%. For doctors, 75% had updated the course. This was a new course introduced in October 2016 and we recognised it would take time for the nursing staff to reach compliance. This course had replaced another safeguarding vulnerable adults course for which training compliance was 85% which exceeded the trust target of 80%.
- The service had admitted 22 children to the unit between March 2016 and March 2017. Although none of the nursing or medical staff had completed child safeguarding training at level three, the paediatric

consultant, who had enhanced child protection training, was present in the critical care unit when children were admitted. This meant nursing and medical staff had immediate access to staff with the recommended level of child safeguarding training where they had contact with a child. The safeguarding children and young people: roles and competences for health care staff: intercollegiate document (2014) recommend: all clinical staff working with children, young people and/or their parents/carers who contribute to the assessing, planning, intervening and evaluating the needs of a child, young person and parenting capacity and where there are safeguarding/child protection concerns, have level three child safeguarding training.

• The trust had policies and procedures to support staff reporting and recording safeguarding concerns. The unit had a safeguarding link nurse with additional skills and training in safeguarding. Staff were aware of their responsibilities and duties to report safeguarding concerns. They knew how to access support from the unit link nurse or the trust's safeguarding lead for both adults and children.

Mandatory training

- Not all staff were up to date with their requirement to update their mandatory/role essential training. Staff received mandatory training in 28 or 29 subjects (depending on their role) including basic life support, basic conflict resolution, end of life care, manual handling, the Mental Health Act 1983, and paediatric basic life support, among others. The trust set a compliance target of 80% for most subjects, and 95% for information governance and record keeping, and child protection level one.
- Nursing staff were compliant in 14 of 29 subjects. Subjects where they fell below compliance included basic life support (75%), paediatric basic life support (77%), end of life care (71%), and moving patients' equipment (73.5%).
- Medical staff, including consultants, were compliant in 22 of 28 subjects. They were significantly below the trust's target in three subjects including National Early Warning Score training (62.5%) and paediatric basic life support (68.8%).

Assessing and responding to patient risk

- Not all of the junior doctors were 'airway competent (able to intubate patients in emergencies). We raised this with the lead consultant intensivist and the lead for clinical governance who were aware of this. They told us that in addition to the on-call intensive care consultant there were always two middle grade anaesthetists in the hospital. One of these covered the operating theatres, and one covered the labour ward. However, it was possible that neither anaesthetist would be available to assist the doctor in the critical care unit at busy times. This meant the service did not meet the recommendation of the Faculty of Intensive Care Medicine (FICM, 2015) standard 1.13. This states there must be immediate access to a practitioner who is skilled in advanced airway techniques. Although there had never been any adverse incidents reported, this was a concern in view of increasing birth rate on the labour ward. This issue had not been escalated to the risk register.
- Rehabilitation assessments were carried out in a timely way. The Faculty of Intensive Care Medicine (2013) Core Standard 1.3.1 recommends all patients have their rehabilitation needs assessed within 24 hours of admission to a critical care facility. A physiotherapist carried out this assessment on all new admissions and used a sticker attached to the patient's notes to document this. We reviewed four patients' medical notes and found their rehabilitation needs had been assessed within the recommended period.
- Staff responded well to patient risks through assessment and reviews. Risk assessments included in the three-day personalised care plan were mostly completed. One area sometimes omitted was around the patient's mental health on admission. This meant the risks to patients with mental health problems might not always be addressed in the early stages of their admission.
- Patients were regularly assessed for risks and any deterioration. Patients were reviewed at three points during the day. Staff held a multidisciplinary safety brief and medical handover each day at 8.30am. There was a 2pm review for medical staff and nurses to assess treatment plans and progress. This was followed by a 6.30pm review and a further handover ward round at 8.30pm. This was in line with recommendations as outlined in the Faculty of Intensive Care Medicine (2013) Core Standard 1.1.5 where it states consultants should be available for 24 hours a day. This standard also

requires consultants to undertake two ward rounds each day. In between these formal reviews of patients, junior doctors carried out daily examinations, and agreed treatment interventions.

- The service met recommended standards for the provision of outreach services. Through recruitment, the outreach service was now able to provide 24-hour cover. Outreach services supported acutely and critically ill patients admitted to general wards and the emergency department in the hospital. This included support staff to detect early deterioration in a patient's condition and provide timely review and request admission to the critical care unit if required. The outreach service had assessed 513 patients during January, February and March 2017, so was assisting with a high number of cases each month.
- Staff were aware of how to refer and access guidance from mental health professionals. The service had a mental health assessment matrix to assess the severity of mental health issues. Once completed the matrix indicated if the patient was at low, medium, medium-to-high or high risk of self-harm and actions to follow to keep the patient safe. In addition, the service had introduced a ligature safety checklist for staff to use to ensure a suitable environment for patients at risk of self-harm.
- Patients were reviewed every hour to check for new or emerging risks. Staff documented information about patients on large bedside charts. This included information such as vital signs, fluid balance, pain assessment, neurological observations and assessment for pressure ulcers. Staff assessed patients hourly or according to their needs, which were regularly reviewed.
- Staff screened all patients admitted against the risks from community-acquired pneumonia. They used the acronym BUNS (blood, urine, nasal swab and sputum) to remind staff of samples to collect for screening. The service had introduced HIV screening for high-risk patients with community-acquired pneumonia. There was a policy/guidance for staff to follow which included advice on consent to obtain blood sample for testing, and support for patients who had positive results.

Nursing staffing

• There were sufficient nursing staff levels in critical care to meet the needs of the patients. The service had a matron in overall charge of the critical care unit. There were four senior sisters (band seven nurses) supporting band six nurses, band five nurses and healthcare assistants. The trust's establishment levels for nursing had been increased to allow for the nurse in charge to be a supernumerary clinical coordinator on the day shift. However, this was not always possible on night shifts. The Faculty of Intensive Care Medicine (FICM, 2013) Core Standard 1.2.5 recommended units with more than ten beds required an additional supernumerary nurse to support the clinical coordinator. Although, the service did not meet this in their staffing establishment levels, there were close to recommended levels for their 12 beds.

- Staffing levels were reviewed on a regular basis. The service carried out acuity assessments throughout the day when patients were admitted, reviewed or discharged. Patients assessed as needing intensive care were cared for by one nurse looking after that one patient at all times. High dependency patients were cared for by one nurse looking after two patients. The nursing rotas demonstrated this nursing ratio was met. There was low use of agency staff. If shifts were not filled with permanent staff working extra shifts, the service used hospital-based bank staff.
- There was a high level of vacancies in the unit at times, but this had recently decreased with successful recruitment. In December 2016, the unit had a vacancy rate of 11.2% for nursing staff. This was higher than the trust target of 8%. However, at the time of the inspection, seven new staff had started or were due to start their induction programme.
- Staff turnover of nursing staff on the unit was lower than targets. The service reported a turnover rate for nursing staff of 7.9% in critical care between January and December 2016. This was lower than the trust target of 13%.
- The sickness levels for nursing staff were similar to the NHS national average. Among nursing staff in critical care, the rate for January to December 2016 was 4.3% against a national average of around 4%.
- In accordance with the FICM Core Standards, there was a role for clinical nurse education (CNE). The service had two nurses sharing the role of clinical nurse educator. They were responsible for coordinating the education and training of nursing staff and the pre-registration mentoring of student nurses. However, this role had only been in place for four weeks at the time of our inspection and the clinical nurse educators were still establishing how the service would function.

• There were arrangements for efficient handovers between staff on different shifts. The nurse in charge handed over to the oncoming nursing team, followed by a nurse-to-nurse handover for each patient. The nurse in charge held a safety brief for all clinical staff before the first ward round/handover of the day. This included details of, for example, patients nursed in isolation, patients at risk of falling, and patients on the end of life care pathway. Medical staff held a handover for each patient where treatment plans were agreed and documented if necessary. The nurse-in-charge took part in this ward round, as did the nurse allocated to each patient as the handover moved around the unit.

Medical staffing

- Clinical medical leadership and consultant cover met recommended standards as outlined in the Faculty of Intensive Care Medicine (FICM, 2013) Core Standards. The service was led by a consultant intensivist (a consultant specialising in intensive care) supported by team of consultants. The team consisted of eight combined intensivists/anaesthetists, one combined intensivist/respiratory medicine and a specialist grade doctor who was closely supported by the other consultants.
- Consultants worked in regular patterns during their rotation in critical care. FICM Core Standard 1.12 recommended a pattern of working in a block of days, followed by days of rest. The consultants covered the unit in blocks of four days on duty, followed by three days of rest. The FICM recommended that one consultant cover no more than 14 patients. As the unit only had 12 beds, this met this standard at all times. In accordance with the standards, consultants did not have any other clinical commitments while covering the unit. This was with the exception of reviewing potential new patients in the emergency department or attending cardiac arrest calls if required. All consultants lived within 30 minutes, which met FICM standards.
- There was a team of junior doctors supporting the unit, although the number did not always meet the recommended levels. The FICM Core Standard 1.13 recommended a ratio of one junior doctor for every eight patients. As the unit had a maximum of 12 patients, this meant there should be two resident doctors at all times. Three junior doctors worked from 8.30am to 6.30pm, one from 8.30am to 9pm (this was the doctor allocated as the resident doctor for the shift)

and a further worked from 12 noon to 10pm. This demonstrated there was adequate cover at these times to meet standards. It also provided daytime support for the outreach nurse on duty, or to enable review of potential new admissions in the emergency department. However, only one resident junior doctor covered the unit overnight between the hours of 10pm and 8.30am.

Major incident awareness and training

- The trust provided training in health and safety, which included major incident training. As of 20 January 2017, 85.3% of nursing staff were up to date with this training. The trust did not report on compliance for medical staff specific to the intensive care unit, but for medical staff in the anaesthetics department where the doctors working in intensive care were included. Compliance with major incident training for this group of medical staff was 90% against the trust target of 80%.
- Staff had practised their roles in major incidents. There had recently been major incident simulation training on the unit, and further training was planned each quarter. Senior nurses had a clear overview of evacuation plans and knew where to find instructions to follow in the event of a major incident.



Good

We rated effective as good because:

- There were experience nursing and medical staff who were supported with training and personal development.
- The service monitored patient outcomes and these were good when compared nationally and to other similar units.
- The service provided 24-hour outreach to the rest of the hospital seven days a week.
- There was an effective service to assess and provide timely treatment for patients admitted with sepsis or acute kidney injury.
- There was access to 24 hour-diagnostic services seven days a week.
- There was access to information required to deliver effective care and treatment.

However:

- Provision for therapy services did not meet national standards. There was insufficient physiotherapy and dietitian support and limited support from other therapies.
- Clinical guidelines were not always reviewed in a timely manner to ensure these met with best available evidence.
- The annual reviews of the nursing staff were not carried out with sufficient staff to meet the trust's target.

Evidence-based care and treatment

- Care and treatment were delivered in line with best evidence-based guidance; Physiotherapists provided follow up for patients who had been on a ventilator when they were discharged from critical care. However, patients were not provided with a rehabilitation 'prescription' when they left the unit. NICE guidance CG83: Rehabilitation after critical illness, recommends patients should be given this document when they are discharged. This document would provide the admitting ward or continuing healthcare professionals with guidance on the patient's future rehabilitation needs.
- Each bed space had a folder with evidence-based guidelines. However, these guidelines were not dated and there was no indication of when they were last reviewed and updated. This meant there was no assurance that the most recent evidence-based guidance was always followed.
- The department had recently appointed a clinical psychologist to support patients on the unit, patients attending follow-up clinics, and support for staff. The person was due to start in April 2017.
- The service had protocols in line with National Safety Standards for Invasive Procedures for most all invasive procedures undertaken on the unit, and some were under development. The service had also developed a safety checklist in line with the World Health Organisation guidance, although this was not yet implemented.
- Staff carried out assessment of delirium for patients admitted to critical care, as is best practice and recommended by the Faculty of Intensive Care Medicine (FICM). 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 relatively common experience in critical care units. The unit

followed the FICM core standard 1.3.3 in screening all patients for delirium. Patients were screened on admission and a reassessment was carried out every 24 hours at least, or sooner should a patient's mental status appear to have deteriorated.

- The trust had an acute sepsis and kidney injury service (ASK). Two band 5 nurses from the critical care unit divided their working hours between the ASK service and the critical care unit. This service was set up to ensure the trust met national targets and those set by the clinical commissioning group, to detect and treat patients presenting with signs of sepsis/kidney injury. Sepsis is a potential life-threatening condition, which requires early detection and swift treatment to avoid patients' deteriorating. The specialist nurses worked with staff on general wards and in the emergency department to support patients with timely treatment when they were admitted. They also delivered teaching to staff about signs, symptoms and treatment. The specialist nurses used a clear and evidence-based flow chart to obtain information and provide guidance about treatment. This flow chart also included early detection of acute kidney injury and guidance of tests and treatment to treat this.
- Critical care participated in the National Organ Donation programme led by NHS Blood and Transplant (NHSBT). The service followed National Institute for Health and Care Excellence guidance CG135 on organ donation and had policy documents to support this. 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 the critical care consultant lead as the clinical lead for organ donation. There was a specialist nurse for organ donation employed by NHSBT. They were part of the South West NHSBT team, and visited the unit every week or when appropriate to do so. We reviewed data about organ donation in the six months from April 2016 to September 2016 and found the service had been involved with four patients eligible for organ donation of which all four (100%) went on to become organ donors. This was higher when compared to the England average (49.5%) and similar units (62.1%).
- However, national standards were not always achieved. The service did not meet the National Institute for

Health and Care Excellence (NICE) guidance CG83 (2009) (rehabilitation after critical illness in adults) and the Faculty of Intensive Medicine Core Standards (FICM, 2013 and 2015) for the support from allied healthcare professionals. This was entered on the service's risk register in January 2016 and although regularly reviewed there was not a satisfactory outcome to this.

- FICM standards recommend that patients receiving rehabilitation be offered a minimum of 45 minutes of each active therapy required for a minimum of five days a week. Of these therapies, physiotherapy is one of the principles and most consistent therapy services for critical care, and should include rehabilitation strategies to optimise patients' physical capacity and reserve. Standards suggest staffing levels are one whole time equivalent (WTE) physiotherapist for every four patients. However, critical care did not have a dedicated physiotherapist. It was therefore possible that patients could be seen by different physiotherapists and continuity might not be assured.
- Physiotherapists were not actively involved with the process of weaning patients from ventilatory (breathing) support. Physiotherapist involvement is a recommendation of the FICM Core Standards. There were also no set weaning protocols or guidance for patients who were on a ventilator (breathing machine). However, this procedure was consultant-led and patient orientated.

Pain relief

- Those patients we were able to talk with said their pain was being well managed. When patients experienced physical pain or discomfort, staff responded in a compassionate, timely and appropriate way. Patients told us staff regularly checked to make sure they were comfortable. When a patient used a call bell if they were experiencing pain, the call was responded to promptly by staff, who addressed the patient's needs appropriately.
- There was consideration for patients who were unable to communicate if they were in pain. Communication aids included a picture board to help identify pain in different parts of the body. Staff used recognised pain scoring tools to ascertain the severity of pain and to assess the effectiveness of pain management. For patients who were ventilated (receiving assistance with breathing) staff observed for physical signs of pain such as raised blood pressure or facial expressions. Coupled

with that, medical staff prescribed a low-dose continuous pain relief infusion to ensure these patients were not in any discomfort that could not be otherwise recognised.

• Staff had access to a specialist pain nurse and this service was used effectively to help manage patients with severe, long-term or chronic pain. The specialist pain nurse provided a clear management plan for patients, and support for nurses of how best to provide efficient pain relief. This met the recommendations of the Faculty of Pain Management Services (2015).

Nutrition and hydration

- Staff evaluated patients' nutrition and hydration needs both on admission and in daily reviews. Staff monitored patients' nutrition and fluid intake, recorded and calculated patients' cumulative or overall fluid balances. Patients who were unable to eat and drink themselves were supported with nasogastric or parental nutrition. They were referred to dietitians for review and ongoing assessment of nutritional needs.
- However, the service did not meet recommended levels of dietitian support. Patients in critical care are at high risk of malnutrition or from the reintroduction of high-quality nutrition. For this unit, recommended levels of dietitian support would equate to between 15 and 30 hours per week. A dietitian told us they had just 2.5 hours a week to review patients in critical care. This meant there was limited time for any teaching, development of protocols, or nutrition-related audits. There were criteria for referrals to dietitians for nurses to follow when looking after critical care patients.
- Access to the speech and language therapy services met patient needs. The Faculty of Intensive Care Medicine (2015) Core Standard 1.3.2 states that all patients with a tracheostomy (an incision in the windpipe made to aid breathing) should have their communication and swallowing needs assessed by a speech and language therapist (SALT), when the decision to wean from the ventilator had been made. This was added to the service's risk register in January 2016, but had been closed without funding for the 0.2 whole time equivalent speech and language therapy support. However, clinical leads confirmed all patients with a tracheostomy were referred and seen by the SALT team who were flexible to meet demands.

Patient outcomes

- The service monitored patient outcomes and compared these to outcomes achieved nationally. Staff collected and submitted continuous patient data to the Intensive Care National Audit and Research Centre (ICNARC). Data contribution therefore met the recommendations of the Faculty of Intensive Care Medicine Core Standards (2013): 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 critical care units 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. Senior nursing and medical staff spoke with confidence about the value of the ICNARC data. Monthly ICNARC information was displayed for all staff to view with a brief evaluation of the outcomes.
- Few patients were discharged before they were ready to leave. Data showed fewer than average numbers of patients were readmitted to the unit within 48 hours of discharge to a general ward. We looked at the ICNARC report covering the period from April 2016 to September 2016 to enable us to compare readmission rates with the England average and that for other similar units. The readmission rate was 0.6%. This was lower than the national average (1.2%) and when compared to similar units (1.1%).
- Mortality levels for patients admitted to critical care were close to predicted levels when looking at trends for the past five years. The likelihood of a patient dying was calculated through ICNARC data using a predictive 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. We looked at data between April 2016 and September 2016 (the latest available data), the result was 0.98. Any number below one shows a result better than predicted levels. This was similar to and slightly better than the national average and when compared to similar units respectively.
- The service undertook local audits such as pneumonia screening, 'time of admission' audits, and management of delirium. Audit results were presented and discussed in regular departmental business and governance meetings as a regular agenda item. Staff were informed of outcomes in staff meetings and from displays on notice boards in staff rooms.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. However, there was a lack of overview with regards to nursing staff annual competency and equipment competence. The service had secured funding for a clinical nurse educator for six months. This was shared between two members of nursing staff and equivalent to 0.8 of a fulltime post. Both the clinical nurse educators had a recognised teaching qualification. The clinical nurse educators were collecting information about staff qualifications, competence and equipment assessments and compiling a database for appropriate staff to access in their absence if required. We reviewed compliance with equipment competence assessment prior to the inspection, which demonstrated some gaps. However, the data we reviewed was not up-to-date and we saw an updated version when we visited the unit. There were plans to bring in a mandatory annual equipment competencies register for all nursing staff as part of the annual appraisal process. There were also plans for a structured programme for training of all staff, to be involved with recruitment and induction and to provide scenario training for all staff. There was appropriate concern about getting new nursing staff skilled and experienced and with succession planning for senior nurses approaching retirement age. However, senior medical and nursing staff felt optimistic about the future teaching and assessment of nurses with the appointment of the clinical nurse educators.
- The service used the national competency framework for adult critical care nurses to enhance the skills and knowledge of nursing staff. The framework provided step one, two and three competencies designed to support nurse development from novice through to competent and independent practitioner. The service used step one as a foundation framework for competency teaching and assessment for new nurses. Nurses on the post registration course in critical care undertook levels two and three.
- There was an experienced nursing team in critical care. There were 35 registered nurses who had completed a post registration course in critical care nursing. This represented 53% of the total registered nurses and was in line with recommendations from the Faculty for Intensive Care Medicine (FICM, 2015) for there to be at least 50% of the nursing team with this qualification. At
the time of our inspection, with a further three nurses on the critical care course, which once completed would increase the proportion of nurses with a post registration course in critical care to 57.5%.

