

Taunton and Somerset NHS Foundation Trust Musgrove Park Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Good



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Good



Surgery

Good



Critical care

Good



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 25 and 29 January 2016. We also carried out an unannounced inspection on 9 February 2016. We carried out this comprehensive inspection at Taunton and Somerset NHS Foundation Trust as part of our comprehensive inspection programme.

This organisation has one main location:

Musgrove Park Hospital, a large acute hospital comprising all acute services. This hospital is the largest in Somerset. However some maternity and outpatients services were delivered at different sites in the county, these were not visited as part of this inspection.

The hospital opened in late 1942, having been built as an American Army Hospital. It became part of the NHS in 1952. Work to modernise the site began in 1987 with the opening of the Queen's Building, which includes the Emergency Department, Orthopaedics, Ophthalmology, Ear, Nose, and Throat, Oral and Maxillofacial Surgery, Endoscopy and Therapy Services. The Duchess Building, including all Medical and Care of the Elderly Wards, Outpatients, Pharmacy and Diagnostic Imaging, was opened in 1995. The new Jubilee building opened to patients on Saturday 15th March 2014. The Jubilee building has three wards, Barrington Ward on the ground floor with 32 beds, Hestercombe Ward on the first floor with 40 beds and Montacute Ward on the top floor with 40 beds. All 112 bedrooms have en-suite bathrooms. It replaces four open plan 'Nightingale' wards in the Old Building. The wards treat mainly surgical patients for the following specialties General Surgery, Colorectal, Urology, Gynaecology, Breast, Orthopaedic, Vascular and Upper GI.

The trust provides a full range of acute clinical services. The trust has 576 Inpatient and 81 day case beds. The trust provides specialist and acute services to approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset.

A previous inspection by the CQC in September and October 2013 found that there were breaches in three regulations around record keeping, equipment maintenance and specialised training. At this inspection we found that some actions had yet to be addressed around specialist training and that it could not always be demonstrated that patients had been consulted regarding do not resuscitate decisions.

During our unannounced inspection we had serious concerns regarding the level of paediatric cover in the emergency department, care for the deteriorating patient and those with sepsis, medicines management and the completion of the surgery checklist. We wrote to the trust explaining the reasons for our serious concerns. The trust took immediate action following this letter implementing a series of reviews and external support. The trust have told us they have since implemented paediatric nurses on every shift within the emergency department and reviewed the training of nurses within the department. They also told us they have implemented a safer storage system for medicines management. They have reviewed the practice for alerting the deteriorating patient and those with sepsis. The trust has implemented a sepsis nurse of the day in the department to ensure that patients with sepsis are cared for in a timely manner. The trust has also reviewed completion of the checklist for surgery. The trust now has an action plan, agreed with CQC, for further actions to ensure the health and safety of patients using the emergency and surgical services. The CQC were reassured that the trust had taken on board the serious concerns and decided to take no further enforcement action in this respect. We will continue to monitor improvements at the trust. This report reflects the issues we found at the trust on our inspection.

Our key findings were as follows:

- There was a strong, visible person-centred culture demonstrated by all staff. We observed staff positively interacting with patients and, patients were treated with kindness, dignity, respect and compassion while they receive care and treatment.

Summary of findings

- We considered the flexibility of the meals service to be outstanding. Patients had plenty of choice from two different menus or could choose what they wanted day or night
- In the emergency department arrangements were not in place to ensure suitable care and treatment was provided to children and the care environment for children was not suitable.
- There was insufficient evidence to ensure resuscitation trolleys were checked in line with trust policy. On some trolleys, we found out of date equipment.
- Staff mostly followed good infection practices but not all clinical areas were clean and tidy. In some areas effective cleaning would not be possible due to aging and damaged estates and furniture.
- Medicines in a number of areas were not always securely stored
- Staff were overwhelmingly caring in delivering care to patients. We witnessed some outstanding examples of care being given to patients and their relatives.
- The senior management team had engendered a culture of learning from incidents and one in which the patient was put at the centre of care provided.
- The environment at Musgrove Park Hospital was a mix of newly built units with excellent facilities and aging departments and wards. This presented challenges in delivering care in units which met current guidelines.
- Children's and neonatal staffing levels did not meet the current guidelines.
- Patients using the service were receiving effective care and treatment, which met their needs. Outcomes for patients were routinely collected and monitored, and were mostly positive.