- The service had an outreach team and was complaint with the Faculty of Intensive Care medicine (FICM, 2015) Core Standard 2.1. The outreach team was fully staffed and provided 24 hour support. The nurses all held a post registration course in critical care, advanced life support and most also held a recognised teaching qualification. However, only one nurse had completed a post registration course in physical assessment, clinical examination and clinical reasoning.
- The service admitted children to the unit for stabilisation prior to transfer to a paediatric intensive care unit. This was outlined in the unit's admission and discharge policy (2017). The unit had a list of nursing staff with a paediatric qualification either at diploma or degree level, and the staffing rota was planned to ensure at least one of these nurses were on duty at all times. However, most of these gualifications had been obtained by staff between 1992 and 2014 and there was little evidence of recent training or competency assessment of paediatric nursing. Of the nursing staff, 77% had completed paediatric life support and 68% of medical staff. However, staff were not trained in immediate or advanced paediatric life-support. To mitigate this, the admission policy clearly stated that a consultant paediatrician should attend when a child was admitted to the critical care unit.
- Not all staff had been given their annual performance review (appraisal). The service provided annual appraisals for all staff and the trust had a target of 80% compliance. Between January 2016 and December 2016, 100% of healthcare assistants and 83% of clerical staff had received an appraisal. However, only 60% of registered nurses had received their formal annual review, and the service was therefore not meeting the trust's target overall. The trust provided support for nurses with revalidation processes as required by the Nursing and Midwifery Council (2016). In the past 12 months, 23 nurses had successfully completed the revalidation process.
- Appraisals for consultants across the planned care division (the division in which critical care sat) was 69%. Appraisals for medical staff in the planned care division

was 72% with 22 doctors not compliant with appraisal and 15 doctors more than three months overdue for their appraisal. We were not provided with data specific to medical staff working in critical care.

- There was a good induction and orientation programme for new nursing 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 orientation pack. New starters worked under the guidance of a mentor who was required to review their competencies as they worked through them.
- The service did not meet standards and recommendations for skills and competence of allied healthcare professionals as outlined by the Faculty of Intensive Care Medicine (FICM, 2015). The Faculty of Intensive Care Medicines (FICM) recommends physiotherapy in critical care be led by a senior clinical physiotherapist with suitable post-registration experience and/or qualifications. The service did not have a designated physiotherapist or physiotherapist lead. The FICM also recommends the dietitian is at least a band seven grade. However, we were told the dietitian who treated patients in critical care was a band six.

Multidisciplinary working

- There was good evidence of multidisciplinary working. We observed a morning round for all patients in critical care, with attendance of a physiotherapist, pharmacist, medical and nursing staff. We observed other specialist nurses review patients in critical care, including the specialist pain nurse, stoma nurse, and the diabetes specialist nurse. Referrals were also made to social services by staff when complex discharges for patients were anticipated.
- Medical staff ensured patients were seen by a specialist consultant best suited to their needs. Surgical patients were seen every day by the appropriate surgical consultant, and staff referred patients to medical consultants, depending on the primary diagnosis on admission.
- There was good support from the pharmacist services. A pharmacist attended the ward round in the mornings and reviewed prescription charts as required. There was a plan to introduce electronic prescribing in the critical care unit to bring the unit into line with the general wards in the hospital. The rollout elsewhere happened

in stages, but the critical care unit was yet to be involved. Prescription charts were in paper format on the unit but when patients were discharged to general wards, these were replaced by electronic records.

- The critical care outreach team provided care and treatment to patients in general wards as required. The service was fully staffed and had provided 24-hour cover since January 2017. The team received referrals via telephone from staff on wards who were concerned about patients that showed signs of deterioration in their vital observations. The outreach team had visited and assessed an average of 171 patients per month since January 2017. The outreach team also followed up patients that had been discharged to a general ward from the intensive care unit.
- Medical staff from critical care supported the outreach team if patients were referred to the unit, and assessed patients in the emergency department on request.

Seven-day services

- There was a consultant intensivist on call 24 hours a day, seven days a week. Consultants told us they stayed in the hospital or on the unit as long as they were required in the evenings to ensure patients were stable. All consultants lived within a 30 minute journey from the hospital if they were at home at night. The on-call consultants were in the hospital from 8:30am to 2:30pm at weekends or longer if required and came in to review patients again in the evening between 6pm and 9pm.
- There was access to diagnostic services such as X-ray, magnetic resonance imaging (MRI), computerised tomography (CT scan) and endoscopic investigations seven days a week.
- There were arrangements for pharmacist cover across the whole week. A pharmacist attended the unit on weekdays and there was an on-call pharmacist out of hours and at weekends.
- However, therapy staff were not available routinely at weekends and 24-hour cover was limited. There was not a designated physiotherapist on the unit, and at weekends, patients received limited rehabilitation physiotherapy.

Access to information

• Information needed to deliver effective care was available and accessible. There was a range of protocols

and policies available via the intranet and staff knew how to access these. Patient documentation and paperwork were easily available for all commonly used care plans and referral pathways as required.

- Staff shared important information about patients with staff on the receiving wards when patients were transferred. Staff in critical care used a discharge pack to ensure all relevant information was handed over to staff on the receiving ward. The discharge pack included a discharge checklist, a National Early Warning Score chart (a chart used for the recording of patients' vital observations, which enables staff to detect deterioration in patients' conditions), fluid balance chart, and a nursing discharge summary. Medical staff provided a discharge summary, which was filed in patients' notes and sent a copy to the patient's GP. Medical staff contacted appropriate doctors when patients were well enough to be transferred to general wards so they were able to receive the patient into their care.
- When patients were admitted, staff requested old medical notes from the medical records department.
 Outside of normal working hours and at weekends, staff contacted the site management team, who could provide access to notes if required.

Consent and Mental Capacity Act

- Staff had a good understanding and application of the Mental Capacity Act 2005 (MCA) and of the Deprivation of Liberty Safeguards (DoLS). However, not all staff were up-to-date with their mandatory training in these subjects. The trust provided mandatory training in relation to the MCA and DoLS. Between April 2016 and March 2017, staff met targets for MCA training (82%), but only 69% had completed this against a target of 80% for DoLS.
- The trust had a DoLS and MCA policy, which included the necessary documentation for assessment, and information for staff to ensure best practice was adhered to. Staff worked with the trust's policy, and had applied the DoLS policy appropriately in an example we saw. Senior staff were aware of how to complete a DoLS application and all staff knew how to access support if required. One of the senior nurses acted a link nurse for MCA and DoLS, and attended specific training and meetings to ensure they were well informed to support other staff members.
- Staff gained patients' consent for care and treatment interactions when the patient was physically and

mentally able to provide this. We observed staff asking patient for their consent before any care or treatment interventions were carried out. Staff also documented that verbal or implied consent was obtained, in patient records. If patients were unconscious or in clinical emergencies, staff acted in accordance with legislation and in the best interest of the patient.

Are critical care services caring?



We rated caring as good because:

- Staff cared for patients with compassion and kindness. Staff treated patients with respect and dignity at all times.
- Staff ensured patient confidentiality was maintained.
- Patients were involved as partners in their care.
- Relatives felt well informed and were involved in decision-making. Staff explained information in a manner that people could understand and answered questions.
- Patients and their relatives praised the care and treatment provided. They told us staff were kind and friendly.
- Patients at the end of their life, and their relatives, received compassionate care from staff.
- Staff held follow up clinics for some patients and encouraged the use of patient diaries.

Compassionate care

- Patients and relatives spoke highly of the care and compassion demonstrated by staff. Patients felt safe and well supported. Comments from patients we spoke with included: "Can't fault the care I have been given."; "They (the staff) are miracle workers."
- Staff interacted effectively with patients and demonstrated good communication skills. We observed staff introduced themselves to patients and their relatives. Staff took time to answer questions from patients and their relatives and ensured the information had been understood.
- Staff took time to interact with patients and demonstrated kindness, understanding, respect and ensured patients' dignity at all times. Staff were considerate and respectful in the manner they attended

to the needs of their patients. There was a presence of a nurse close by at all times. Each room had curtains, which were drawn to ensure patient dignity when care interventions were carried out.

• Staff received many positive letters of thanks. The theme in the seven cards we read received by the unit from November 2016 to March 2017 were of real gratitude for the manner in which staff cared for both patients and their relatives. One former patient sent staff a card on the anniversary of their discharge from the critical care unit. They expressed how such was the positive impact of the care they received, that they were thankful even a year after they were discharged.

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. Staff were respectful and considerate to the needs of patients and their families and answered questions they asked.
- Patients said they felt they had been involved in decisions about their care and treatment as much as they were able to be. If patients had questions about their treatment, nursing and medical staff answered these with honesty and compassion, taking the time to ensure the patient and their relatives had understood the explanation given.
- Relatives told us that staff kept them informed and involved. Staff ensured visitors were identified and only gave information they were entitled to have. Visitors were asked to wait in a visitors' room and those we spoke with stated they understood if there were delays before they could visit their relative, but that they did not wait long.

Emotional support

- Staff provided emotional support for patients and their relatives. We saw how staff cared for a patient at the end of their life. We saw that staff had compassion and treated the patient with dignity. They ensured there was privacy for the family to be with the patient. We reviewed 'thank you' cards from bereaved relatives. Relatives described the care as outstanding and one said: "... felt lucky that in their darkest hours, there was a team of people who were dedicated and cared..."
- The service had been successful in the appointment of a psychologist two mornings a week from April 2017. The

role of the psychologist was to support patients with their emotional needs, participate in follow up clinics, and support a bereavement group set up by two nurses. This group was still in its infancy, but included the two nurses sending out a card to bereaved families and followed this up with a telephone call.

- Staff encouraged the use of patient diaries for patients who were on a breathing machine for more than three days. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances after discharge. Diaries can provide comfort to patients and their relatives both during the stay and after the patient returns home. They not only fill the memory gap, but can also be a caring intervention to promote holistic nursing. Staff gave the diaries back to patients when they attended a follow up clinic. If patients did not want to attend a follow-up clinic, staff sent out the diaries via the post if patients wanted them back.
- The trust provided a chaplaincy service and a dedicated space was set aside for quiet contemplation elsewhere in the hospital. The chaplaincy service could facilitate contact with a minister of any faith or support from a layperson. Staff knew how to access this service if required.



We rated responsive as good because:

- The provision of the service met the needs of most people.
- Patients' individual needs were met wherever possible.
- Patients had access to care and treatment as it was needed.
- Patients and their relatives were encouraged to provide feedback about care and there were few complaints.

However:

- There was a slightly higher than national average of delayed discharges. However, this did not mean patients were not provided with care when it was needed.
- Patients were occasionally transferred to general wards at night when this is recognised as not an optimal time to move any patient.

Service planning and delivery to meet the needs of local people

- The service met the needs of local people. The unit admitted approximately 900 patients a year. If patients were admitted with conditions that required specialist treatment, there were arrangements in place to transfer patients to another NHS hospital that could provide this specialist care. The service had not transferred any patients to other critical care units for non-clinical reasons in the last 12 months.
- The critical care unit was located adjacent to the operating theatres with an interconnecting corridor. This meant staff could transfer patients who need critical care treatment postoperatively effectively and in a timely manner. The Department of Health recommended critical care was co-located with the emergency department, but this was some distance away. This arrangement was not, however, atypical of other NHS hospitals, where critical care was more likely to be close to the operating theatres than the emergency department.
- The critical care unit met most of the recommendations of the Department of Health: Health Building Note 04-02 (2013). However, there was not a reception desk within the unit for visitors. The ward clerk worked from a desk in the main unit, where they could answer phones, answer the intercom system and monitor CCTV. They also went to the main entrance to the unit, to greet visitors. The ward clerk did not work fulltime, and when they were not at work, nurses collectively took on these responsibilities.
- Staff could arrange access to a home ventilation and weaning unit. This was a service designed for patients who had complex ventilation needs, and were able to be supported at home. However, this was not a regular requirement for patients in this service, and had not been needed in the last couple of years.

Meeting people's individual needs

• The service took account of individual patients' needs. Needs were assessed as part of the documentation framework used on admission and as ongoing assessment of patients' condition and recovery. This included obtaining information about patients' communication needs although it was not always completed. Senior staff had identified this and made it a focus for development. There were information

displayed in the staff room and certain parts of the admission documentation was outline with a high lighter to encourage and remind staff to complete the section. This was in line with the Accessible Information Standards (2015) which directs and defines a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

- Staff had access to a translation service and was aware of how to access this. The trust had engaged third-party services providing face-to-face, telephone, and written translation services.
- There were arrangements to provide support to patients with cognitive impairment or additional communication needs. Staff had access to picture boards, pictorial alphabets, or would encourage patients to write questions down if they were able to. Staff received training in dementia awareness and records demonstrated that 81% of nursing staff and all medical staff had completed this.
- 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. Patients needing renal replacement therapy for acute kidney injury were treated on the unit, and not transferred elsewhere for this specialist therapy.
- All patients received care and treatment in single rooms, which allowed for optimum privacy and dignity. There were arrangements for patients the opportunity to watch television, DVDs or listen to the radio if they wanted to. There was information on the trust's website about visiting times for visitors. People were encouraged to visit in the afternoons when possible, as the mornings were often busy with ward rounds. There were otherwise no restrictions for visitors in order to accommodate the best interests of the patients and their loved ones.
- Dedicated staff provided access for patients to attend a follow-up clinic. Critical illness may leave patients at risk of long-term physical and psychological problems, and follow-up clinics can have a fundamental role in assessing long-term outcomes. The follow-up clinic was for patients who had been ventilated (on a breathing machine) for more than 72 hours. Staff invited patients and their relatives or friends to attend a clinic around six months after their discharge. A questionnaire was given

in advance for the patient to complete as a focus for discussion. It also provided an opportunity for the patient to revisit the critical care unit if they wished to. When patients were discharged from the unit, staff wrote a letter to their GP to inform them of any long-term issues or recommendations. This was in line with recommendations from the Faculty of Intensive Care Medicine and guidance from the National Institute for Health and Care Excellence (NICE) guidance.

• Patients were complementary about the food and said staff offered them fresh and/or hot drinks 'all the time'. We saw that patients' drinks were within easy reach.

Access and flow

- Patients were treated in a timely manner. Between March 2016 and March 2017, four patients had a delayed admission. We reviewed four medical records and found patients had been admitted within four hours of referral in line with recommendations form the Faculty of Intensive Care Medicine (FICM, 2015) standard 2.3.
- The unit recorded bed occupancy. 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. Staff recorded a monthly snapshot of how many of the critical care beds were occupied at that time. Between January 2016 and December 2016, the occupancy varied between 60% and 85%. Four of the 12 months were lower than the England average with the others slightly above.
- A consultant in intensive care medicine reviewed patients within 12 hours of admission to critical care in line with FICM (2015) Core standard 2.6. The rotas for the consultants meant an intensivist was in the unit from 8.30am to 9pm.
- There were a slightly higher than national average of delayed patient discharges from the unit. FICM (2015) standard 2.11 recommend patients are discharged from an intensive care unit to a general ward within four hours of the decision. ICNARC data provides the opportunity for critical care units to compare data to other and similar services. We reviewed data from April 2016 to September 2016 (the latest quarterly quality report available at the time of inspection) and found the service reported 6.8% of patients were discharged more than eight hours after the decision to discharge was made. This was slightly above (worse than) the average

for all units (5%) and that of similar units (5.9%). Staff did not always report this as an incident. The service had processes to ensure patients could be discharged in a timely manner once a bed was available on the receiving ward. The service reported no non-clinical transfers from the unit to other intensive care services in other hospitals between January 2016 and March 2017.

- Patients were not always discharged at the right time for the patient, although this was similar to the national average. Data showed seven patients (2%) were discharged from the unit between the hours of 10pm and 7am. This was similar to other (2%) and similar critical care units (2.5%) when reviewing data from April 2016 to September 2016.
- Although there were challenges with patient flow, patients were staying on the unit for a similar length of time when compared to the national average. Research shows that it is sub-optimal for patients in social and psychological terms, to remain in critical care for longer than necessary. ICNARC data reported the average length of stay for surviving patients between April 2016 and September 2016 (the latest available data) was 3.4 days. This was below (better than) the national average of 4.4 days, and when compared to the average for other similar units (3.8 days)
- There were escalation procedures for managing patients when the unit was full. The service had a patient admission policy, which set out the referral process for patients being considered for admission to the unit, and arrangements for escalation if there were no beds available in critical care. We observed a daily operational site meeting where availability of beds was discussed. This ensured the hospital regularly reviewed bed occupancy and flow issues in the unit.

Learning from complaints and concerns

- The service listened to people's concerns and complaints and these were used to improve the quality of care. Between February 2016 and January 2017, there were three complaints about critical care. We reviewed how the service dealt with complaints and found that these were dealt with efficiently and timely. If there was anything learning or changes to processes following complaints, these were identified and actioned to ensure service improvements.
- Patients and their relatives were encouraged to provide feedback about their care, treatment and experience. Staff were aware of how to support people if they

wanted to make a formal complaint and would refer them to the trust's patient liaison team. Information about how to make a complaint was also available on the trust website.

Are critical care services well-led?



We rated well-led as good because:

- There were clear governance and risk management processes in place.
- There was strong leadership and teamwork.
- Staff were encouraged to take different roles to enhance patient care and personal development.
- The views of patients and their relatives were valued, and shared with staff. There was evidence of improvements from feedback.
- The service supported innovation and improvement projects to enhance patient care, treatment and experience.

Leadership of service

- There was a strong leadership of the service. There was clear evidence that medical leads and nursing leads worked well together to review and improve service delivery. Medical and nursing staff attended meetings and leaders listened to suggestions about service improvement. However, although members of the therapy team attended the multidisciplinary ward round there was otherwise limited input from therapy staff to the leadership team. Therapy staff were managed by senior allied health professionals in the trust, which is not unusual. However, they were not always actively contributing to service improvement initiatives or involved in critical care unit meetings. However, this was primarily due to the limited time they were assigned to review and treat patients in critical care.
- Nursing staff felt well supported by their team leaders and the senior nurses. They said they were experiences, knowledgeable, and supportive. Senior nurses felt well supported by the matron who was approachable for all staff if needed. Junior medical staff felt supported by consultants at any time if they had concerns about patients or other clinical areas.

- There was still some work in progress to ensure the optimal leadership for the outreach service. At the time of our inspection, the outreach service was managed by the matron until the leadership structure had been finalised.
- There were regular staff meetings and displays on notice boards were regularly updated to reflect current issues. For example, there was a display of February's performance data (ICNARC data and harm free care). In the staff room, there was a notice board about service improvements such as reminding staff to now use the safety checklist for tracheostomies.
- Staff told us the Divisional Director of Nursing visited the unit regularly, although they saw members of the Executive Team less often.

Vision and strategy for this service

- Since our last inspection, there had been changes to practices and a focus on improvement to the delivery of care and treatment. Senior managers told us there was still some work to do but that areas for improvement had been identified and there was a vision and strategy to resolve these. The overall aim was consolidate and embed new practices and to continue with service improvement.
- Staff told us there was a "different feel about the place", that there was a "buzz" around improvements, and practices were being reviewed and improved where this was needed.

Governance, risk management and quality measurement

• Changes to the governance framework meant there was now an effective structure in place to support the delivery of good quality care. The governance framework and strategy had been revised, and staff were aware of the new structure and the different roles within the framework. This had been discussed in departmental meetings, and there was a display in the staff room. The new framework concentrated on five themes: 'Has care been safe in the past?' (Incident reporting and feedback, complaints and mortality and morbidity reviews); 'Reliable clinical systems' (audits, protocols and improvement projects); 'is care safe today?' (shift safety briefings, ward rounds, staffing levels); 'Preparedness' (mandatory training, specialist training, research, monitoring of sickness and absences); 'Dashboards' (risk register, divisional governance and ICNARC data).

- There was a clear structure of how information fed into a departmental monthly business and governance meeting. We reviewed the minutes of meetings from January to March 2017. The minutes were organised with a set agenda to ensure all areas were discussed and actions were followed up. We also reviewed minutes of meetings from monthly planned care division board meetings from December 2016, February and March 2017. Although these minutes of meetings were less structured and informative, there was evidence that matters pertinent to the critical care unit was also discussed at this level regularly.
- There were regular team meetings. The matron held monthly meetings with the senior nursing staff. We reviewed minutes of meetings from December 2016 and January 2017. There was a set agenda but information was not always available or shared for all agenda items. For example, we noticed there was no feedback to senior sisters from the divisional board in either of the meetings. This meant we could not be assured that information from divisional level was always shared effectively.
- Monthly staff meetings were not always well attended and not all agenda items were discussed in meetings. Senior sisters chaired these meeting and there was a set agenda to ensure a standardised approach and that relevant governance, quality and safety items were discussed. We reviewed minutes of staff meetings held in February and March 2017 (total of three meeting minutes). The minutes were structured and informative however, there were several agenda items that were not discussed included audits and feedback from divisional meetings. This meant that we could not be assured that information was always shared effectively with all staff. These meetings were not always well attended with only between ten to 15 members of staff attending from 68 members of staff. However, minutes of meetings were available in the staff room for staff to read if they could not attend the staff meetings.
- There was a comprehensive risk register for the service. This demonstrated identified actions to mitigate risks and that progress against the actions were regularly reviewed. Risks were assigned to a risk owner/manager,

and target dates for completing or reviewing actions were identified. The risk ownership demonstrated that nursing and medical staff worked together to review and manage risks within the service.

Culture within the service

- The culture within the service encouraged candour, openness and honesty. There was a strong sense of teamwork and staff told us they worked well together. Care and improvements were patient focused and there was support for training and development. Staff were able to raise concerns about care, felt listened to and felt empowered to suggest service improvement ideas. Staff told us they felt positive about their work and service development on the unit.
- The matron and the medical leads were proud of the improvements in the delivery of care. They were complimentary about the way patients were cared for and of the dedication of all staff.

Public engagement

- The service gathered the views of people through feedback cards, compliments and complaints. The views of relatives and others vising the unit were shared with staff. Information from feedback was also displayed on a notice board in the main corridor. This held information about safe care, nursing staff levels on duty, and any compliments or concerns raised from visitors in the last month.
- Feedback from patients was good. Some feedback was provided by patients completing the NHS Friends and Family Test. However, this feedback was more generally requested when the patient was discharged home, and that was usually from a general ward. To increase patient feedback, staff gave patients a pink card to comment about the care they had received specifically in the critical care unit. The ward clerk collated the feedback and ensured staff received the responses. We looked at feedback from 51 patients between October 2016 and December 2016. Patients were asked if they were likely to recommend the unit to friends and family if they needed similar care or treatment: Fifty patients 'agreed a lot' and one patient 'agreed a bit'. The pink card offered patients the opportunity to highlight good practice and areas for improvement. Overall comments were complimentary about staff and care on the unit, with only six suggestions for improvement. Two comments suggesting improvements were related to

the menu, one to used mugs left in the room used for consultants speaking with relatives, one to equipment for personal hygiene, one patient had difficulty hearing what was said, and one patient felt the doctors could improve by always introducing themselves.

- Feedback from patients and visitors had improved the service. For example, the service said it had ensured housekeeping staff check the relatives' waiting area and consultation rooms regularly to ensure they were clean and tidy.
- There was information for visitors displayed in the waiting room. There was a display in the corridor with patient information leaflets about various health issues and useful information about the service and the hospital.

Staff engagement

- Nurses of all grades told us they felt respected and valued. They were encouraged and supported to take on different roles to develop the critical care service and for their professional development. For example, there were two nurses working in the sepsis and kidney injury (called ASK) service. There were three nurses who spent some of their time working on Intensive Care National Audit and Research Centre data. The two nurses who ran the follow-up clinic did this in their own time, and were then given time off in lieu to suit them and the staff rotas. However, while this demonstrated willingness and positive input from staff, it was not a sustainable solution in the long term.
- The service encouraged staff engagement. Staff had submitted photographs of their pets to a competition in the critical care unit. The winning entries were enlarged and printed on canvas and displayed on the walls in the visitors' waiting area.
- Staff had a closed social media application to share information and alert staff of unfilled shifts available for extra hours. Staff felt this was a useful way to fill shifts at short notice if there was staff sickness. Staff said, however, this did not make them feel obliged to volunteer for extra shifts if they were not able to work.

Innovation, improvement and sustainability

- The service had introduced improvements since the last CQC visit. These included:
- New equipment for insertion of tracheostomies based on national guidance and to ensure best practice.

- Introduction of daily safety briefings before the multidisciplinary ward round in the mornings.
- Provision of outreach services 24 hours a day, seven days a week.
- Enhanced focus on teaching and learning with the appointment of a clinical nurse educator role although this was only for six months. There was also increased teaching from the governance consultant lead.
- There was a better understanding of the importance and engagement with the assessment of patients for delirium.

- The service had appointed a clinical psychologist to support patients and staff.
- In line with national recommendations, the service had secured funding to ensure the nurse-in-charge was able to coordinate the shift, and not assigned to care for an allocated patient.
- Staff engaged with the local critical care network and visited other critical care units to share practice and evaluate effective ways to introduce service improvement.

Safe Requires improvement Well-led Requires improvement Overall Requires improvement

Information about the service

The Great Western Hospital provides services for children and young people living in Swindon and Wiltshire. Inpatient services are provided for children and young people, up to 18 years of age, with medical, surgical, ear nose and throat, ophthalmology, dermatology and orthopaedic conditions. The hospital ward also provides care for children with complex and chronic illnesses, many of whom require investigative or day care treatment.

The children's unit, which provides care for children and young people, consists of a general ward, Paediatric Assessment Unit, a local neonatal unit known as special care baby unit (SCBU) and an outpatient department. Children and young people are also cared for in other areas of the hospital depending upon their needs. A children's outreach nursing service is also based at the children's unit. The service provides nursing support at home for children living across Swindon and Wiltshire.

The Shalbourne Suite is a ward for patients who are privately funded. It is located in a separate part of the hospital and children aged 12 to 17 years can receive care as day cases in this area.

The general paediatric ward has 20 beds that are arranged in three, four-bedded bays, and eight cubicles. Two of these cubicles could be used for admissions as high dependency rooms for children if staffing levels allow. The ward provides facilities that enable parents to stay with their child overnight. The ward also has a schoolroom with teaching staff that allow children to receive education during their hospital stays.

The Paediatric Assessment Unit (PAU) is adjacent to the general ward and was opened in 2014. It provides rapid access for GP referrals for children and young people to gain urgent advice from paediatricians without having to attend the hospital's emergency department. It is open from Monday to Friday between 10am and 10pm. The Special Care Baby Unit (SCBU) provides care and treatment for babies who are born prematurely, have difficult deliveries or are the subjects of other antenatal concerns. The unit has 18 cots, including six high dependency cots. Parents are encouraged to assist with their babies' care whenever possible. Additional SCBU facilities include a playroom for siblings, a breastfeeding and expressing area, a parents' sitting room and accommodation in which parents can sleep.

Children are also cared for in other areas of the hospital; for example, when they need to undergo surgery, when they visit outpatients or radiology, and in the area where dental surgery is undertaken. At times they are cared for in the intensive care unit.

We spoke with 44 staff members including nurses, consultants, medical staff, managers and support staff during our inspection. We also spoke with the parents of six children. We visited all paediatric areas, as well as areas in which related facilities were shared with adults. We observed care and examined care records and other documents in all inspected areas.

The Great Western Hospital admitted 5,504 children and young people to the children's unit between November 2015 and October 2016. 95.1% of admissions were emergency admissions, 4.2% were day cases and 0.7% were elective.

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Summary of findings

This was a focused inspection to follow-up on concerns from our previous inspection in September and October 2015. At this inspection we only inspected the safe and well-led domains, and we rated both of these as requires improvement. We found the trust had not addressed all of the requirement notices from our inspection in 2015 and had remained at requires improvement in the safe well-led domains.

We rated the safe and well-led domains as requires improvement because:

- Nursing staffing levels did not consistently meet recommended levels on the children's unit or the special care baby unit. There were high levels of nursing vacancies. An acuity tool was not being used to review staffing levels on a regular basis, and this placed patients at further risk from understaffing.
- Medical staff in children's services failed to meet the targets for any mandatory training courses.
- There was poor compliance across all staff groups for paediatric basic life support.
- Out of hours medical cover was shared with numerous other areas of the hospital which meant the service did not always have the medical cover it needed to care for children as per recommended levels.
- There was a lack of some basic equipment available to nurses on the children's unit.
- The culture of the service did not promote staff wellbeing. Nursing staff told us they often worked for long periods without a break, or in some cases access to a drink.
- The strategy for the women and children's division was unknown to many of the staff who worked within it.
- The women and children's division felt disconnected with the rest of the hospital, and staff did not feel connected with their leaders. There was no paediatric representative at board level, which compounded this issue.

However:

- There was a positive incident reporting and learning culture. Staff were confident to report incidents and opportunities for learning were recognised and shared.
- We saw examples of positive learning from case reviews that were embedded in practice, and staff at all levels were aware of these.
- There were creative initiatives in place such as consultant-led simulation training, which was well received by staff.
- Staff understood their roles and responsibilities to safeguard children from potential risks or abuse and received supervision on a regular basis. The trust's safeguarding teams worked with community and social care colleagues to identify and support children who may be at risk.

Are services for children and young people safe?

Requires improvement

We found the requirement notices and concerns raised following our inspection in October 2015 had not all been met. We found additional concerns that meant the safe rating remained as requires improvement.

We rated safe as requires improvement because:

- Nursing staffing levels did not consistently meet recommended levels on the children's unit or the special care baby unit. There were high levels of nursing vacancies and a regular reliance on agency and bank staff. An acuity tool was not used to regularly assess required staffing levels on the children's unit, although there was a plan to introduce one. This was raised in the previous inspection.
- There was poor compliance across all staff groups for paediatric basic life support.
- Mandatory training for medical staff in the children's service was below target in all subjects. This was raised in the last inspection.
- Out of hours medical cover was shared with numerous other areas of the hospital which meant the service did not always have the medical capacity it needed to care for children as per recommended levels. This was raised in the previous inspection, but had not been addressed at the time of our visit.
- There was a lack of some basic equipment available to nurses on the children's unit, for example thermometers and tape. Not all equipment was maintained in accordance with guidance, for example heated water blankets did not have expiry dates or water change dates recorded.
- Safeguarding training levels did not always meet intercollegiate guidance, and compliance with safeguarding training did not always meet targets. Staff did not always have ready access to relevant safeguarding notes on a patient's records due to a filing backlog.

However:

- There was a positive incident reporting and learning culture. Staff were confident to report incidents and opportunities for learning were recognised and shared.
- Standards of cleanliness and hygiene were well-maintained and minimised the risks to patients from cross-infection.
- Medicines, with the exception of oxygen, were managed and stored appropriately to keep people safe.
- We saw examples of positive learning from case reviews that were embedded in practice, and staff at all levels were aware of these.
- Staff understood their roles and responsibilities to safeguard children from potential risks or abuse and received supervision on a regular basis. The trust's safeguarding teams worked with community and social care colleagues to identify and support children who may be at risk.

Incidents

- Between January and December 2016, the trust reported no incidents which were classified as Never Events for children's services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The trust reported one serious incident in children's services which met the reporting criteria set by NHS England between January and December 2016. The reported incident was a treatment delay and took place in September 2016. We saw learning from this incident was discussed at governance meetings, with the root cause analysis being shared at a perinatal meeting. Recommendations following this had been implemented at the time of our inspection, for example training was being offered to junior staff by consultants in the recognition of symptoms that could indicate serious illness.
- The women and children's division measured their safety performance regularly. The children's service completed the trust's safety thermometer on a monthly basis. This system recorded incidences of patient harm at a set point each month. However, the incidences that it monitored were tailored to adults in the hospital setting. Therefore, the service used a bespoke safety monitoring system which captured incidents and risks

within the children's service. This information was then used to formulate a monthly clinical risk report. It also fed into the risk register, and was discussed at bi-monthly governance meetings. The children's service did not benchmark its safety performance against similar services.

- Staff understood their responsibilities to raise concerns, record safety incidents, and report them. All staff we spoke with demonstrated knowledge of the incident reporting system and discussed with confidence how they would report an incident. Staff stated they received individual feedback when they reported an incident, if they wanted this. We were told that any themes from incidents, or learning of note, was also disseminated at regular ward meetings. However, of the five sets of meeting minutes we looked at, only one had any reference to incidents, and incidents did not appear as a standing agenda item.
- Mortality and morbidity meetings were held for babies in the neonatal period to review the circumstances surrounding death of babies in this period. The neonatal period refers to the time from birth until 28 days of age. However, there were no comparable meetings for older babies or children. A consultant paediatrician attended a multi-agency child death overview panel. This was held bi-monthly with the local safeguarding board. Learning from these meetings was brought back to the trust and disseminated appropriately, as well as being used specifically for training.

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 relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Training around the duty of candour was mandatory and included in the induction for all staff. Staff we spoke with were able to demonstrate an understanding of the principles of duty of candour and describe a process of being open and honest with patients and their families or carers.

Cleanliness, infection control and hygiene

• The trust had policies for infection prevention and control which followed National Institute for and Health and Care Excellence (NICE) guidelines.

- Standards of cleanliness and hygiene were well maintained. All areas we visited were visibly clean and free from offensive odour. We observed staff at all levels washing their hands using hand sanitiser as per the trust's policy. Dispensers and sinks were readily available across all areas we visited. We saw toy cleaning schedules which demonstrated toys were cleaned regularly. The toys we saw were all made of materials that could be wiped clean. We saw the appropriate use of personal protective equipment such as aprons and gloves.
- In the CQC children's survey 2014 the trust scored 8.7 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.
- The trust had a procedure to undertake monthly infection prevention and control audits which assessed staff compliance with activities to help keep people free from infection. These audits were only carried out in months when the care being audited was provided. For example, if no children with a central line were cared for, this activity was not audited. Activities that were audited included a monthly audit of hand hygiene, care of a central line, peripheral line care, (both of insertion and ongoing care), and pre and post-operative surgical site infection.
- During 2016, the children's service was 100% compliant for 11 out of 12 months. The remaining month achieved 98.3% compliance for hand hygiene. It was 100% compliant with practices around the management of central line care. It scored above 90% consistently for care around the insertion of peripheral line, and 100% for the management of surgical site infection.
 Compliance with the ongoing care of peripheral lines was changeable; ranging from 63.2% in April to 100% during four of the remaining eight months the audit took place. We saw evidence that audit outcomes were discussed at meetings. We did not see any action plans which described how poor compliance would be managed.
- We saw safe practices in relation to the storage and dispensing of breast milk on the Special Care Baby Unit (SCBU). The unit provided facilities for new mothers to express and store milk for their babies. We saw that regular cleaning of breast pumps was carried out and recorded on cleaning schedules kept alongside the pumps. Expressed milk was stored safely in clearly labelled bottles in designated boxes inside refrigerators.

The same was true of freezer facilities for milk. Refrigerator and freezer temperatures were checked daily by nurses and recorded. There was a clear process to follow should temperatures deviate from acceptable parameters. Clear guidance was provided to mothers on how to label and store their milk, for which they took responsibility.

- Opportunities for cross-infection were minimised by the use of side rooms. There were a number of side rooms available for the care of children on the ward. This enabled children with suspected infectious illnesses or poor immunity to be cared for safely without risk to, or from, other children.
 - The SCBU had nine cases of Methicillin-resistant Staphylococcus aureus (MRSA) in August and September 2016. This had affected five babies and four members of staff. We saw it had been discussed at ward and governance meetings and the cause investigated. Despite investigation, the source was not identified. However, the investigation did lead to some changes in practice, such as less travelling between the children's unit and the SCBU through a connecting door. In addition, all babies in the SCBU were screened weekly for MRSA. At the time of our inspection, there were no cases of MRSA.
- There was one incident of Clostridium difficile (C. diff) in the year prior to our inspection; this was acquired outside of the hospital.

Environment and equipment

- The design, maintenance and use of facilities and premises specific to paediatrics kept children safe. All of the children's specific areas we visited within the children's unit had been purpose-built for the care of children. The children's ward area consisted of bays with space for four beds or cots. All of the single occupancy side rooms had en-suite bathroom facilities. The paediatric assessment unit (PAU) was separated into bays with beds, cots and chairs where parents and children could wait to be seen; either for tests or for further assessment by a doctor.
- All areas had safe spaces for children to play. There was a separate room in the children's ward for teenagers, which had a high door handle so it could not be accessed by smaller children. This room had a games console and other age appropriate activities for adolescents. In addition, the children's unit was designed in such a way that adolescents could be cared

for away from younger children. There were a number of single rooms; or if needed a bay could be designated for use by adolescents. During our visit adolescents were being cared for in a separate bay to the younger children.

- The SCBU had a total of 18 cots, which included an intensive care bay or a single cubicle, depending on the need of the child.
- Systems, processes and practices that were essential to keep children safe were identified, and put in place. Entrances to all areas were via an electronic system, linked to closed circuit monitors. Visitors to the ward or SCBU had to ring a bell and be allowed entry by staff. A recent security audit had highlighted the issue of the door being held open by people leaving the ward area to allow people in. Because of this, the same electronic system was used in the children's unit for exiting, meaning that people could only leave when the door was opened by a member of ward staff. However, the exit system was not employed in the SCBU, and we were not made aware of any plans for this to change. This posed a potential risk to the security of the unit as the entry door was some distance away from the reception area of the unit and could not be observed at all times.
- In the SCBU we were not assured of safe practice around the maintenance of warmed mattresses. These were devices that were filled with water, and heated via a thermostat. Advice from the electro-biomedical engineering department stated each mattress should have an expiry date written on it. However, none of the mattresses we saw had an expiry date written on them. In addition, only one mattress had any indication of when the water had been changed. Staff were not able to provide evidence of regular water changes as per guidelines for these devices. We were told there was a schedule but it could not be located during our visit. All of the attached boxes did have stickers on them confirming they had been checked by the electro-biomedical engineering department.
- All other equipment for use by staff in the care of children on the SCBU, the ward, in PAU and in children's outpatients had been checked and was ready for use. We saw schedules for the servicing of this equipment.
- Each dedicated children's area had resuscitation equipment appropriate for babies, children and young people. We saw this equipment was consistently

checked daily. Tamper-evident tags were in place and were dated. All bed spaces had equipment available for use in an emergency with a variety of paediatric sizes available.

- The design and use of facilities not specific to children did not always keep children safe. Children accessed the day surgery unit when undergoing elective day case surgery. This unit was extremely busy at the time of our inspection, and was being used for adult surgical patients as a ward, as well as for day surgery. The environment here was in need of decoration and was untidy. There was a separate waiting room for children prior to their surgery, which had toys and equipment for children. However, in order to change ready for surgery, children had to walk through communal areas to one of four cubicles, separated by curtains. Adults also used these cubicles to change ready for surgery. In addition, toilet facilities were unisex and used by adults and children.
- Some children were looked after in other areas of the hospital not designed specifically for children. Children used general outpatient's clinics as well as radiology, which were also used by adults. In ophthalmology there was a separate waiting area for children, however in all other outpatient and radiology areas there was no separate waiting area and children waited alongside adults for their appointments. This posed a potential risk to young people who may not be accompanied by a parent or carer to their appointments. There was access to paediatric-specific emergency equipment, which was tamper-evident and checked regularly. In all of these areas, plug sockets did not have protective covers over them.
- In the recovery area of theatre, there was the opportunity for children to come into contact with adults. Upon leaving theatre, children were wheeled passed adult patients who were also recovering from surgery, and so could not be kept from view. There was a designated children's recovery area, however being in such close proximity to the adult patients meant children may have witnessed distressing behaviour from adult patients in recovery.
- Dental services provided separate facilities for children, which were child-friendly and contained suitable equipment for children.
- Equipment was not always made available that supported staff in the care of children. We were told by nurses on the children's unit, that they were purchasing

some of their own equipment due to a lack of supplies on the ward. We saw nurses with their own surgical tape, used to secure bandages, and probes on children. We were told they had purchased their own because it was not made available on the ward as it was expensive. This was remedied during our visit when supplies of surgical tape were ordered. However, we were also made aware that nurses were purchasing their own thermometers as they often spent large amounts of time searching for them on the ward as there were too few. Managers told us there were issues with thermometers going missing and they often purchased new ones, but they also disappeared. At the time of our inspection ward managers were in discussions about possible solutions to the problem.

- We also heard concerns about a lack of patient water jugs, which meant that for patients who weren't mobile there was a lack of access to water. When we looked, we could not see any water jugs available for patients. There was however a water cooler available on the ward which we were told was preferred by children who were able to access it.
- Sluice areas were tidy with clinical waste appropriately stored and removed by support staff.
- The trust had policies which described contingency arrangement for the use of electricity powered equipment in the event of an interruption in the power supply.