We saw several areas of outstanding practice including:

- The trust had a Joint Emergency Therapies Team (JETT) and Older Persons Assessment and Liaison service (OPAL) which assessed all patients over the age of 75 with the view to prevent avoidable admissions.
- General Practitioners (GPs) worked in the emergency department. GPs supported management of patients in the ambulatory stream with primary care problems.
- The hospital was named as one of the top hospitals in the 2015 CHKS awards, (CHKS is a provider of healthcare intelligence and quality improvement services), and was highly commended for patient experience. The CHKS awards commended the cancer care team, in the International Quality Improvement category, for their work.
- Investors in People awarded the gold standard to the the whole Haematology, Oncology and Palliative Care Directorate (which included the Beacon Centre), one of only 7% of accredited organisations to win this.
- Colorectal Specialist Nurses had been trained to use clinically developed criteria and pathways to direct patients to the relevant test or clinic thus avoiding unnecessary steps or diagnostic procedures in the patient's pathway. This improved the speed of diagnosis for patients with suspected colorectal cancer.
- We saw the use of a number of initiatives to mitigate the risks identified as a direct result of previous low staffing levels and skill mix. These included; banked Hours; clinical supervision; an on call system; the appointment of a Practice Educator and; the band five and six development programmes.
- Critical care participated in the Potential Donor Audit (PDA). PDA audit results for the reporting period April 2015 to September 2015 showed the trust as the best trust in the South West region for; approaching patients and, securing a good number of donors.
- A tracheostomy ward round, led by a consultant intensivist in collaboration with a nurse specialist for 'head and neck', took place daily to assess tracheostomy care and improve standards both in critical care and throughout the hospital
- As part of the ABCDE assessment of new admissions to critical care, the team had added F (for family) to remind staff to communicate with the family about any concerns or worries they may have.

Summary of findings

- Local safety projects were in place to highlight current incidents and areas of concern and included the 'take note project' and, 'raising standards project'.
- One of the midwives at the service had also recently won a MAFTA award for her innovative ideas. She had designed a fabric placenta as a teaching aid and designed the "smoke free buttons" located throughout the hospital, which when pressed plays a voice recording outside to remind patients and visitors of the smoke free message.
- Two paediatric consultants developed an App, whose aims was to develop a single care pathway from home through to community healthcare and into hospital. The app 'HANDI Taunton' was launched in March 2015 and provided parents with 'clear and concise advice' about the six common childhood illnesses. The conditions covered included, diarrhoea, chesty baby, chesty child, high temperature, abdominal pain and common new-born problems.
- The Marie Curie companion service is the only one currently in the country. It uses the innovative approach of using trained volunteers to help provide emotional comfort to patients. There was overwhelming praise from staff about this service and the report of the six-month review of the service showed positive feedback from family members. The service was shortlisted for the National End of Life Safer Patient Award in June 2015.
- In partnership with the complex care GPs and a neighbouring community NHS trust palliative care consultant team, the trust had made a successful bid to the Health Education South West to develop a health improvement programme between hospital and community. The aim of the programme was to increase effective communication with regard to those who are dying. This project was on-going at the time of inspection.
- The trust had an end of life poetry project. This was led by a staff member, whose aim was to help make colleagues comfortable with having difficult conversations with patients and their families.
- The orthotic department could facilitate the provision of prosthetic boots within 15 days following an appointment. This was considered an exceptional service as this could take several months in some areas.
- The trust e-referral advice and guidance system. This enabled GPs to discuss symptoms with a specialist consultant who would advise on the preferred treatment pathway, reducing the need for hospital attendance.
- The clinical support directorate clinical lead had undergone specialist training in change management to the implementation of seven day working.
- There was priority access to imaging services for trauma and patients suspected of having suffered a stroke.
 - The outpatients department worked closely with the health community setting up testing hubs in general practitioner (GP) practices. Patients could have cardiac assessments and be fitted with a 24-hour tape. Results were transferred to MPH cardiology department. This meant that only those patients who needed to attend hospital would receive appointments.

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

Importantly, the trust must:

- Ensure all emergency lifesaving equipment, is sufficient and safe for use in all clinical areas and that there is evidence it has been checked in line with the trust policy.
- Medications were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons. The trust must ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.
- Ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department, critical care and children's ward.
- Ensure trained health care professionals triage all patients attending the emergency department within 15 minutes of arrival, and have systems in place to escalate and mitigate risks where this is not achieved.