Medicines

- We saw babies, children and young people had any allergies clearly recorded both on their nursing notes and within their medical records and medicine administration charts.
- In the areas we visited, we found medicines were securely stored in locked rooms. Controlled medicines were stored in separate locked cupboards and were checked daily by two qualified nurses to ensure stock levels were correct. Nurses were able to explain policies around the storage and administration of controlled drugs, which complied with the Nursing and Midwifery Council standards for medicines management.
- Staff followed trust protocols by checking and recording medicine refrigerator temperatures daily. This ensured medicines stored in fridges were kept at the correct temperature to be safely used.
- Intravenous fluids were stored safely away from access by children and visitors.

- The children's unit used paper medicine charts. These were legible and laid out to clearly differentiate between different types of medicines; for example antibiotics and pain relief.
- We saw that all children were weighed upon admission as per NICE guidelines, and this was recorded both on the front of their admission paperwork, and their drug chart.
- We were not assured of safe practices around the administration of oxygen. The trust had policies to ensure the safe management and storage of medical gases. It also had a medication administration policy which stated that oxygen should be prescribed before use. The prescription of oxygen was also discussed during the bi-monthly drug reference group meeting. However, we did not see this practice during our inspection. We were told oxygen was not routinely being prescribed before use, which contradicted the trust's policy. Pharmacists were aware of this issue and were focused on trying to improve practice. There was no formal action plan to address this issue.
- We saw staff following trust protocol when administering medicines to children, using the name band and talking to children and parents to verify identity.
- There was a bi-monthly drug reference group meeting. This group was made up of a clinician, a paediatric pharmacist and a ward manager from both the children's unit and the SCBU. At these meetings discussion was open and centred around anything pertinent that was medicines related. For example, finance, changes in recommendations from the national formulary, NICE guidance and incidents.
- There was a limited amount of specialist paediatric pharmacy support in the trust. The trust employed a paediatric pharmacist, although this person had other aspects to their role, and estimated that only 30% of the role was in paediatric pharmacy. Specific paediatric pharmacy advice was not readily available out of hours, although staff could access general pharmacist advice at this time. This posed a potential risk to the safe management of paediatric pharmacy issues during this time.
- We saw incident reports that identified medicine errors. We saw these were discussed at the regular drug reference group meetings, with actions put in place to minimise the chances of the errors reoccurring. The overarching theme for the majority of these was missed

administration of antibiotics. This was attributed mainly to having to wait for blood levels prior to administration, or that cannulas needed to be re-sited causing extended delays.

• Administration of antibiotics to babies in the post-natal period featured on the SCBU risk register. Recent changes in NICE guidelines had increased the number of babies who required antibiotics and included babies being cared for on the post-natal ward. The staffing structure of the post-natal ward meant they were unable to administer antibiotics to babies. As a workaround, babies were taken to the SCBU to have their antibiotics administered by the nurses there who were trained. We were told this created a significant increase in the workload of these nurses, especially when the SCBU was busy. We were assured, however, that significant consideration had been given to the safest way of managing the situation, and that the system employed was working at the time of our inspection.

Records

- Children's records were managed in a way that kept them secure. Patient records were stored electronically, or in a paper format within a trolley secured by a number-coded lock. The electronic system held information about the child or young person's medical history and child protection issues, and was used to communicate with GP surgeries.
- Charts used for monitoring a child or young person's condition and nursing needs, such as fluid charts and observation charts, were kept at the end of each bed, cot or outside side rooms. This meant they were available for staff to use when caring for the child.
- Each area to which a baby, child or young person may be admitted had its own system for recording the patient's needs. The records we looked at documented information specific to the needs of the child and we saw core screening had been completed for each child.
- Children's individual care records were written and managed in a way that mitigated the risk of harm. We looked at a number of patient records, both nursing and medical notes, as part of our inspection. We found they were completed legibly, in chronological order and contained the information needed to care for children safely.
- Observation charts which recorded temperature, pulse and blood pressure were available for children and

young people of different ages. These charts were comprehensive and included a Paediatric Early Warning Score (PEWS) section, a pain management and assessment section and a handover section. The observation charts we looked at had been completed consistently and warning scores calculated. PEWS scores were clearly recorded on the front page of admission paperwork.

- In the SCBU a PEWS system was not used. We were told this was because acceptable parameters for babies in the neonatal period did not fit with the pre-defined parameters of the PEWS system. Instead, the unit had developed a local observational system which was designed to alert staff to deteriorating babies by recording observations hourly. We saw this was completed in the records we looked at in the SCBU. At the time of our inspection a neonatal early warning system was to be implemented, which contained modified parameters for neonates.
- The trust completed an annual audit of health records. This audit sampled notes from across a division and focused on key areas of record keeping, with a target in all areas of 100%. These areas included the dating and signing of entries, compliance with trust protocol, and being stored in chronological order. Overall compliance within the Women and Children's division had decreased from 81% in 2015, to 60% in 2016. Specifically in the SCBU, this had decreased from 73% to 47%, and in the children's ward it had decreased from 87% in 2015, to 61% in 2016. We did not see any evidence that explained how this performance was being addressed. However, the records we looked at were completed fully.

Safeguarding

- Processes were in place to support staff to manage child safeguarding situations. The trust had a team with responsibility for safeguarding children, which consisted of named individuals. This team included clinical and nursing leads, together with midwifery safeguarding leads. The team also consisted of an administrative co-ordinator role with links into the vulnerable adult's team.
- The divisional director of nursing for women & children's services attended local children's safeguarding board meetings and fed relevant information back to colleagues.
- There were arrangements in place to safeguard children from abuse that reflected relevant legislation and local

requirements. The trust had adapted policies from the south west child protection network and the overarching hospital safeguarding policy referenced these. These policies were launched and communicated with staff via divisional directors and through safeguarding training, with additional visits to specific areas when required.

- We were not assured that all staff working with children had the required training to be compliant with intercollegiate requirements. Staff working with children in non-paediatric specific areas did not always follow intercollegiate guidance on the levels of training achieved by people working with children. These staff provided care to children but were not specifically paediatric trained. The guidelines state all staff clinically involved in the care or assessment of children should attend safeguarding training at level three, but this was not always the case.
- The trust set a range of targets for completion of safeguarding training modules, the minimum being 80% for adult safeguarding training and 90% for child safeguarding training. Medical and dental staff in children's services achieved their target for level three child protection training (90%) but failed to meet safeguarding training targets for all other training modules. Safeguarding vulnerable adults level two was significantly off target, at 16%. Nursing and midwifery staff in children's services achieved or exceeded their target for safeguarding training courses for three training modules. Level three child protection (at 89%) and child protection level three specialist training (at 89%) almost made their 90% target. Safeguarding vulnerable adults level two training was at 29%, well short of its 80% target. Safeguarding training contained training around recognising the signs of female genital mutilation (FGM) and child sexual exploitation (CSE). We did not see any action plans to address poor compliance with safeguarding training.
- Staff we spoke with had varying levels of confidence regarding raising safeguarding concerns. However, all spoke highly of the support they received from the safeguarding lead and said they would be confident to approach the safeguarding team for advice and support. There were a total of 63 incidents reported in 2016 that related specifically to safeguarding issues, and as such were raised with local authorities as safeguarding concerns.

- There were systems in use that highlighted children who were subject to child protection processes or safeguarding concerns. If a child entered through the emergency department information of concern could be added to the electronic system. There were spaces for this information to be recorded on paper records and we saw this was completed in all sets of records we looked at. Staff could also be made aware of children subject to protection processes or safeguarding concerns through a flagging system which alerted staff when they accessed their electronic records.
- Where children or young people failed to attend an appointment, either as a new appointment or a follow up, a "managing child missed health appointments" policy provided guidance to staff on how to follow this up. The process involved contacting other professionals involved in a child's life, for example a GP or a social worker. Staff we spoke with were aware of this policy and what it contained.
- Safeguarding supervisions were offered to nursing staff on a group basis, every three months. This was an opportunity for staff to discuss with the safeguarding lead any issues that were relevant to their practice at the time, or discuss any particular cases. For medical staff, peer reviews occurred weekly and were an opportunity for doctors to discuss cases that were difficult and to gain the support and advice of the clinical lead. Feedback was that both doctors and nurses found these opportunities helpful in developing their confidence around managing safeguarding situations. It was, however, difficult for some nursing staff to be released from their shifts to attend these opportunities and as such some were not able to receive this supervision as often as three monthly. However, staff were able to request individual safeguarding supervision at any time.
- The trust could not be assured of the ongoing safe care for vulnerable children it was caring for or was planning to discharge. An audit in 2016 had identified that discharge information was not always shared with the professionals involved in their care. Trust requirements included a discharge planning meeting for all vulnerable children under a child protection plan, and the completion of alert boxes on their electronic records. In addition it was also a requirement that the looked after children's nurse was informed of all vulnerable children discharged. The audit found overall compliance with these requirements to be only 62% against a target of 100%. The risk of this non-compliance was that children

could be discharged into vulnerable situations without the knowledge of all the professionals involved in their plan. There was no action plan attached to this audit which detailed how the non-compliance would be addressed.

- We saw good examples of where learning from serious case reviews had improved practices around safeguarding. For example, a weekly safeguarding ward round took place on the SCBU where each child being cared for was discussed and any child protection or safeguarding concerns were raised and actions planned. This was seen favourably by all the staff we spoke with. Following another serious case review, the SCBU had introduced a "baby diary". This was a document which captured details of visits to babies, the care given to them by visitors, times of visits or any other relevant information. The aim of this was to pick up any behaviours of concern before a baby left the unit. Actions following serious case reviews were also added into training to ensure it remained relevant.
- The safeguarding team received daily updates from both Wiltshire and Swindon local authorities about children who were the subject of child protection, or child in need plans. They did not receive this information from the other local authorities that surrounded them, but used their own knowledge and skills to raise alerts should the need arise.
- We were not assured of safe systems around the management of case conference notes for children. The team talked of positive relationships with the local child safeguarding board, which included receiving case conference notes for children who had a child protection plan. These notes were then added to medical records for use by clinicians in delivering care. However, a lack of administrative support had led to a backlog of notes waiting to be placed in children's medical records. We were told of a "filing cabinet full of case conference notes" that were waiting to be added to patient records. This presented a risk to these children as it meant the staff treating them did not have all of the information about the children. This issue had been raised as an incident but we did not see any actions to remedy the problem at the time of our inspection.

Mandatory training

• There were systems in place to identify need and provide mandatory training for staff. The trust had a core list of mandatory training it required all staff to

complete. This consisted of the subjects needed to keep patients safe, including health and safety subjects, infection prevention and control, moving and handling, basic life support, information governance and record keeping. In addition, all staff received an induction program when they started their employment.

- Staff told us they were alerted when their mandatory training needed updating. We saw evidence of completion rates of mandatory training displayed on the wall in the staff area of the SCBU. The trust's target for completion of mandatory training was 80% for all areas, apart from information governance training for which the target was 95%.
- Nursing staff performed at or above trust targets for the completion of all except two of the mandatory training subjects. They fell below target for moving and handling (71%) and paediatric basic life support (66%).
- Medical staff in children's services failed to meet the targets for any mandatory training courses, with adult basic life support, paediatric basic life support and fire safety awareness compliance all below 30%.
- In other areas of the trust, where children may visit, levels for the completion of paediatric basic life support did not meet trust targets. Specifically, compliance amongst medical staff in outpatients was 35%. In surgery, only 62% of nursing staff and 45% of medical staff had completed paediatric basic life support. Overall in the trust completion of paediatric life support training stood at 61.3%.

Assessing and responding to patient risk

- Risks to children who used the service were assessed and their safety was monitored and maintained, with clear procedures in place for the care of patients who became unwell. Each child had a paediatric nursing assessment on admission. These included risk assessments in relation to manual handling, nutrition, pain and pressure ulcers and were completed in the records we examined during the inspection.
- All the wards and departments where children were cared for used an age-specific observation chart. With the exception of the SCBU this included the completion of a paediatric early warning score (PEWS) that helped staff to detect when a child's condition was deteriorating, and when to seek help. The completion of PEWS scores was regularly discussed at team meetings and was audited for compliance. Recent audits had shown a downward trend and poor compliance with the

completion of PEWS charts. Compliance had deteriorated from 94% in August 2016 to 76% in February 2017. As a result, this had been added to the risk register for the children's service with a set of actions describing how the risks were to be mitigated, including the spot-checking of these documents by senior nurses. The staff we spoke with were familiar with the PEWS system and described where deteriorating children had been escalated appropriately.

- The children's ward had two rooms near the nurse's station which could be used for children with high dependency care needs, or who needed closer observation. However, the trust was not funded to provide high dependency care, and therefore was not staffed to provide such care. We were told the unit had an escalation plan which could be used in the event of receiving a child with high dependency needs. This plan involved closing beds in order to raise the patient to staffing ratio, and gave comprehensive guidance around the numbers of beds to be closed in order to safely care for children with high dependency health needs. In addition, all staff had completed training in the provision of high dependency care to children.
- Handovers were completed in inpatient areas, where staff discussed the clinical needs of the patients and followed this with a more individualised handover in bays. Within the SCBU, handover included the checking of charts to ensure staff were fully informed of the baby's conditions.
- The service used a sepsis screening and action tool to assess the risk of, and treat, sepsis in children. This tool was aimed at identifying the likelihood of sepsis in unwell children, and provided clear guidelines for staff to follow in assessing patients for sepsis. It also described the actions to be taken in specified circumstances.
- The trust did not have a specific intensive care facility for children and young people. However, there was provision within the intensive care unit for children requiring intensive care prior to being transferred to specialist units in other hospitals. We saw the intensive care unit had a specific resuscitation trolley for paediatric patients, which was a different colour to the adult trolley. This aided easy identification in an emergency.
- Within the day surgery unit, when children were admitted we were told of a process whereby the co-ordinator would phone the children's unit and check

for the availability of an inpatient bed if the need arose post-operatively. There was also a daily "operation status at a glance" meeting which identified provision of the intensive care facility, beds, and recovery capacity for the day ahead. This appeared to work well in planning for surgery for children.

• World Health Organisation (WHO) surgical safety checklists were used in theatres and for dental procedures requiring anaesthetic. The staff we spoke with were all aware of the checks that needed to be done to make sure consent had been obtained for each child for the correct procedure.

Nursing staffing

- Nursing staffing levels on the children's unit, PAU and SCBU did not consistently meet recommended levels. Staffing levels on the children's unit were assessed and planned using the Royal College of Paediatric and Child Health (RCPCH) guidelines; however, the actual numbers of staff regularly fell below recommended levels. There was no formal process to modify the capacity of the unit should it run understaffed. However, there were informal arrangements between units to provide staff to each other in the event of an emergency.
- On the children's unit, each shift had a nurse in charge; a band six who acted as co-ordinator and was qualified in European paediatric life support. On the ward, expected staffing levels were four registered nurses (including the co-coordinator) and one nursery nurse. At night the expected levels were three registered nurses and a nursery nurse on the inpatient ward. On the day we visited, a registered nurse (bank) had not arrived for their early shift due to confusion over the booking of that shift, and a registered nurse (bank) for the late shift had also cancelled their shift. This meant the unit was short-staffed for the entire day. The unit was not full and the staffing levels were safe for the number of patients on the ward. However, if further patients were admitted the staffing levels would not have met the RCPCH guidelines. No attempt had been made to cover these vacant shifts due to under occupancy on the unit. There was therefore a lack of ability to respond to unforeseen changes - either in occupancy or acuity of existing patients. We were told that in the event of increased patient occupancy it was usual practice to review the staffing and re-allocate as required from other areas or bank/agency. This was part of the trust's escalation policy.

- On the paediatric assessment unit, planned levels were for one band six nurse as co-ordinator, plus another registered nurse and a nursery nurse. On the day of our visit, there were two registered nurses on duty. The nursery nurse shift had not been filled.
- Data provided to us prior to the inspection showed gaps in unregistered nurse cover at night during the preceding three months at an average rate of 17.6% of all night shifts. Information we were provided with showed registered nurse shifts at night in the same period were all covered. Uncovered shifts during the day averaged 3%. However, of the three days we visited the children's unit and PAU, two were understaffed by a nursery nurse and a registered nurse
- Staffing levels were reviewed at six-monthly board meetings. There was an ongoing issue with recruiting experienced paediatric and neonatal specialist nurses which was not improving. During our inspection, two new band five nurses had been offered posts on the children's unit, but these were newly qualified nurses who would not be able to start for a further six months. In addition, these nurses would require extensive preceptorship as newly qualified staff.
- The children's service did not use a patient dependency score at the time of our inspection because there was not a nationally recognised acuity tool. However, during our visit the ward manager attended a conference on high dependency paediatric care, and was made aware of a reliable acuity tool being developed nationally that could be used with children. We were told this would be implemented as soon as available nationally as part of an ongoing plan looking at the care of children with significant care needs. The Trust was part of the national group developing the acuity tool. Safer staffing reviews were undertaken and reported on a six monthly basis in line with the rest of the trust. Combined with the lack of staff on the children's unit, the lack of dependency scoring increased the risk that the children's unit could be staffed outside of safe levels.
- Outpatient staffing levels met the needs of the department. Children's outpatients was staffed by a health care assistant and two clerks from the general outpatient department. When clinics were being held there was always a senior medical practitioner or qualified nurse in the department.
- The children's outreach nursing team consisted of six band seven nurses, one band six nurse, and two band five nurses. Each nurse had a caseload, which was

tailored to their specialisms. The team had one whole time equivalent registered nurse vacancy at the time of our visit. We were told caseloads were heavy, but generally manageable.

- The trust told us that in the SCBU, they used the British Association of Perinatal Medicine (BAPM) guidelines to determine staffing levels. The unit had six high dependency cots and 12 special care cots. Planned cover was for four registered nurses per shift, plus a nursery nurse. If all of the cots were occupied, the planned staffing levels would not meet BAPM guidelines. In addition, these nurses were administering antibiotics to babies from the post-natal ward within their working establishment. Although this task happened on the SCBU, it was away from the main body of the unit and so nurses were unable to care for the babies staying on the unit whilst administering these medicines. We were told staffing levels were reviewed at six-monthly board meetings. At the time of our visit, the unit was not full and staffing levels met with BAPM guidelines. However, there was not provision if this situation changed.
- There was a lack of paediatric specialism outside of children's areas. The day surgery unit and the Shalbourne suite had no paediatric nurses within their teams. This meant that children being cared for in these areas were not in receipt of care from staff with specialist paediatric qualifications or training. However, these areas were able to call on support from the children's service should the need arise.
- There was a reliance on bank and agency staff within the children's services. In the three months prior to our inspection, the children's unit's reliance on temporary staff ranged from 15% to 23%. Within the SCBU, reliance on temporary staff ranged from 6% to 15%. There were significant nursing staff vacancies within both the children's unit and the SCBU. The children's unit had five vacant registered nurse posts at the time of our inspection. They also had four registered nurses who would start maternity leave in the months following our visit. There was also a staff member on long term sickness absence, and one full time registered nurse who was leaving. The whole team planned establishment was 28.7 whole time equivalents. Within the SCBU, there were three registered nurse vacancies and one nursery nurse vacancy. Both the children's unit and the SCBU relied heavily on bank and agency cover, which we were told caused a strain on those substantive

nursing staff. These were not often paediatric trained staff and so there were limits to the tasks they could complete. There was an induction process for bank and agency staff. There had been little progress in recruiting to vacant posts in the SCBU, although advertisements were ongoing. In the children's unit interviews were booked and staff had been offered posts. However, these posts were not filled at the time of our inspection. There was no provision for the maternity leave cover at the time of our visit. It was envisaged this would be covered by bank or agency staff for the duration.

- Between January and December 2016, the trust reported a turnover rate of 21.5% in children's services against a target of 13%. We did not see any evidence of actions being taken to understand the high turnover rate.
- Sickness rates within the children and young person's service were amongst the highest in the trust at a rate of 6% amongst nursing staff. This caused an extra reliance on temporary staffing arrangements. There was active management of staff sickness and a number of initiatives in place aimed to improve the working environment to support staff morale.
- RCPCH guidelines state there should be 24 hour access to a senior nurse (band eight or above) who is paediatric trained. There were no formal arrangements made for this level of cover within the service. Historically, staff were able to call a ward manager out of hours (who was band seven), but this was on their personal number when they were not officially on call. The service aimed to have a registered nurse at band six level on shift at all times who could provide support to staff.

Medical staffing

- The trust employed 12 consultant paediatricians at the time of our inspection, with various specialisms. These staff covered all areas of the hospital. There were no paediatric consultant vacancies. Registrar vacancies stood at 40% at the time of our inspection which had caused difficulties in the children's service. To combat this shortage, consultants had "acted down" into registrar shifts to ensure adequate medical cover.
- Between April 2015 and March 2016, the children's service reported a bank and locum usage of between 1.7% and 5.3%. There was a downward trend over the period. All locums were expected to complete an

induction booklet prior to working at the hospital. This included core mandatory subjects to ensure locums were aware of expectations; for example, infection control and incident reporting.

- Medical cover varied out of hours and at weekends. During the week, a consultant was available in the hospital until 8.30pm, with off-site, on-call arrangements after this time. On-call consultants were within 30 minutes of the hospital when called. Consultant cover was available on-site at the weekends between 9am and 5pm. Outside of this there was one middle grade doctor (a registrar) covering the service, alongside a junior doctor. In addition there were on-call consultants available out of hours. Medical cover was shared between the children's unit, the SCBU, maternity services and the emergency department. There was ongoing concern about the lack of medical cover within the women and children's division, should it be needed when the doctors were elsewhere in the hospital. We were told that at busy times out of hours, patients often had to wait long periods for a doctor to arrive when they were occupied elsewhere in the hospital. However, we did not see any incidents reported that demonstrated this was an issue or ongoing risk to patients. We were told there had not been any actions put in place to address this issue.
- Between January and December 2016, the trust reported a turnover rate of 8.3% in children's services against a trust target of 13%. In the same period, sickness rates amongst medical staff were 0.6% in children's services.
- We observed handovers between all grades of medical staff, which included discussions about consent, discharges, safeguarding and planned investigations.

Major incident awareness and training

- Staff we spoke with were aware of their roles in the event of a major incident and were able to describe the actions they were required to take.
- The bed capacity on the children's unit changed during the year to take account of winter pressure, for example respiratory conditions. Between June and October capacity was reduced to 16 beds from 20 to take account of the reduced demand.
- The trust set a target of 80% for its health and safety training module, which included major incident training.

As of 20 January 2017, 80.8% of staff in services for children and young people were up-to-date with this training course, slightly higher than the trust's target of 80%.

Are services for children and young people well-led?

Requires improvement

We found the concerns raised following our inspection in October 2015 had not all been addressed. We found additional concerns that meant the well-led rating remained as requires improvement.

We rated well-led as requires improvement because:

- The culture of the service did not promote staff wellbeing. Nursing staff told us they often worked for long periods without a break, or in some cases access to a drink.
- The strategy for the women and children's division was unknown to many of the nursing staff who worked within it and was detached from the trust's strategy. This was also raised in the previous inspection.
- The women and children's division felt disconnected with the rest of the hospital, and some staff did not feel connected with their leaders. This was raised in the previous inspection and did not appear to have improved. A new leadership structure at ward level had recently been implemented and was not yet embedded so the impact of this was not yet clear.
- There was no representation of children and young people's needs at trust board level and no executive champion for the service.

However:

- There were creative initiatives in place such as consultant led simulation training which was well received by staff.
- Medical staff spoke highly of the division, its leadership and culture.
- Divisional managers spoke highly of the dedication of their staff, and the good will on which they relied for the smooth running of the service.

• Extensive fundraising had paid for a range of equipment which improved the capacity of the service to provide care to children, together with a new play area for use by children in hospital.

Leadership of service

- Leaders understood the challenges to good quality care and could identify the actions needed to address them.
 However, they did not feel supported or empowered at executive level to make these actions happen.
- Staff at the highest level of the women and children's division right down to front line staff told us that as a service they felt disconnected from the rest of the trust. The trust board had recently conducted "walkabout" initiatives in the hospital. The children's service leaders told us that as a service they had not received a visit during this initiative. Since the inspection, we have been told by the trust that "patient safety visits" occurred by the executive team in January 2017.
- There had been a number of changes at different leadership levels in the weeks leading to our inspection, some of which were interim roles. This included the ward manager of the children's unit, and the children's service matron. This had led to some uncertainty about how much longer some people would be in post. Staff were aware at local level who their line managers were but were not able to describe what these relationships were like as they had not had a chance to become embedded at the time of our inspection. The posts had been filled by staff already employed by the trust. Medical staff spoke highly of the leadership of the division and were clear about the roles of leaders.
- Nursing staff told us they saw their direct line managers regularly. There was varying feedback about how well supported these staff felt by their line managers. Some felt very supported, whilst others did not. In the inpatient services, line managers were band seven nurses who had a combination of clinical roles and non-clinical leadership roles. In the children's unit, the manager post was being covered by a secondment whilst the substantive post holder took the matron's role. Staff told us that beyond this level they had very little interaction with any divisional managers with the exception of the director of nursing who made herself visible and was very approachable.

- Within the community outreach nursing team, staff felt the team leader provided an effective line of communication both upwards to management, and also back from management.
- On a shift by shift basis, leadership was provided to teams by a designated co-ordinator. This was a band six nurse who would ensure the smooth running of the unit. This was the system across the children's unit, the paediatric assessment unit and the SCBU. A number of nurses had recently been promoted to band six, and this clear daily leadership structure appeared to be working well. Feedback from bank staff who were not based in the unit was that it gave them clear direction and support in their work.
- Opportunities were lost to connect the front line staff to wider divisional and trust messages.
- We looked at five sets of meeting minutes across the children's unit and the SCBU. The nurses in charge of these wards were not present at any of these meetings, and there were numerous items that needed to be followed up by them. These meetings were a chance for staff to discuss pertinent issues, and for key messages to be disseminated. However, the absence of a ward leader at these meetings meant this did not always happen.
- The trust identified a paediatric consultant lead for anaesthesia and radiology. However, there was no formal paediatric consultant lead for surgery within the trust. This meant there was no designated lead responsible for managing quality assurance of paediatric surgery. This was not in line with the guidance of the Royal College of Surgeons.
- We were told by executive directors that they made themselves visible by visiting ward areas regularly, and conducting walk arounds in the hospital. However, the majority of nursing staff we spoke with said they would not recognise them. All said there was a regular e-mail that was sent with trust updates. However, staff told us they did not often have time to read these communications during the course of a shift.

Vision and strategy for this service

• There were clear values for the service and trust which put patient care and service at the forefront. The trust had four values, known as STAR: service, teamwork, ambition and respect. These were displayed on posters in many areas we visited. Staff knew about the values and were able to describe them.

- We were told of the strategy for the women and children's division. This consisted of three main aims: recruitment, creating combined consultant rotas and building capacity into the service. This was a five year plan that had been devised by division leaders and was monitored annually. As a strategy, it was detached from the overall trust strategy, as it had been devised without input or influence from outside the division. We were told the strategy had been developed based on the identified needs of the service to make it more responsive and flexible to the needs of its population. The overall strategy for the division was not clear to any of the front line staff we spoke with. They were unable to tell us what the key aims for the service were. Discussions held at board level did not appear to filter through to staff.
- There were no action plans for the children's unit or the SCBU addressing how the service would move forward. We were told the children's service had been waiting for the completion of trust-wide work prior to completing local strategy plans. Action plans were due to be written in the months following our inspection.

Governance, risk management and quality measurement

- There was no representation of children and young people's needs at trust board level. There was no champion or director for children and young people's services. Senior staff within the division told us it was difficult to get agreement for initiatives within the children's services due to the lack of presence on the board. There was no paediatric lead for surgery within the hospital, and it was felt this was because there was a lack of anyone "flying the flag" for children's services on the board. Division leaders felt the disconnection of the children's service was because of the lack of representation at board level.
- At the time of our inspection, governance arrangements were under review. Divisional leaders were aware of this but not what the transition plan would look like. The divisional director was also leading planned care, and had a vacant deputy post. We were told this post was frozen pending the outcome of the review, and that this had caused an increase in their governance-related workload.
- Staff were clear about their responsibilities in meeting the needs of children and young people. A system of audit demonstrated their performance and was

reported to the board quarterly. The audit programme included a wide range of subjects, such as compliance with paediatric early warning score (PEWS) recording, infection control processes, and completion of records.

- There were effective arrangements in place to monitor risks. Overview of the risk register was managed at service and divisional level. Risks were managed and reviewed firstly at department meetings, which fed in to divisional monthly board and risk meetings. Any risk rated highly was then fed into the executive performance meeting and executive committee meeting. Items recorded on the service's risk register reflected what staff reported as being on their list of concerns. The risk register was a standing agenda item on the quarterly acute children's services governance meeting. These issues included the vacancy rate of registrars, administration of antibiotics to babies from the post-natal ward on the special care baby unit (SCBU), and the lack of a formally funded high dependency (HDU) facility on the children's unit.
- The service leads used a number of tools and audits to gather data which was needed to meet the trust's governance arrangements. Incidents, accidents and near misses were recorded and investigated in accordance with the trust's reporting system.
- Issues on the risk register, together with other issues of concern, were discussed at the acute children's service governance meeting, which occurred quarterly. Included on the agenda were reviews of incidents and associated investigations. It also featured discussions around the outcome of audits, and a discussion around complaints and learning from these. However, the most recent minutes showed complaints had not been discussed at that meeting. At the previous meeting, complaints were mentioned but no learning from complaints.

Culture within the service

• There was a feeling in the children's division radiating from directors to front line staff, that the service was not connected to the rest of the trust. We were told that this meant that ideas for initiatives to improve services were ignored and the lack of a children's representative at board level exacerbated this.

- Few of the front line nursing staff we spoke with felt valued by anybody other than their peers. We saw peers interacting positively and warmly with each other, and with their patients.
- The trust had a performance management policy that supported line managers to manage staff whose practice did not meet expected standards. Leaders spoke confidently about using this process to improve the practice of staff.
- There was a culture of candour, openness and honesty within the service and with patients and their families.
 Staff we spoke with reported they were encouraged to raise any issues or questions. Staff told us they felt confident that they could take concerns to their manager and that they would be listened to. However, they didn't feel confident that anything would change if they did so.
- There was a lack of formal opportunities for leaders on the SCBU to be assured of their staff's wellbeing. With the exception of safeguarding supervisions there were no other supervision opportunities offered to staff on the SCBU. Interactions tended to be on an ad hoc basis and were not recorded.
- The culture centred on the needs and experience of the children who used the service. However, we were not assured that staff wellbeing was promoted within the services we visited. Staff told us they enjoyed their jobs because they felt they made a difference to the lives of children and young people. However, what they didn't enjoy was the feeling of not having enough time to work in the way they would like. Staff spoke of working long hours, often short of staff, without the opportunity for a break. On the children's unit, staff were not allowed any drinks at all in the ward area,. This meant they could work a long number of hours without the opportunity for even a drink. On the day of our visit, we did not observe any staff member take a break or have a drink. We were there for four hours.
- We heard from both front line staff and leaders of ongoing differences between the children's unit and the SCBU. This mainly took the form of disagreements about whether staff could be freed up to help out when services were struggling, or about the transfer of babies from the SCBU to the children's unit. This was viewed as normal with no plans to address the issue. We did not witness this behaviour, and it did not feature in meeting minutes as a subject for discussion. Between the children's services as a whole, and other services from

which children may receive care, collaborative working was seen as a priority. This could range from sharing expertise, to advising on the provision of child friendly facilities, to the outreach team working hard to prevent admissions when the children's unit was especially busy. Collaborative working was seen as a mechanism of improving the experience of children both in and out of hospital.

Public engagement

- The children's unit and the SCBU had suggestion boxes in clear view of parents and children. Family and friends feedback forms were usually given to parents and carers to take away and complete, although this did not always happen. This had been recognised by the service and mechanisms for receiving feedback were being addressed, with staff being reminded to give these cards to all children and families or carers.
- The children's service benefited from a large amount of financial donations. We were told enough money had been raised through a campaign to finance the building of a new play area. We were also told of a number of pieces of equipment which had been funded through donations to the service.
- We were given an example in the SCBU where parents had suggested a better area to be able to prepare and store food whilst their babies were in hospital, often for long periods. As a result a 'parents' pantry' was created to allow parents to provide their own meals as opposed to having to visit the hospital café.
- The children's service used a social network platform to communicate updates and encourage feedback from patients and their families and carers.

Staff engagement

- Staff we spoke with told us they would escalate concerns through their line managers. They were not all aware of other meetings they could attend such as open meetings for staff to attend.
- There were no formal arrangements or tools to encourage staff engagement.
- Leaders told us they encouraged staff feedback by having open communication with their staff. This was an informal process, and was based on what the leaders felt was a good rapport with staff.
- We were given examples of how, at local level, staff were thanked when they went the extra mile. This was done

through email, or face to face when needed. The leaders of the service spoke of a culture of offering constant feedback. One member of staff had been nominated for an award during 2016 due to her outstanding efforts.

Innovation, improvement and sustainability

- Consultants had devised and delivered simulation training to staff in the children's service. This included supporting staff to learn how to manage difficult situations, for example child protection issues. This had been very positively received by all the staff we spoke with, and was seen positively outside the trust where consultants networked.
- Staff in the SCBU demonstrated a focus on improving quality of care for neonates upon their discharge. They had developed an outreach service for parents and babies when they went home in response to the recognition of the frightening nature of this for some

parents. This service provided weekly visits for a period of three weeks to help families settle in at home. This had been well received, and had also been successful in highlighting potential child safeguarding concerns at an earlier stage.

 The children's unit had taken a proactive approach to the management of children with high dependency needs. Although not funded to provide dedicated high dependency care, they often provided this service. Nearly all of the registered staff employed by the unit had completed training on high dependency paediatric care which gave them the skills to do so. In addition, the ward had purchased equipment required in the care of these children rather than having to borrow it from other areas of the hospital. The division was in the process of writing a business plan to go to the local clinical commissioning group, in the hope of securing funding for the provision of high dependency care.

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

Information about the service

Great Western Hospitals NHS Foundation Trust provides outpatient services at Great Western Hospital and six different community hospitals. Some of the outpatient services came under the trust's diagnostics and outpatients division with the others coming under the responsibility of individual specialities.

Great Western Hospitals NHS Foundation Trust provides a full range of diagnostic imaging, including general radiography, computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine, cardiac imaging and interventional radiology. Radiotherapy services.

Between November 2015 and October 2016 the trust saw 441,983 patients from the specialities that make up the outpatients department with 404,370 being seen at the Great Western Hospital site. Outpatient services were also provided in community settings; however these did not form part of our inspection. The specialities where the largest number of patients attended were ophthalmology, physiotherapy, anticoagulation services and trauma and orthopaedics.

During our inspection we visited the two general outpatient units, Wren and Osprey, as well as orthopaedics, fracture clinic, ophthalmology, cardiology, anti-coagulation services, phlebotomy, physiotherapy, dermatology, ear nose and throat and gastroenterology.

We spoke with 18 patients and 100 members of staff .We observed care and treatment and looked at 14 records of care. We reviewed information relating to performance

about the hospital prior to and following our inspection. We also received feedback via comment cards from patients. We observed interactions between patients and staff and inspected the environment where services were provided.

We had previously inspected the outpatients department in October 2015 where the service was found to require improvement in the safe, responsive and well led domains.

Summary of findings

We rated this service as requires improvement because:

- Access to resuscitation equipment could be compromised due to the sharing of equipment between departments.
- Within some departments people were waiting too long for appointments.
- There were delays in the typing and sending of letters to GPs and the reporting on images.
- Aging and failing equipment had resulted in lost clinic time and cancelled appointments.
- Not all staff were up to date with mandatory training.
- There was an inconsistent approach to the provision of clinical supervision and peer review.
- Services were not always able to deliver and take account of the needs of different people.

However:

- There was a good incident reporting culture where openness and transparency was encouraged.
- There were clearly defined systems and processes to keep people safe and safeguarded from abuse.
- Peoples care and treatment in both outpatients and diagnostic imaging was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Staff worked effectively together in a coordinated way in the patients best interests. There was clear evidence of multi-disciplinary working within departments, the hospital, as well as other acute and community health services
- Feedback from patients and relatives had been consistently positive. They praised the way the staff really understood their needs and treated them as individuals.
- There was a clear statement of vision and values for each department and division, driven by quality and safety. It was translated into a credible strategy for outpatients with defined objectives that were regularly reviewed and relevant.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Access to resuscitation equipment could be compromised due to the sharing of equipment between departments.
- Daily cleaning checklists were not consistently used and recorded across the outpatient departments.
- Levels of mandatory training compliance were not in line with the trusts target of 80%. In particular for basic life support, fire training and paediatric life support for medical and dental staff.
- Only 20% of medical and dental staff had received training in level two safeguarding vulnerable adults against a trust target of 80%.

However:

- There was a good incident reporting culture where openness and transparency was encouraged.
- There were clearly defined systems and processes to keep people safe and safeguarded from abuse.
- Techniques used ensured cleanliness and infection control measures were in line with National Institute for Health and Care Excellence (NICE) quality standards.
- There were safe systems for the storage and administration of medicines, with audit trails to monitor the use of controlled drugs. Contrast and controlled medications were stored in locked cupboards and fridges and fridge temperatures were checked daily.
- Risks to people who used the service were assessed and their safety was monitored and maintained.

Incidents

• There was a good incident reporting culture where openness and transparency was encouraged. Staff were confident to report incidents using the electronic reporting system. Staff understood their responsibilities to raise concerns and record safety incidents and near misses. Staff received feedback on the incidents they reported, however, they did not always feel that feedback was helpful or addressed the issues raised.

- Where incidents occurred, they were investigated with actions put in place to reduce the risk of reoccurrence. Learning as a result of the incident was shared throughout the departments.
- In 2016 there were 257 incidents reported for the outpatient clinics and 167 for the diagnostic imaging service. Of these three were categorised as serious incidents. These related to one failing to act on test results, one incident relating to a surgical procedure and one delay in treatment. One of these serious incidents was classified as a never event. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The never event involved a procedure on the wrong site. The investigation showed that the clinician had been unable to access the diagnostic scan that would have prevented this error from occurring. Learning and changes of practice had occurred which included a review of the World Health Organisation surgical safety checklist, to state that an image must be viewed prior to undertaking procedures. This learning was shared through governance and team meetings. Staff we spoke with had a good awareness of the incident and the learning that had occurred.
- Staff understood their responsibilities to report incidents externally. Of the 19 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incidents that had occurred between January 2016 and January 2017, 14 were reported to the Strategic Executive Information System (STEIS). One IR(ME)R incident involved an agency member of staff undertaking a CT scan using a scanner they had not been trained on. Following this, a full investigation was completed and the standard operating procedure for agency staff was changed. A new induction pack was introduced and communication was improved with agency groups. Staff were informed of the incident in team meetings and posters detailing the incident and learning from it were displayed in the diagnostic imaging department.
- Other examples of action and learning as a result of incidents included the checking of chairs within the waiting room. Unsafe chairs were removed and a business case submitted for replacements.

Duty of Candour

- 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.
- All new staff were introduced to the principle of being open and duty of candour and given training in the requirements during their induction. Staff from all levels of the organisation had an understanding of duty of candour, when they would use it and the actions they would take. They explained there was an open and honest culture with patients.
- We saw evidence of investigations and the learning from them being shared with the patients involved. Clinicians would also offer to meet with families when things had gone wrong.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from a healthcare-associated infection. High standards of cleanliness were maintained in most areas of the outpatient and diagnostic imaging departments. Areas appeared visibly clean, tidy, clutter and dust free. Some daily cleaning was carried out by staff with deep cleaning being undertaken by cleaning staff employed by another company. However, not all departments kept a cleaning checklist to provide assurance that cleaning had occurred. We saw completed daily checklists in haematology and orthopaedics but not ophthalmology.
- Some outpatient areas used 'I am clean' labels. These were placed on equipment that had been cleaned, however this was not consistently used across the outpatient and diagnostic imaging areas. This meant it was not always clear what equipment had been cleaned ready to be re-used.
- In all outpatient and diagnostic imaging areas, staff were bare below the elbow, in accordance with trust policy. Staff used aprons and gloves correctly to prevent the spread of infections. Staff washed their hands or used antibacterial hand gel immediately before and after patient contact in line with the National Institute for Health and Care Excellence (NICE) Quality Statement 61 (Statement 3). Hand gel facilities were available and clearly signposted in all departments we visited.
- Hand hygiene audits were completed on a monthly basis. Between April to December 2016 departments

had achieved between 98-100% compliance. Audits were also undertaken to assess compliance with NICE Quality Standard 61 Statement 4: People who have their risk of infection minimised by the completion of specified procedures necessary for the insertion and maintenance of the catheter as soon as it is no longer needed. From April 2016 to December 2016 the Trust achieved compliance between 92-100% per month.