Summary of findings

- Ensure there are robust systems in place to assess, monitor, and mitigate risks to deteriorating patients in the emergency department.
- Emergency department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
- The hospital must improve the accuracy and timeliness of patient risk assessments. Delays present serious risks to patients who are deteriorating or seriously ill and could result in a delayed treatment.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- The medical staffing levels for the provision of advanced airway management, in the absence of the consultant, did not meet the Core Standards for Intensive Care 2013.
- The registered provider must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units
- The obstetric anaesthetic staffing levels for the provision of emergency work on the delivery suite, did not meet the guidelines for Obstetric Anaesthetic Services 2013.
- Trained nurse staffing did not fully meet 'British Association of Perinatal Medicine Guidelines (2011)'. (BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance. (Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.
- The children's service were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.
- The registered provider must ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- Ensure an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- Develop a comprehensive framework for governance, risk management and quality measurement for end of life care.
- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- The registered provider must ensure that staff in the emergency department and children, and young peoples services staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.

Summary of findings

- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.

In addition the trust should:

- The trust should ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance.
- The trust should ensure maternity staff report all incidents and near misses through the trust incident reporting system.
- The trust should ensure regular mortality and morbidity meetings take place in the emergency department.
- The trust should consider reorganising or amalgamating morbidity and mortality meetings to ensure learning is captured and shared across all specialities.
- The trust should ensure there are a suitable number of staff with the appropriate skill mix available in the emergency department and Jowett Ward at all times.
- The trust should ensure patients hydration levels are monitored whilst in the emergency department and this is documented in their care records.
- The trust should ensure there is a screening tool in place to assess risk of physical abuse in children.
- The trust should review children's provision in the emergency department to meet the 2012 Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings.
- The trust should ensure staff consistently adhere to local guidelines available in the emergency department.
- The trust should review the way in which the treatment areas for children in the emergency department are used, to ensure they are always available to deliver care to children.
- The trust should ensure there is a robust system in place for delivering and recording the induction of locum and agency staff working in the emergency department.
- The trust should ensure the safeguarding checklist is completed on all children's records when they attend the emergency department.
- The trust should consider confidentially displaying the most recent early warning score for patients in the department on the electronic computer system.
- The trust should ensure it reviews critical care services in line with the Core Standards for Intensive Care Units 2013 to address areas where they are not meeting these standards.
- The hospital must improve the accuracy and timeliness of patient risk assessments.
- Should take measures to ensure procedures are followed regarding the safe management of sharps boxes.
- The hospital should ensure patient records are securely stored.
- The hospital should ensure, where appropriate capacity assessments are clear and visible in patient medical records.

Summary of findings

- The trust should ensure local clinical guidelines in critical care have been monitored and reviewed to ensure consistency of practice.
- The trust should ensure there is a program of work/time-line identified to establish when national standards (HBN 04-02) will be met in critical care.
- The trust should consider reviewing the discharge process for critical care.
- The trust should meet the OAA/AAGBI Guidelines for Obstetric Anaesthetic Services 2013 which state that there should be a minimum of 12 consultant anaesthetist sessions per week.
- The trust should ensure staff that are recovering post-operative patients, regardless of the method of anaesthesia, should have appropriate training to comply with the recommendations of the British Anaesthetic and Recovery Nurses Association (2012).
- The trust should benchmark critical aspects of performance on the maternity dashboard to ensure staff are able to check that performance falls within acceptable levels.
- The trust should implement a system of “red flags” for midwifery staffing incidents in line with NICE NG4 guidance “Safe midwifery staffing”.
- The trust should ensure that staff that have appropriate additional training in the care of the critically ill women in line with guidance from the Royal College of Anaesthetists 2011.
- The trust should ensure the provision of dedicated elective section list that is not interrupted by emergency cases or the lack of theatre staff.
- The trust should ensure that all staff have access to the trust’s report and gap analysis of the Kirkup report and are aware of the recommendations and the implications for their practice.
- The service should look to provide a more cohesive service for all gynaecology patients receiving care at Musgrove Park Hospital.
- The trust should ensure that all staff have completed mandatory and role specific training and should ensure that the training record held by the service is accurate.
- The trust should consider a regular audit programme to ensure that water temperatures in birthing pools are within safe limits.
- The trust should consider the implementation of a system in maternity services that allows staff to know a piece of equipment is clean.
- The trust should ensure that they have written formal arrangements in place with the children and adolescent mental health team so that the needs of children and young people with mental health problems are met.
- The trust should review its paediatric high dependency service to ensure that it has sufficient funding and staffing in place to operate the service safely.
- The trust should ensure that staff have an understanding of the Frazer guidelines and Gillick competence in relation to consent processes for children and young people.
- The trust must ensure that an experienced, senior nurse as identified within Royal College of Nursing guidance (August 2013) works during the 24-hour period to provide the necessary support to the HDU children’s nursing team.
- The trust should continue the strategy to improve 18 week target referral to treatment times in those areas currently non-compliant.