- Where patients had suspected or confirmed infections specific imaging rooms were used and slots were allocated at the end of lists when clinics were quieter. This allowed appropriate cleaning of the rooms and equipment following their procedure.
- 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 was unacceptably full.
- Disposable curtains were not used in all outpatient and diagnostic imaging departments, however the material curtains used were cleaned and replaced monthly to help prevent the spread of infection.
- Waiting area furniture was clean and in good condition, fully wipe able and fully compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment.
- Since our last inspection the ophthalmology department had ensured access to a surgical scrub sink which was required for hand washing prior to certain procedures.

Environment and equipment

- The design, maintenance and use of facilities and premises did not always keep people safe within the outpatients and diagnostic imaging departments.
- The design, maintenance and use of facilities and premises did not always keep people safe within the outpatients and diagnostic imaging departments. Outpatient and diagnostic imaging departments had access to resuscitation equipment however; this access was sometimes compromised due to the sharing of equipment. The orthopaedic department shared access with the Betjeman clinic and discharge lounge. There was a risk to patients that if the emergency equipment was required it could be in use elsewhere. This had been risk assessed by the hospital and found to be in compliance with resuscitation guidelines. However, there was not a grab bag available to staff in the

orthopaedic department which did not comply with the trusts resuscitation policy and procedure which stated: 'All in-patient, out-patient and non-clinical areas must have access to a resuscitation trolley or grab-bag'.

- We reviewed checklists for resuscitation equipment and found that regular checks were carried out. All staff knew where the resuscitation equipment was located. In areas where resuscitation equipment was shared there was clear scheduling stating which department had responsibility to carry out the monthly and weekly checks.
- Some equipment in use within the outpatients and diagnostic imaging departments was past the manufacturers recommended age. Although there was no evidence of patient harm, the age of equipment had resulted in repeated equipment failure and downtime. Staff had reported every time equipment had failed and this was included on the hospitals risk register.
- Waiting rooms within the outpatients department were arranged in a way so that patients were visible to reception and nursing staff. This meant that patients could be observed and any deteriorating patient detected. However, patients waiting within the diagnostic imaging department could not always be viewed and although there were cameras in each of these areas they were not always monitored by staff.
- Staff used equipment safely and we saw a detailed competency checklist for each member of staff working in the different radiological modalities. Staff told us these were constantly updated and reviewed.
- The imaging service had ensured that non-ionising radiation premises in particular Magnetic Resonance Imaging (MRI) scanners had arrangements in place to control the area and restrict access ensuring patients or visitors could not enter and be exposed to the magnetic field. Each area or room where radiation could be in use were clearly highlighted and signposted.
- Equipment in outpatient departments had regular servicing carried out. Equipment clearly displayed the date it last underwent a portable appliance test, the date it last underwent a service and the date the next service would be required. Within the diagnostic imaging department there was a register which monitored the age of equipment and helped plan when equipment needed to be replaced.

Medicines

- Arrangements for managing medicines and contrast media kept people safe. Medicines, including those requiring cool storage, were stored safely and kept within recommended temperature ranges. During our inspection we found that all medicines were stored securely, and were only accessible to authorised staff. All cupboards were locked and the stocks well organised.
- Daily temperature records for fridges storing medication were completed and contained minimum and maximum temperatures to alert staff when they were not within the required range.
- There were reliable systems for storage, recording and the administering of contrast media. Computed Tomography (CT) scanners kept contrast containers in warming cabinets. Batch numbers of contrast containers used in both CT and MRI were recorded on the computer records for each patient.
- Prescription pads were secured in locked cabinets. A log of prescriptions was maintained which included patient identification, serial number of the prescription sheet and the name of the provider.
- Patient group directions (PGDs) were seen to be in date, with clear review dates documented as well as clear inclusion and exclusion criteria, dose, frequency and storage. PGDs permit the supply of prescription-only medicines to patients, without individual prescriptions. There was clear documentation about the qualifications and training needed for healthcare professionals to use a PGD.
- The imaging service took account of The Medicines (Administration of Radioactive Substances) Regulations 1978. Administration of Radioactive Substance Advisory Committee certificates were in date clearly stating the different licences and which radiopharmaceuticals could be administered and for what purpose.

Records

- Patient's individual care records were written and managed in a way that kept people safe. In the outpatients department we looked at 14 sets of patient records. All 14 were clearly written and legible, accurate, up to date and signed.
- Patient records within the diagnostic imaging department were stored electronically on the hospitals computer system. Each staff member had an individual password to ensure these records were secure.

Computers were locked when not in use and were password protected to prevent unauthorised access. Notes were stored securely within the outpatients department with no records left unattended.

 Systems were in place to manage computer system failure. The diagnostic imaging department had a continuity plan to manage a loss of their Cross-Site Reporting and Imaging Sharing software (CRIS) and Patient Archiving Communication System to ensure patient safety. If The CRIS system failed, imaging requests could be printed via another computer system. If both these systems failed, a paper imaging request could be printed from the hospitals intranet.

Safeguarding

- There were systems, processes and practices in place to keep both adults and children safe from abuse. Staff had good knowledge of the trust's safeguarding policy and were able to show us the contact information for the safeguarding leads within the Trust and local safeguarding services.
- Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and non-clinical staff who had contact with children and level three for staff working directly with children and young people. Training records provided by the trust showed 100% of nursing staff had received level one, two and three child protection training and 100% in level one and two safeguarding vulnerable adults. However training records for medical and dental staff showed that only 20% had received training in level two safeguarding vulnerable adults against a trust target of 80%.
- Staff were able to demonstrate a good understanding of their responsibilities and the process involved in raising a safeguarding concern. We heard of an example where a safeguarding alert was raised in regards to the relative of a patient who had attended for an outpatient's appointment.
- Staff had received training regarding female genital mutilation (FGM) and were alert to when to report any identified or suspected risks from FGM to women and children.
- Staff had received training on the governments PREVENT strategy. Prevent is part of the government's counter-terrorism strategy and aimed to stop people becoming terrorists or supporting terrorism. Prevent focuses on all forms of terrorism in a pre-criminal space,

and provides support and re-direction to vulnerable individuals at risk of being groomed into terrorist activity before any crimes are committed. Staff received training in this area as part of their mandatory training.

Mandatory training

- Almost all staff received training in the systems and processes which helped keep people safe. A corporate induction and local induction policy created a framework in which all staff, whether temporary or permanent, were effectively and appropriately introduced to the trust culture, environment and ways of working.
- The hospital provided a programme of mandatory training for staff which included dementia awareness, information governance, manual handling, basic life support, major incident, health and safety and infection prevention and control.
- Data provided by the trust showed that nursing staff achieved or exceeded internal targets for all the mandatory training. However, for medical and dental staff there were areas where training levels were below the trusts target. This included only 20% of medical and dental staff receiving training in adult basic life support and fire training against a target of 80% as well as only 35% having received training in paediatric life support against a trust target of 80%. Staff we spoke with in the outpatients department were aware of the outstanding mandatory training for medical and dental staff. We were informed that this had been discussed and an action plan had been put in place to increase compliance over the next few months.
- Managers and individuals were informed through an email flagging system of those staff members whose training was due to expire. Managers were aware of the current status for staff.
- Mandatory training was delivered via classroom based learning and electronic learning. Most staff within the outpatient department reported they were given the time to attend training sessions which was engaging and responsive to their needs. However we were told that within the diagnostic imaging department it was becoming harder for staff to find the time to undertake the online training sessions due to work demands and staff shortages.

Assessing and responding to patient risk

- Risks to people who used the service were assessed and their safety was monitored and maintained with clear procedures in place for the care of patients who became unwell. There were clear pathways and processes for the assessment and management of deteriorating patients within outpatients who were clinically unwell and required hospital admission.
- Risk assessments were carried out in line with national guidance. The radiology department required woman to sign to confirm they were not pregnant prior to undergoing any radiation exposure.
- The imaging service ensured that the World Health Organisation (WHO) Surgical Safety Checklist was used as a checklist when carrying out non-surgical interventional radiology. Audits in to the use of the WHO checklist were carried out weekly providing a percentage overall for that month. Results showed 100% compliance in the January and February and 100% and 97% for the first two weeks in March 2017.
- There were processes in place to ensure the right person received the right radiological scan at the right time. Staff told us they used stop and check procedures as recommended by the Society and College of Radiographers and pause and check posters were seen in each imaging area we visited. In August 2016 there had been an incident where the wrong person received the wrong scan. Following an investigation in to this the importance of the pause and check were reiterated and this was disseminated to staff through team meetings.
- The radiation protection advisor was easily accessible for providing radiation advice. The department had recently changed to a new radiation protection advisor following assessment and concerns raised about the response times and pro-activeness of the previous organisation. The radiation protection advisor was present on site three days a week with quarterly contract meetings held with the diagnostic imaging managers.
- The radiation protection advisors were responsible for carrying out risk assessments for new or modified uses of radiation which would then be discussed during meetings. These risk assessments addressed occupational safety as well as consideration of risks to people who use services and the public.
- The diagnostic imaging service ensured that the 'taking' of an X-ray, MRI, nuclear medicine or other radiation diagnostic test, was only made by staff or approved persons in accordance with Ionising Radiation (Medical

Exposure) Regulations (IR(ME)R). This was stored securely on the intranet along with a list of medical and non-medical referrers for the requesting of imaging. Within the hospital only those staff members who had permission to request imaging were able to do so through a computer system.

There were local policies for the risk assessment and prevention of contrast induced nephropathy, which is when renal/kidney function is impaired following the administration of a contrast. Staff were aware of these policies which were in keeping with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Radiologists standards for the administration of intravascular contrast agent administration. Staff told us estimated glomerular filtration rates (eGFR) were always checked for patients receiving iodinated contrast agents. This was to check how well patients kidneys were functioning. To ensure this test was undertaken a safety checklist was carried out before imaging which would highlight those patients in need of eGFR checking.

Nursing staffing

- As of December 2016, the trust reported a vacancy rate of 12.4% in Outpatients and Diagnostic Imaging. Within Wren unit there were 6.6 whole time equivalent vacancies. Staff reported that this had affected their ability to run extra clinics however it had not impacted on routine clinics.
- There were staff vacancies at all levels within the diagnostic imaging department which meant along with an increase in demand this had been affecting performance including report turnaround times. There was no finance or capital replacement plan in place to fill these areas meaning despite an increase in demand the staffing establishment had not been increased to manage this. Staff reported the lack of staff had resulted in an increase in the on-call or out-of-hours shifts they had been working. It had increased from once or twice in ten weeks to at least once a week. At the moment these were being filled on the good will of staff and there was no plan in place to manage this in the long term.
- Where possible, sickness or annual leave was covered by staff within the outpatient department. However, bank staff would be used to assist with additional clinics provided

• The diagnostic imaging department regularly relied on bank or agency staff to fill shifts. In the 13 month period of March 2016 to March 2017 405 shifts were filled by bank staff and 166 were filled by agency staff.

Medical staffing

- Medical staffing was provided by the specialities running the individual clinics within the outpatient departments. This ranged from junior doctors to consultants.
- As of December 2016, the trust reported a vacancy rate of 10.3% and a turnover rate of 7.2% in Outpatients and Diagnostic Imaging for medical staff. This was below the trust turnover target of 13%.
- There was two consultant radiologist vacancies within the diagnostic imaging department. We were informed that an assessment had been carried out to determine the number of reporting staff to achieve timely reporting and this had shown an additional 5 radiologists would be needed. The department had employed one radiologist and one locum radiologist. There were no plans in place to meet the staffing requirement and the delay in reporting had been placed on the risk register.
- On call reporting was provided by an external source between the hours of 11pm to 7am. Evening and weekend cover was provided by medical staff employed by the hospital.
- Between January 2016 and December 2016, the trust reported a sickness rate of 1.8% in Outpatients and Diagnostic Imaging which was below the trust target of 3.5%.

Major incident awareness and training

- Major incident training was incorporated into the trusts health and safety training. As of January 2017, 88.7% of staff within the Outpatients and diagnostics department were up to date with this training with the target being met for each individual staffing group.
- The staff we spoke with were aware of the major incident plan for the hospital and their department and their roles in it. Within the orthopaedic clinic they kept a stock of plaster of paris to enable them to respond to a major incident in a more time efficient manner.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Although we inspected the effective domain in outpatient and diagnostic imaging services we did not rate them due to the lack of national data available to CQC. We found that:

- People's care and treatment in both outpatients and diagnostic imaging was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Staff had the right qualifications, skills, knowledge and experience to do their jobs.
- Outpatient departments took part in national and local audits.
- We saw good evidence of multi-disciplinary working within the departments, hospitals, other hospitals and community services.
- Improvements had been made in the availability of records with 96.4% of notes being available at the start of clinic and 99.4% by the end of clinic.

However:

- There was an inconsistent approach to the provision of clinical supervision and peer review.
- Only 45% of non-clinical staff had received an appraisal.
- The diagnostic imaging service did not always ensure that it met best practice for time taken to report on images.

Evidence-based care and treatment

- Relevant and current evidence based guidance; standards, best practice and legislation were identified and used to develop services in outpatients and diagnostic imaging. Any alerts or information were shared at either safety briefings or staff meetings. For example, in orthopaedics they followed the gold standard for diabetic foot care whilst the anti-coagulation services followed national practice for venous thromboembolism (blood clot) assessment of patients with lower limb fractures.
- Compliance with current evidence based guidelines and practice was monitored. Within the physiotherapy department an audit was being undertaken to assess the impact psychological factors had on pain and the

outcome of physiotherapy treatment. This had enabled staff to produce a functional patient outcome and had given staff a better understanding of the impact psychological factors could have.

- The Commissioning for Quality and Innovation (CQUIN) payment framework enabled commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. A CQUIN was in place within relevant outpatient departments for the reduction in antibiotic consumption per 1,000 admissions and for the review of those antibiotics prescribed.
- National Institute for Health and Care Excellence (NICE) guidance were followed in the diagnostic imaging departments. The diagnostic imaging department followed NICE guidance relating to the imaging of patients who have sustained a head injury and that a provisional written radiology report should be made available within one hour of the scan being undertaken. They also followed NICE quality statement three relating to the imagin of adults with suspected spinal cord compression. This states that adults with suspected metastatic spinal cord compression who present with neurological signs or symptoms should have an MRI of the whole spine within 24hours of the suspected diagnosis.
- The imaging service used diagnostic reference levels (DRLs) to check the correct amount of radiation being used to image a particular part of the body as required under Regulation 4(3) (c) of IR(ME)R 2000 and IM(ME) amendment regulations 2006 and 2011. Staff were able to locate and explain how they used these as a tool and we saw evidence of them being displayed in the diagnostic imaging departments. The DRLs were reviewed yearly and changes were being made to determine the correct DRL based on a patients weight in line with best practice and guidance.
- The diagnostic imaging department had undergone an Ionising Radiation (Medical Exposures) Regulation assessment were it was deemed they were not compliant with the Ionising Radiations Regulations 1999. An improvement notice was issued which was subsequently removed in June 2016 following work and improvements made by the department.

Pain relief, nutrition and hydration

• Staff said it was unusual to have to give patients pain relief in the outpatients department. However, if a

patient was in pain and required pain relief then they would take the patient to the walk in centre located in the hospital where a doctor could assess them and provide any pain relief required.

Patient outcomes

- A governance framework was in place to ensure that a range of outcomes were reviewed and discussed, however these were done within the individual divisions rather than across all outpatient departments.
- Patient outcomes were also assessed through audit and national benchmarking. The physiotherapy department submitted data every two years based on the size of department, hospital staff and vacancies. This was then used to compare physiotherapy departments nationally. The Trust also participated in national audits including the national rheumatoid and early inflammatory arthritis and national diabetes foot care audit.
- Local benchmarking and changes to practice also occurred. For example, as part of the Sustainability and Transformation Partnership pathways relating to faecal protecting were being assessed and modified at Great Western Hospital and two other NHS trusts. The aim was to increase protein testing on individuals which would help in reducing the number of procedures patients would have to undergo.
- The diagnostic imaging department also participated in South West benchmarking. Managers attended the South West regional radiologists managers group where benchmarking in regards to agency costs, staffing levels, vacancies and scanner utilisation was looked at.
- The diagnostic and imaging department did not have accreditation through the Imaging Services
 Accreditation Scheme (ISAS). This is an assessment and accreditation programme which covers a list of quality standards covering quality, delivery, safety and patient experience. Staff informed us that although discussion had occurred relating to trying to obtain ISAS accreditation, it had been decided that there were not sufficient staff to enable service to continue to run efficiently whilst undertaking the work required to obtain accreditation.

Competent staff

• Staff had the right qualifications, skills, knowledge and experience to do their jobs when they started their employment, or when they took on new responsibilities. For example, any member of staff who ran the CT

scanner had undertaken formal training in each machine and it was ensured that they felt confident to run the scanner unassisted before doing so. There were written competencies in both the outpatients and diagnostic imaging departments.

- However, not all staff had their learning needs identified appropriately through an appraisal. As of December 2016 77% of staff had received an appraisal against a trust target of 80%. Out of the eight staffing groups, five had reached the trust target. However, there were areas of low compliance in particular non-clinical support staff where only 45% of staff had received an appraisal. Most staff that we spoke with had received an appraisal, and informed us they felt it was a worthwhile process where their developmental needs were addressed and acted on. We discussed the low appraisal rates for certain staff groups with managers who informed us an action plan had been established to address and improve this over the upcoming months.
- All staff administering radiation were appropriately trained to do so. Those staff that were not formally trained in radiation administration, were always adequately supervised in accordance with legislation set out under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). For example, we saw students working alongside qualified radiographers, who provided supervision and guidance for the students.
- Staff within the outpatient and diagnostic imaging departments said that although they received regular appraisals there was no current system in place to ensure regular peer review or clinical supervision.
- Staff within the outpatients department reported they were given the opportunity to develop and improve the care given to patients. Some nurses within the ophthalmology department had undergone training in post-operative care which meant they were able to support and provide care for their patients post operatively. Staff within the orthopaedic clinic had undertaken additional training in tissue viability to help treat diabetic patients that have leg ulcers but may also require a plaster cast. However, staff within the diagnostic imaging department reported it was often difficult to find the time to attend courses to develop due to work demands.
- Any new member of staff underwent a comprehensive trust and local induction to prepare them for their job role. We spoke with a new member of staff within the physiotherapy department who underwent a local

induction programme on the unit and had to complete core competencies before they were able to undertake on call or weekend working. They were also given a buddy who they would contact for help and advice as well as a contact telephone number during their first weekend on call.

Multidisciplinary working

- There was good evidence of effective multidisciplinary working. All necessary staff, teams and services were involved in assessing, planning and delivering patients care and treatment. Relationships throughout the outpatient departments, diagnostic imaging department and hospital were good.
- Staff worked well with social care services in the area. The ophthalmology department had access to a liaison officer who could provide support to patient and relatives and ensure they had an understanding of the finance and social care and support that was available to them.
- Skills and knowledge were readily shared to improve patient care. The trauma and orthopaedics team had recently arranged and provided evening training sessions for junior doctors, training them in how to apply casts. The aim of this was to prevent any unnecessary hospital visits for patients by enabling them to be treated on their initial visit and thus reducing the need for a further appointment.
- As part of the justification process to carry out exposure to radiation, the imaging service always attempted to make use of previous images of the same person requiring the test, even if these have been taken elsewhere. The trust had an image exchange portal (IEP), which meant images could be transferred between hospitals at any time of day or night. Staff told us that they found this system easy to use.
- Improvement and learning was shared amongst teams within the hospital. The diagnostic imaging manager had been nominated for a Star of the Month aware for the help and shared learning provided to the maxillofacial department on IR(ME)R compliance
- Staff worked well with other departments in the hospital. The cardiology outpatients team had recently won a Point of Care Foundation Award for the end of life pathway devised between the cardiology and end of life team.
- Staff worked with both staff within the hospital and from other hospitals to deliver effective care and treatment.

The diagnostic imaging team had recently visited another NHS hospital to learn how MRI scans could be carried out on non-conditional pacemakers with a view to incorporating this practice in to Great Western Hospital.

Seven-day services

- Most outpatient services ran a traditional five day service. However, due to high demand and to maintain or improve referral to treatment performance some clinics were now providing both weekend and out of hours services. When clinics were closed and patients required advice or help they were directed to their GP, 111 services or the accident and emergency department.
- Some diagnostic imaging services were available seven days a week. Those that were available such as CT, MRI and ultrasound had weekend availability that had been previously limited to emergencies only. However, due to demand, MRI was now available for outpatient appointments seven days a week as well as the CT scanner which was available for urgent outpatient appointments.

Access to information

- Most of the information required to deliver effective care and treatment was found in patient case notes. The availability of these is a requirement of NICE quality statement 15 (statement 12) which states that patient should experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. An audit in to the availability of notes was carried out on a monthly basis. The last audit carried out in December 2016 showed that 96.4% of notes were available at the start of clinic against a trust standard of 95% and 99.4% by the end of clinic against a trust standard of 99%. In the five months previous to this note availability was always above the standard.
- The diagnostic imaging service did not always ensure that it met best practice for reporting on images. Data provided by the trust showed that 39% of urgent X-rays were not being reported within the 24 hour time frame. Also 25% of routine X-rays were not being reported within the five day time frame. Managers reported this was due to shortage in staff. An action plan was in place to improve reporting turnaround which included in and outsourcing of radiologists to report.
- The diagnostic imaging service provided electronic access to diagnostic results for all referring staff in the hospital via its requesting system and also for all clinical staff via its PACs system. However, there was no PACs manager within the hospital with support being given by one IT lead. Staff reported that if this lead was on annual leave or was ill it was difficult to get things fixed if the PACs system failed.
- At the time of our inspection the outpatient departments we visited were using paper records, whilst the diagnostic imaging department used electronic records. Audits were undertaken to ensure that paper records were stored in the correct place. The initial audit undertaken showed 82.5% of notes were tracked correctly, this had decreased very slightly to 82% when a re audit was undertaken.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Training in the mental capacity act was provided by the trust as part of mandatory training. Data provided by the trust showed that as of February 2017 88% of all staff within in the Outpatients and Diagnostic Imaging service had completed Mental Capacity Act (MCA) training.
- Regular audits were undertaken in consent, mental capacity and deprivation of liberty safeguards (DoLs). The most recent audit data showed that previously there had been 51% compliance in correct assessment and documentation of DoLs and this had increased to 78%; however this was still below the trusts target of 100%. There were action plans in place to improve compliance in line with the trust's target.
- Staff had a good knowledge and understanding of the processes involved in determining whether a patient had capacity, how to gain adequate consent and their responsibilities surrounding this. We heard examples where clinicians had concerns surrounding a patient's ability to consent. When this occurred best interest meetings were held to determine if patient had capacity and whether they could be supported in giving consent.
- Throughout the inspection we saw staff explaining the assessment and consent process to patients and any need to share information with other professionals such as GPs. We saw consent forms were signed by patients.

We were informed of an incident where a relative claimed to have power of attorney for health of a relative but did not have the required documents. The staff member contacted the patients GP to gain confirmation of this meaning the patients appointment did not have to be rearranged.

• Where it was deemed patients had capacity, staff still recognised the need for relative's involvement in supporting patients to make a decision. We observed carers and relatives being encouraged to attend clinic appointments

Are outpatient and diagnostic imaging services caring?



We rated caring as good because:

- Feedback from patients and relatives had been consistently positive.
- Patients said staff were caring and compassionate, treated them with dignity and respect, and involved them in decisions.
- Relatives were encouraged to be involved in care as much as the patient or relative they wanted to be.
- Staff talked about patients compassionately with knowledge of their circumstances and those of their families.

However:

• Patient assessments and conversations could be overheard in the ophthalmology department.

Compassionate care

- Care from the nursing, medical staff and support staff was delivered with kindness and patience. We observed staff giving patients the time to respond and patients told us they were always given time to ask any questions and staff listened to their concerns.
- Patients we met spoke highly of the service they received. All the feedback we received from the patients was very positive about the care delivered. The comments we received during our discussions with patients included, "everybody is most kind from the porters and reception staff, to the consultants" and "both treatment and care have been great"

- We observed compassionate interactions between staff, patients and their relatives. For example, when a relative became concerned about the length of time their relative had been receiving treatment, a member of staff went to find the relative to check all was ok and then returned to reassure the concerned relative that everything was alright.
- There was good attention from all staff to patient's privacy and dignity with doors being shut when confidential conversations were taking place. Staff knocked and waited to be told it was ok to enter clinical rooms. However, within the ophthalmology department there was a clinical area where interconnecting rooms were separated by curtains. This meant confidential conversations could be overheard. We were informed that an assessment had been carried out on whether doors could be attached, however it was deemed this was not possible.
- There was a chaperone policy in place to promote the privacy and dignity of patients. A chaperone would be offered for any patient who was undergoing an intimate examination.
- The NHS friends and family test was used in diagnostics and outpatients. In February 2017, 98% of patients said they would be likely or extremely likely to recommend the service to friends and family. The diagnostic and outpatients department received an overall score of 4.82 out of five with all areas achieving a score of 4 of above. These areas include dignity and respect, involvement, family involvement, privacy and information given.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. Staff explained things to patients in a way they could understand. They ensured they then checked the patient understood what had been said. 89% of 81 patients within the diagnostics department survey reported that staff answered their questions either extremely or very well.
- Patients reported that they felt they had access to the information needed to make an informed decision and felt confident in raising and concerns or questions if they didn't.
- We observed staff introduce themselves, their role and explain each step of what they were doing.
- Staff recognised when patients needed additional support to help them understand and be involved in

their care and treatment. They had knowledge surrounding supporting patients where English wasn't their first language or patients living with a visual or hearing impairment.

Emotional support

- Staff understood the impact the care, treatment or condition might have on the patient's wellbeing and on those close to them both emotionally and socially. We saw evidence of thank you cards given to staff containing comments such as, "most caring and supportive staff", "it makes the ordeal so much easier to deal with".
- Treatment options were discussed and patients were encouraged to be part of the decision making process. Letters detailing the outcome of appointments were sent, one patient we spoke with said "we receive fully comprehensive letters which are excellent and very informative".
- There was good awareness of the impact health care has on individuals close to the patient. Staff told us they felt they not only had a duty of care to the patients but also to their families.
- Staff ensured that patients were treated as individuals. One patient told us, "you are always seen as an individual and staff always listen to your point of view".

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- For three months out of the past 10 the trust was performing worse than the national standard for two week urgent cancer referrals.
- There were delays in GPs receiving appointment outcome letters which could impact patient care.
- There were areas where a high number of patients were awaiting an appointment, in particular ophthalmology.
- Age of equipment had resulted in lost clinical hours and clinics being cancelled.
- Services were not always able to deliver and take account of the needs of different people for example bariatric patients and patients whose first language was not English.

- Shared learning from complaints across the outpatient departments was inconsistent.
- Data on waiting times were not collected or audited.

However:

- Staff showed a good understanding of the support that would be given to a patient with additional needs.
- At the time of our inspection within the outpatients departments referral to treatment targets were better than the national average.

Service planning and delivery to meet the needs of local people

- Changes had been made to the delivery of some services in response to the needs of the patient. For example the cardiology service provided virtual and nurse led clinics. Here, nurses had the ability to prescribe which consultant's time could be used more effectively to ensure patients had more timely access to care and treatment.
- Appointments were arranged where possible around the needs and requirements of the patient. For example, staff within the diabetic team informed us that patients choose the most appropriate time for their appointments. New patients were given longer for appointments to enable them to ask any questions that they may have. Staff told us appointment length was dependant not only on the medical condition but also the needs of patient.
- Patients received text reminders or phone messages reminding them of their upcoming appointment which had helped to reduce 'Did Not Attend' rates. It also gave patients the opportunity to cancel or rearrange their appointments freeing up clinical space which could be utilised rather than cancelled.
- Waiting areas were appropriate and patient centred. There were facilities and toys to keep children entertained. Within the rheumatology department there were posters with sitting exercises which could be completed whilst waiting as well as access to origami. This had been introduced in response to patient feedback on what they would find enjoyable and engaging.
- The use of technology within the diagnostic imaging department to meet the needs of patients had recently won an award. The department had won the British Medical Association award for Patient Information in

2016 for the use of videos to show what patients can expect from an MRI scanner. Patients could find the video on line via a hyperlink that was sent prior to their appointment.

- Some departments had started to use virtual clinics as an alternative to face to face clinics. The fracture clinic had set up a virtual fracture clinic and has shown a decrease in 40% of unnecessary appointments. They had also introduced telephone appointments giving patients the required information they needed following attendance at A&E, thus preventing patients having to attend the hospital again. This telephone call was followed up by a confirmation letter.
- Information was provided to patients in accessible formats before diagnostic imaging appointments, which included information about contact details, information about the examination the patient was coming for and options for travelling to the hospital.
- Waiting rooms within the outpatients and diagnostic imaging departments contained a variety of toys for children as well as televisions and magazines for adults. Water coolers were also available for patients
- To ease parking on the hospitals site, a shuttle bus was available for patients to use to get to and from the town centre.
- In each outpatient department there were water facilities available for patients. Snack boxes were stored for those patients who required transport as well as vending machines and cafes throughout the hospital with signposting to these displayed.

Access and flow

• Within outpatients, referral to treatment targets stipulate that patients should be treated within 18 weeks of referral. Between January and December 2016 the trust's referral to treatment time (RTT) for incomplete pathways showed an improvement, with seven months of the year being above the national target. The areas where referral to treatment times (RTT), in March 2017, were below the national average were gastroenterology which was achieving 86.3% against a national average of 92.2%, dermatology, 88.2% against a national average of 92.4% and ophthalmology, 87.2% against a national average of 91.4%. However, other departments were above the national average for referral to treatment times, this included cardiology, neurology, rheumatology and urology.

- Referral to Treatment timeliness was monitored on a weekly basis within the different departments and divisions and this was reported at performance meetings and to the trust board on a monthly basis. Each speciality reported to a divisional lead that held them to account for actions against an action plan. Individual patients who were waiting longer than 18 weeks and those deemed high risk and needed to be seen sooner were discussed with consultants on at least a weekly basis to ensure that the patients at highest risk were seen first.
- Urgent GP cancer referrals need to be seen within two weeks to ensure timely diagnosis and treatment. The trust was performing below the operational standard of 93% at the time of our inspection with 82.1% being seen as of January 2017, however the trust had exceeded the standard for seven out of ten months between April 2016 and January 2017. It was achieving above the national operational standard, 96%, for people waiting less than 31 days from diagnosis to first definitive treatment; as well as being above the national operational standard 85% for people waiting less than 62 days from urgent GP referral to first definitive treatment. At the time of our inspection it was achieving only 81.8% in January 2017 for cancer screening within 62 days against a national standard of 90%, however it had been above the operation standard for the previous nine month period.
- A contributing factor to the two week cancer referral targets is the access and reporting of diagnostic imaging. The diagnostic imaging service did not always ensure that it met best practice for reporting on images. Data provided by the trust showed that 39% of urgent X-rays were not being reported within the 24 hour time frame. Also 25% of routine X-rays were not being reported this was due to shortage in staff. An action plan was in place to improve reporting turnaround which included in and outsourcing of radiologists to report.
- Action plans to manage and improve referral to treatment times was managed within sub specialities. Actions to meet these included most outpatient clinics running additional out of hours and weekend clinics. However, in order for these to run, staffing of these clinics relied on good will. Staff described this as not being sustainable.

- The follow up to new appointment ratio, which is the ratio of new patients seen compared to those already seen, from November 2015 to October 2016 was 1.76 which was lower than the national average of 2.2. This meant the hospital could free up more time to see new patients.
- There were issues with the number of patients awaiting appointments. In particular within the ophthalmology department where as of March 2017 there were 5,317 patients awaiting an appointment. To mitigate any risk the patients classified as urgent were reviewed twice weekly with all patients being reviewed on a monthly basis. At the time of our inspection five high risk patients had been waiting above the six to eight week target, this had increased to 22 by the 30th March 2017. Concerns were raised as some patients who may be high risk may not have been identified and were therefore only being reviewed monthly. We were informed by some ophthalmologists that concerns were raised about the risk of medium and low risk patients sight deteriorating whilst waiting for appointments. Management told us that there was no evidence of impact on patient condition and patients would be asked to attend a nurse led clinic where their visual fields and pressure would be measured to monitor any deterioration in condition prior to an ophthalmologist's appointment being available. However, staff felt that although an action plan was in place to improve the current situation an improvement was not being seen. The number of patients on hold past the date they should be seen within ophthalmology had shown some improvement over the past six months with 1158 being past the date they should be seen in March 2017 compared to 1276 in November. However this number had both increased and decreased over this six month period so it could not be guaranteed that this improvement could be maintained.
- The number of patients awaiting a follow up appointment had also increased. Within the outpatients and diagnostics division the number of patients who had breached the targeted follow up time was 9672 in December 2016. This was above the trusts target of 2500 and had increased from 7625 in April 2016. The high number of patients awaiting a follow up appointment in each unit was on the hospitals risk register. Actions to address those patients in breach were discussed and put in place, however the number of patients in breach of follow up had increased.

- Between January 2016 and December 2016 the percentage of patients waiting more than six weeks to see a clinician was on average higher than the England average of two percent. However, since October 2016 waiting times had improved with less than 1.5% of patients waiting longer than six weeks in December 2016.
- There was a delay in GPs receiving appointment outcome letters. At the time of our inspection there was a backlog of letters waiting to be typed and sent to patients GPs. In ophthalmology the delay amounted to 2232 hours. As a result, GPs were not receiving letters of the outcome of a patient's initial appointment before the patients' next appointment. This had meant that GPs were unaware of the outcomes and thus may not be able to offer the advice and treatment most suitable for the patient. The trust had a target of letters typed within two to four days, however in February 2017, haematology reported only 11.5% were typed in two days and 12.2% in four days. An action plan had been put in place to address this, such as the employment of more administrative staff. However, managers felt this would only help manage the current demand and would not address the backlog.
- Between November 2016 and October 2016, the number of patients classed as 'did not attend' was slightly higher (worse) than the England average. The trust had a policy in place to manage this. Patients were given one opportunity to attend and then clinically reviewed to determine the appropriateness of being discharged following an appointment not being attended. Each division used its own central booking system. However, members of the public reported that it was often difficult to get through on the phone and it was challenging to change appointment times. Of the 256 complaints received between February 2016 and January 2017, 32.8% related to communication issues and 22.7% related to appointments including delays. The trust audited the number of calls that went unanswered and had set a maximum limit of 10%. The percentage of calls unanswered by the booking centre for the outpatient and diagnostics division was 14% in November 2016, which was above the target. However, it had decreased from 23% of calls going unanswered in April 2016.
- Patient outcomes such as "did not attend" and cancellation rates were monitored in each outpatients

department as well as centrally by the divisional appointment booking managers. Between November 2015 and October 2016 the 'did not attend' rate for the hospital was slightly higher than the England average.

- Although waiting times were clearly displayed in each clinic, the trust did not collect any data or audit this.
 This meant there was no way for the trust or departments to determine if waiting times were high or increasing and thus no action plan could be put in place to address any issues that may relate to this.
- Some equipment within areas of the outpatients and diagnostic imaging departments were past their replacement age, for example the II Phillips Matilda CT scanner was eight years past its replacement age. This had resulted in repeated equipment failure and downtime. The age of equipment was on the risk register in both the ophthalmology and radiology departments. We were informed that in the last 12 months, equipment failing had resulted in 540 MRI imaging slots being lost which amounted to 15 days and 248 CT imaging slots which amounted to 4.5 days lost. Within ophthalmology, an update to the lens star had been delayed. This had resulted in two weeks of inactivity for this equipment meaning 80 patients had to be cancelled. Each department had a clear business plan of the equipment requiring replacement and the cost and a plan had been put in place to replace some equipment however, this would not address all areas of outdated equipment.

Meeting people's individual needs

- Services were not always able to deliver and take account of the needs of different people. Staff had access to a translation and interpreting services for patients. This was a telephone service which was available 24 hours a day, 365 days a year. However, staff reported that this wasn't always suitable for the situation they were in. For example the use of a telephone translation service was not conducive for use in an MRI scanner where instructions are required to be given but a phone could not be used in the scanning room due to the magnetic field. Staff also reported they weren't always informed if a patient required translation service before their attendance at the hospital meaning appropriate adaptations could not always be made.
- Transport services were available for service users with mobility problems. Staff reported that sometimes patients were dropped off late, meaning their

appointment slot had been missed, or had to wait a long time to be picked up. When this occurred staff would report it as an incident on the hospitals reporting system and raised at team and departmental meetings. Issues with transport been placed on the hospital risk register and work was on going with the transport services on how to manage this.

- Appropriate support was not always available for bariatric patients. This had been on the risk register since June 2015. Although some bariatric couches and a scanner had been purchased with a greater weight limit, there were still areas that were not accessible due to the width of doors. This included the ophthalmology department where doorways were too narrow for bariatric patients or patients on trolleys to be seen in clinical rooms. Instead they would be seen in the corridor with a divide put up. This not only compromised patient's dignity but would also result in three other clinical areas being blocked and thus unusable during this time.
- For patients with visual impairments, letters would be sent in large print and staff informed us that communication would be tailored to the needs of the patient. For example within the ophthalmology department patients could be telephoned and audio tapes were also available containing patient information. However, the sending of letters printed on yellow paper, which is easier for patients with a visual impairment to read, had recently been stopped. Staff reported this was due to cost.
- The outpatient and diagnostic imaging departments had a wide selection of information leaflets available to patients. These leaflets contained advice and guidance regarding medical conditions, support group and how to make a complaint. Within the ophthalmology department these were available in large print; however, they were not available in other languages
- There was disabled access to all the outpatient and diagnostic imaging departments, and the reception desk had a lowered section for wheelchair users in most clinics.
- Staff had a good understanding of how to support people living with dementia. Outpatient clinics we visited had information boards containing information on support groups and sessions available in the local area. Staff would be made aware of those patients living with dementia by a flagging system on their notes.

- Religious needs of patients were also met and respected. The chaplaincy provided spiritual, religious and pastoral care to all patients, relatives and carers of all faiths and those of none.
- Staff showed a good understanding of the support that would be given to a patient attending with a learning disability. For example within the diagnostic imaging department staff would be highlighted to a patient requiring additional needs through the computer request system. If this patient was an inpatient then they would contact the ward and arrange a time that was suitable for the patient ensuring the carers were present and that where possible the same radiographer would be used.
- Staff and teams worked collaboratively to deliver good quality care. We heard how if a patient attended with a visual impairment staff would contact the ophthalmology clinic who would provide staff assistance and any aids required.

Learning from complaints and concerns

- Between February 2016 and January 2017 the outpatients department received 256 complaints of which 181 were upheld or partly upheld. The trust took on average of 22.9 days to respond to each complaint. This is in line with the trusts complaints policy which states that a response should be given within 25 working days. The themes of these complaints included communication, appointments including delays, clinical treatment and staff.
- Patients and visitors we spoke with did not all know how to make a complaint or raise a concern. However, they all reported they would feel confident in not only enquiring how to do this but also in raising the complaint. Information regarding how to make a complaint was displayed in the individual outpatient departments in the form of leaflets and posters.
- Staff had good knowledge of the complaints procedure and the action they would take.
- Concerns were encouraged through feedback forms. When a complaint had been received action was taken to address and improve practice. For example, a complaint was raised in the diagnostic imaging department relating to the support given following a difficult diagnosis. The complainant and relative

Good

attended a meeting with the diagnostic leads where their views and ideas were used to change how difficult information was given. This had also led to greater connections and links with external support groups.

• Learning from complaints was shared at team meetings and governance meetings. However, shared learning from complaints across the outpatient departments was inconsistent and limited to divisions rather than across all outpatient units.

Are outpatient and diagnostic imaging services well-led?

We rated well-led as good because:

- Each outpatient department and division had a clear governance framework that ensured peoples responsibilities were clear and quality, performance and risks were understood and managed.
- Individual departments had their own vision with clear strategies for their departments and division.
- Leaders had a good understanding of the challenges departments faced and the future development of their service.
- There was a culture of candour, openness and honesty within the service.
- Oversight of the divisions and the need to strengthen quality, safety and performance had improved since our last inspection with fortnightly meetings with the deputy chief operating officer and the appointment of an outpatients manager.
- Where issues had been identified there were actions taken to address these with oversight being provided by the executive committee and the deputy chief operating officer.

However:

- Patient forums had been introduced, however this was not consistent across all departments.
- Staff did not always feel their views and opinions were acted on to shape and improve services.

Leadership of service

• Leadership and oversight of the outpatient services was at divisional level with overarching leadership being

provided by the deputy chief operation officer and executive committee. Since our last inspection, actions had been taken to improve the service via the transforming outpatients programme which held fortnightly meetings with each division. The trust had also recently appointed an outpatient manager, who although wasn't in post at the time of our inspection, the view was for them to have oversight of the outpatient services.

- Leaders understood the importance of working with local commissioners of service. A twice monthly meeting was held with leaders from each local clinical commissioning group. This had helped ensure there was clear guidance and team work in the development and commissioning of services. For example working together on the movement towards cardiac Magnetic Resonance Imaging.
- Staff informed us that leaders were visible and approachable. Staff felt respected and valued by their managers. However, they felt that the leadership was reactive rather than proactive, for example the way in which extra clinics were staffed and the lack of plan in place to manage this.
- Staff reported that within certain services there had been a lot of change in leadership which had led to confusion and inconsistency in approaches. In particular within gastroenterology, where one member of staff we spoke with reported they had nine line managers in three years and another three or four managers in the last two years. At the time of our inspection an outpatient's manager had just been appointed and was due to start in April. The aim for this role was for the outpatients manager to have the oversight of all outpatient departments and help drive change.
- To improve leadership and continuity across the outpatient services, the trust had recently introduced a monthly senior sisters meeting. Although the meetings had only just commenced at the time of our inspection and thus little evidence of the impact of these meetings, the aim was to improve continuity and shared learning.

Culture within the service

• There was a culture of candour, openness and honesty within the service. Staff we spoke with reported they

were encouraged to raise any issues or questions. We heard of incidences where staff challenged if they had any concerns, this included concerns surrounding safeguarding.

- The culture centred on the needs and experiences of people who used the services. All staff we spoke with mentioned patient care was at the forefront of their focus.
- There were regular awards given to teams and individuals that excelled. We saw evidence of nominations and awards won in different outpatient departments and diagnostic imaging. For example a member of the cardiac outpatients team had recently been nominated for the working together award and a member of the diagnostic imaging team had been nominated for the outstanding leader of the year award.
- Staff reported they felt comfortable to offer their views and opinions. However, they also reported they didn't always feel listened to and their ideas or opinions acted on. We heard examples of when ideas had been put forward to improve services but changes had not been made and staff were unsure of the reason for this although felt it was sometimes due to financial constraints.

Vision and strategy for this service

- There were clear values for the outpatients and diagnostics service which put patient care and service at the forefront. Staff had a good understanding of the core trust values of: service, teamwork, ambition and respect. All staff we spoke with said they were committed to providing the best quality care for patients and their relatives.
- There was no overarching outpatient wide strategy, with the different outpatient's strategies lying within their divisions rather than individually. However, all departments spoke of a vision to improve quality of care by reducing referral to treatment and waiting times for patients. Each department had a clear strategy of how they aimed to achieve this through more nurse-led and virtual clinics and workforce remodelling.
- The progression of each department was reviewed fortnightly by the chief operating officer as part of the outpatients transformation programme. This programme assessed how each department was developing and where they were on completing action plans.

• The diagnostic imaging department had a vision to decrease the reporting backlog and ensure bids for new equipment were submitted and achieved. The bid was based on urgency and need with a clear replacement need over the coming years. However, the success of this was reliant upon financial support from the trust.

Governance, risk management and quality measurement

- There was a clear governance framework within each division that ensured staff responsibilities were clear and that quality, performance and risks were understood and managed. Each division had their own but similar governance framework to ensure this. Information was disseminated down to staff through staff meetings and newsletters. There was a set agenda for these meetings which included incidents, audits, the risk register, any divisional incidents and learning from complaints. We saw evidence of these discussions taking place in the minutes for these team meetings. Staff were clear about their roles and what they were accountable for.
- Although an effective governance framework was in place there was also a drive to improve where possible. The trust had recently undergone a review of their governance framework by an external company. A plan was in place to review and relaunch the framework in the future so that it was in line with the suggestions of the review. At the time of our inspection the proposed changes were out for consultation and discussion at divisional board meetings.
- Outpatient managers attended monthly divisional board meetings where good practice and learning was shared. This was shared at the monthly executive committee meetings. Learning between the different outpatient departments was shared at the executive committee, and we heard how the success of a dictation service which had been successful in one area was shared and practice changed in other departments. A new senior sister's forum had been introduced two weeks prior to our inspection. It was planned that this meeting would occur monthly and be attended by band 7 nurses with an aim to increase shared learning amongst the individual outpatient departments.
- Where issues had been identified there were actions taken to address these. For example a transformation outpatients programme had been established to address issues such as referral to treatment times and

the mitigation of any risks associated with this. This programme was overseen by the deputy chief operation officer who met fortnightly with the divisions to review where they were on the recovery plan and any outstanding actions. Other risks were reviewed and discussed at monthly departmental and divisional board meetings with any high risks being discussed and overseen by the executive committee.

- There were effective arrangements in place to monitor risks however; they were not always managed in a timely way. Overview of the risk register was managed at service and divisional level. Risks were managed and reviewed firstly at department meetings which fed in to divisional monthly boards and risk meetings. Any risk rated highly was then fed into the executive performance meeting and executive committee meeting. However, there were risks that had been present on the risk register for a number of years. This included the provision of care for bariatric patients and the risk related to ageing equipment. An action plan had been put in place to replace some of the ageing equipment; however it would not replace all equipment that was due for replacement and thus not mitigate all the risk posed.
- The senior management within both outpatients and diagnostic imaging were realistic in their request for staffing and equipment, and backed their bids up with operational evidence, such as using the reporting backlog to justify the recruitment of more staff.
- There was an effective governance framework to support the delivery of the strategy and good quality care which included a twice yearly lonising Radiation (Medical Exposure) Regulations (IR(ME)R) meeting which all radiation protection supervisors fed risk assessments into. We saw evidence of (IR(ME)R) incidents and reports as well as radiation protection advisors reports being discussed at the imaging radiation protection meeting. There was clear discussion around incidents, risks and the actions taken to address these.

Public engagement

• Patients and relatives views and experiences were gathered through friends and family tests and comment cards. Comment cards were visible in each outpatient and diagnostic imaging area we visited and there was

evidence that comments were acted upon. For example, following feedback from a paediatric survey in outpatient's improvements had been made to the toys available within the oral day surgery department.

- Friends and family test results were displayed on doors within some areas of the outpatient departments. This included the departments found on Osprey Unit where they had achieved a score of 98% for February 2017.
- Some individual departments had established patient forums; this included the diagnostic imaging department. However, this was not consistent throughout the outpatient departments and there was no systematic approach to ensure the views of patients were used in the delivery of services within each department. However, staff told us there was a view to incorporate all outpatient departments into the existing patient participating groups. Of the patient engagement meetings that had occurred, and would occur every 3 months, changes had been made. These included the display of waiting times and the introduction of televisions. Outcomes of these meetings were displayed in the waiting room.

Staff engagement

- Since our last inspection listening events had been introduced for staff within the outpatient departments as well as, 'you said we did' events. This gave staff a platform to voice any concerns or views on how improvement within the service could be made. However, not all staff were aware of these events and had been unable to access them due to them being held in clinical hours.
- Monthly team meetings were also used as a platform to gain the views and opinions of staff. However, within the diagnostic imaging department staff reported it was often difficult to attend and as they were now held at lunch time it meant a lot of staff didn't attend as following long and busy shifts most staff required a break.
- Quarterly staff drop in sessions were available to staff within the diagnostic imaging department. However, managers reported they weren't always well attended due to staff working.
- The latest available staff survey results from 2015 showed that across the hospital there were high engagement scores which were above the national average. Results which scored above the national averages included fairness and effectiveness of

procedures for reporting errors, near misses and incidents. However, 79% stated that they had worked extra hours which was higher than the national average of 72%.

Innovation, improvement and sustainability

- When services were developed or changed the impact on sustainability was assessed. The diagnostic imaging department had recently changed the allocation of patients to the two available Computed Tomography scanners, with emergency and in patients using one and outpatients using the other. The aim of this was to increase flexibility and prevent outpatient appointments being delayed or cancelled. The impact of this change was audited with the first audit showing a 5% improvement in number of patients scanned over a five day period and the second audit showing a 12% increase in number of patients scanned over a two week period.
- Leaders had a good understanding of the ways in which services could be sustained and were involved in the

NHS Sustainability and Transformation plans. We heard how work was being undertaken on the sharing of pathology staff with other NHS organisations due to the issues faced with recruitment.

- The orthopaedic clinic had recently introduced the use of finger straps which enabled them to treat certain fractures without the need for surgery. Most staff we spoke with said that the increase in the number of weekend and out-of-hours appointments to manage waiting times was unsustainable. Currently these were being filled by the good will of staff which was not sustainable.
- The cardiology department were actively involved in clinical studies and research studies to drive improvement. They were the highest recruiter in the UK in a study looking at heart failure, and a regional study looking at stress echocardiography as well as being the first UK hospital involved in another study looking at heart pacing.

Outstanding practice

- The work of the education lead in the emergency department to improve education through various initiatives and work steams including improved appraisals, training as part of the governance days and introduction of structured workbooks and teaching sessions.
- The understanding and involvement of patients and those close to them in the paediatric emergency department during observed triages. The nurse put the patient at ease and made sure that the process was explained in a compassionate way.
- The understanding of the emergency department leadership team of performance, governance, risks and its impact on patient care.
- The use of an emergency department monthly governance day to engage staff with governance and learning from incidents, concerns or near misses.
- The use of social media in the emergency department to engage staff to be more engaged with governance, share learning and discuss concerns with senior members of staff.
- The work of the clinical trials team in the emergency department to increase trial recruitment from very few patients a year to several hundred patients a year and the impact this has had on patient experience in the department.
- The medical care service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The medical care service had introduced digital technology for patients living with dementia which enabled them to access personalised reminiscence material.
- The trauma unit within surgery provided a picture menu which showed photographs of all food options that the hospital provided. This could be used for

non-verbal patients or patients with learning disabilities so they could more easily identify what food they would like at mealtimes. This had been hugely successful on the ward and at the time of the inspection this was being rolled out across the hospital.

- The outpatient service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The outpatient service had introduced digital technology for patients living with dementia which enabled them to access personalised reminiscence material.
- The trust had introduced acute neurology clinics, located close to the short stay/ambulatory care unit, for patients who attended the acute medical unit and would have needed to be admitted in the past for further opinions and tests. These patients could now be discharged with an appointment, either the following day or the day after. This initiative had led to a significant number of admissions being avoided and provided a positive experience for patients.
- The cardiology department inserted the first four lead pacemaker for a patient in the world. The medical staff were monitoring the patient's recovery and rehabilitation as part of an international research project to assess the advantages of the new technology.
- A GP was employed in ambulatory care four days a week. The purpose of this new position was to improve communication with GPs to ensure basic tests had been completed prior to the patient attending the ambulatory care unit. It was anticipated that this would help to increase the flow of patients through the department and prevent patients attending the unit unnecessarily.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that the emergency department observation unit is sufficiently staffed to keep people safe.
- Ensure that medical staff in the emergency department receive appropriate mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that daily checks are conducted on resuscitation equipment and medicine fridges in the emergency department to assess that they are safe to use.
- Continue to develop and initiate plans and work streams in line with the improvement plan to improve flow in the emergency department as pace to improve safety and patient flow in the department.
- Ensure the promotion and control of infection at all times and in all areas within medical care.
- Ensure the security of patients' confidential and personal information at all times within medical care.
- Ensure the safety of patients at all times within medical care including ensuring sufficient staff are on duty to monitor and provide care and treatment to the patients. The trust should ensure patients are not left unattended in the ambulatory care department as a result of staff lone working.
- Ensure that the privacy and dignity of patients in medical care is respected and ensure that breaches of the national mixed sex accommodation do not occur.
- Ensure that staff in medical care consistently meet the trust target for mandatory training.
- Ensure that handovers take place consistently in medical care when transferring patients between wards and departments. The trust should ensure that assessments were carried out promptly by doctors following patients being admitted to the medical expected unit.
- Ensure that there were clear pathways in medical care, including staffing levels, regarding the care of patients who required non-invasive ventilation (NIV).
- Ensure nurse staffing levels on surgical wards meet expected standards as per hospital guidelines to keep patients safe.

- Improve the number of staff on surgical wards who have completed all their mandatory training in line with the hospital target.
- Improve access to patient toilet facilities within the surgical assessment unit and theatre recovery area.
- Improve the response times for patient complaints within surgery.
- Improve the timely completion of discharge letters to GP's, including reducing the large backlog of letters which have not been sent within surgery.
- Ensure there are adequate allocated hours from allied healthcare professionals in critical care to meet national recommendations.
- Ensure there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff in areas where children are cared for in line with national guidance.
- Ensure all staff involved with the care of children are up-to-date with paediatric basic life support and mandatory training.
- Ensure medical and dental staff in outpatients and diagnostic imaging have received training in level two safeguarding vulnerable adults
- Ensure medical and dental staff in outpatients and diagnostic imaging are up to date with mandatory training including adult basic life support, fire training and paediatric life support

Action the hospital SHOULD take to improve

- Ensure that there are suitable quantities of cardiac monitors and trolleys in the emergency department to ensure that they keep people safe at times of crowding.
- Ensure that alcohol and substance misuse support is available in the emergency department for patients who require it.
- Ensure that the executive team is more engaged with staff in the emergency department and plan times of visits better to prevent a negative impact on staff morale.
- Ensure that equipment used in for personal care within medical care services is fit for purpose and that

staff could provide assistance promptly if the patient became unwell while using equipment. This relates to showers which staff had to lift a chair over a lip for patients who could not step over to access.

- Ensure that clinical equipment in medical care, such as needles and blades were stored securely. The trust should ensure the safe storage of medicines, including creams and ointments at all times. This should include ensuring that medicines were stored following manufacturers guidelines.
- Ensure that where oxygen cylinders were stored in medical care, there was appropriate signage to inform staff and visitors to the area.
- Ensure that staff working in all departments in medical care have access to emergency equipment and medicines in order to be able to respond promptly to medical emergencies.
- Ensure within medical care that care documentation, including care plans, pain and risk assessments were completed in sufficient detail to inform staff of the individualised care and treatment that was required for each patient.
- Ensure that nursing staffing levels in medical care consistently met the assessed and agreed staffing establishment for all wards and departments.
- Ensure that within medical care performance against national audits is improved.
- Ensure that within medical care the patient's confidentiality was consistently respected when requiring assistance with interpretation and/or translation.
- Ensure that within medical care the complaints process was followed in a timely way and in accordance with the trust policy and procedure.
- Ensure that staff within medical care are consistently informed and knowledgeable about the risk registers for their wards and departments.
- Ensure that NEWS scores are completed accurately within surgery.
- Improve referral to treatment time target compliance for surgical patients.
- Ensure fabric curtains in critical care are replaced by disposable curtains to meet national standards.
- Ensure processes to monitor and audit compliance with cleaning processes in critical care are in place.
- Ensure effective processes to learn from mortality and morbidity meetings in critical care.

- Ensure staff check essential equipment daily in critical care in line with policy.
- Ensure patients' allergies are always documented and that staff sign for all medicines they administer in critical care.
- Ensure the safe storage of medical gases in critical care.
- Ensure all patient medical records are stored securely in critical care.
- Ensure practice guidance is regularly reviewed and updated in critical care.
- Continue to support the clinical nurse educator role in critical care to comply with national recommendations.
- Review the training and competency assessment of medical staff in critical care to ensure there are always staff on duty that are airway competent.
- Review paediatric competencies and training within the nursing staff in critical care, to ensure this is up-to-date and current.
- Explore the improvement of the patient toilet in critical care to include shower facilities so that these facilities are not shared with relatives.
- Review the arrangements for the provision of follow-up clinics in critical care to ensure these are sustainable.
- Ensure staff have access to appropriate equipment necessary in children's services to carry out their roles and provide care effectively and efficiently.
- Ensure all staff involved in the care and assessment of children and young people have safeguarding training in line with intercollegiate guidance.
- Ensure that systems are in place to ensure case conference notes of vulnerable children are filed in their records in a timely manner.
- Consider the wellbeing of staff within children's and young peoples services in terms of regular access to rest breaks and hydration.
- Consider mechanisms which could improve the connection of, and communication between, front line staff and divisional leaders within children's and young peoples services.
- Consider options for improving the connection between the Women and Children's division and the rest of the trust, together with considering the representation of children's services at board level.
- Ensure patients within all of the diagnostic imaging waiting rooms can be monitored by staff.

- Ensure that departments within outpatients have access to resuscitation equipment in line with hospital policy
- Provide leaflets within departments in outpatients and diagnostic imaging that are available in different languages.
- Ensure access for bariatric patients in outpatients is improved so they can be assessed and treated without compromising their privacy.
- Make improvements on the follow up backlog waiting list to meet people's needs and minimise possible risk and harm caused to patients through excessive waits on outpatient appointments and excessive waits on the reporting of images.
- Make improvements on the backlog in typing time times in outpatients and the delay in letters being sent to GPs
- Ensure arrangements are in place to replace aging diagnostic imaging equipment identified at risk of failure

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10 (1) Service users must be treated with dignity and respect
	10 (2) the things which a registered person is required to do to comply with 10(1) include
	(a) ensuring the privacy of the service user
	We found that patients' confidential and personal information were not always held securely within medical care.
	We found that the privacy and dignity of patients was not always respected and that breaches of the national mixed sex accommodation occurred.

Regulated activity

Diagnostic and screening procedures Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12 (1) Care and treatment must be provided in a safe way for service users.

12 (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

(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;

We found that processes to ensure that resuscitation equipment, medicine fridges and blood glucose monitors were safe in the emergency department were not being followed. There were multiple occasions where daily checks had not been completed putting patients at risk.

(h) the things which a registered person must do to comply includes assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Not all equipment patients used was cleaned thoroughly within medical care. Urine was left unattended and uncovered in toilets for prolonged periods of time and carried in uncovered bedpans through the ward.

There were inconsistencies in the handover when transferring patients between wards and departments in medical care. Assessments were not carried out promptly when patients were admitted to the medical expected unit.

There were not clear care pathways for patients requiring non-invasive ventilation in medical care.

Regulated activity

Diagnostic and screening procedures Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

15 (1) All premises and equipment used by the service provider must be –

(f) appropriately located for the purpose for which they are being used

There was a lack of toilet facilities for patients within the surgical assessment unit and the theatres recovery area.

Regulated activity

Diagnostic and screening procedures Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

16 (2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Complaints were not always dealt with within 25 or 40 working days in line with the hospital policy.

Regulated activity

Diagnostic and screening procedures Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part.

17 (2) without limiting paragraph (1) such systems or processes must enable the registered person, in particular, to –

(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of services users in receiving those services).

The provider must continue to develop and initiate plans and work streams in line with the improvement plan to improve flow in the emergency department at pace to improve safety in the department.

The service did not meet the Faculty of Intensive Care Medicine (2015) Core Standards for the provision of support from allied health therapies (physiotherapy, dietician, occupational therapy, and speech and language therapy). This also meant the service was not compliant with national guidance from the National Institute for Heath and Care Excellence (CG83)

Regulated activity

Diagnostic and screening procedures Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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 were not sufficient staff on duty in medical care to ensure the safety of patients at all times to monitor and provide care and treatment to the patients.

There were not always sufficient levels of nursing staff in the children's unit to meet RCPCH guidance. There was no acuity tool in use to support leaders to assess staffing needs when caring for children. In addition doctors of sufficient grade to make decisions about children's care were often covering large areas of the hospital out of hours. This presented a potential risk to the safety of children being cared for by the trust.

We found that there were not sufficient numbers of staff in the emergency department observation unit. Staff had too many competing priorities to monitor and observe patients.

18 (2) Persons employed by the service provider in the provision of a regulated activity must –

(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform.

Medical staff in the emergency department were significantly below the trust target for all of the mandatory training modules expected of them. This included paediatric life support, fire safety, infection prevention and control and adult basic life support.

Within medical care staff were not consistently meeting the trust target for mandatory training.

Within surgery staff were not consistently meeting the trust target for mandatory training.

Insufficient staff were compliant with mandatory and role essential training in critical care, including child protection training at level three.

There was no evidence in critical care for the assessment and review of nursing staff's paediatric nursing and emergency procedures' competence.

Immediate access to staff competent in advanced airway management techniques could not always be guaranteed in critical care.

Mandatory training compliance for medical staff within the children's services was very low and placed patients at risk.

Compliance with paediatric basic life support training was low across all staff groups in children's services. This placed patients at significant risk in the event of deterioration.

Within outpatients and diagnostic imaging staff did not consistently meet the trust target for mandatory training, including safeguarding training.