Summary of findings

- The trust's end of life strategy should be implemented as a matter of urgency.
- The trust should implement version two of the individualised end of life care plan with full educational support, so that comprehensive plans are consistently recorded in patients records.
- The trust should ensure all patients in the last days/hours of life are prescribed anticipatory medicines.
- The trust should consider increasing the number of nurses within SPCT and consultant palliative care cover to meet the recommendation of the Commissioning Guidance for Specialist Palliative Care.
- The trust should develop a coordinated systematic approach for the provision of all EOLC training and education, including considering make end of life training part of the mandatory training programme.
- The trust should ensure DNACPR decisions are recorded in line with trust policy.
- The trust develop a comprehensive framework for governance, risk management and quality measurement for end of life care.
- The trust should take steps to ensure staff receive annual appraisals.
- The trust should provide training on the Mental Capacity Act and ensure that all staff are suitably skilled and knowledgeable.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

Overall, we rated emergency and urgent services as requires improvement.

The safety of emergency and urgent services was inadequate because patients were not protected from avoidable harm. Systems, processes and standard operating procedures were not always reliable or appropriate to keep people protected from avoidable harm, particularly around the assessment and management of the deteriorating patient. We saw staff were not adhering to the clinical response guidelines when patients were showing signs of deterioration, this meant patients were at risk of not receiving early interventions which could prevent further deterioration in their condition. There was not an effective system in place to ensure that patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of presentation to the department. Not all patients were screened for sepsis and we saw patients who had met two of the sepsis criteria were not screened for sepsis or commenced on the Trust's sepsis proforma; this put patients at risk of not receiving the correct treatment in a timely manner.

Some essential lifesaving equipment was out of date or unchecked and medicines were not always stored safely. Arrangements were not in place to ensure suitable care and treatment was provided to children. Not all nursing staff had received the required training to care for children and facilities were not suitable for children. Staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times. Staff did not consistently adhere to local guidelines, for example escalation of the deteriorating patient and sepsis screening. There was not sufficient consideration paid to the flow of children in the department. Facilities and premises were not appropriately used for the delivery of care to children, whilst in the department. Despite a dedicated children's

Summary of findings

treatment and resuscitation area being available, we saw that adults were treated in these areas despite children requiring treatment being in the department at that time.

The leadership, governance and culture did not always support the delivery of high quality patient-centred care in relation to the care of children. Risks were not dealt with or escalated appropriately. Department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as the provision of paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.

However we found emergency preparedness plans were in place. Openness and transparency about safety was encouraged. Where incidents were reported there was investigation and shared learning.

Patients using the service were receiving effective care and treatment, which met their needs. Patients care and treatment was planned in line with current evidence based guidance, standards and best practice. Patient needs were assessed throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and College of Emergency Medicine (CEM) guidelines. Information about patients care and treatment and their outcomes were routinely collected and monitored. This information was used to improve patient care.

Patients were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients who used the service and those close to them was positive about the way staff treated them. Patients were treated with dignity, respect and kindness during all interactions with staff. Staff helped people and those close to them cope emotionally with their care and treatment

Patient's needs were mostly met through the way services were organised and delivered. Waiting times and delays were minimal and managed appropriately. Care and treatment was coordinated

Summary of findings

with other services and providers. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning.

Candour, openness, honesty, transparency, and challenges to poor practice were evident. Staff actively raised concerns verbally and felt listened to. There was a clear vision and strategy for the department. Medical and nursing staff appeared to work well as a team.

Medical care (including older people's care)

Good



Overall, we rated medical care services, including care of older people at Musgrove Park Hospital as good, but safety requires improvement. We rated caring as outstanding.

We found:

Patients received evidenced based care and treatment and we saw policies based on national guidance. Staff assessed and managed patient's hydration, nutrition and pain appropriately. The trust took part in local and national audits to assess patient outcomes and the quality of care. Results from these audits were mostly positive. There was evidence of some seven day working particularly from diagnostic imaging and reporting. The service had very positive friends and family test results with an average of 100% and 98% for HOPE and Acute Medicine directorates respectively. This meant almost all patients were would recommend the service to others. Staff treated patients with compassion, dignity and respect and we saw staff going the extra mile for patients. Patients were positive about their care and we saw that they were involved in their care and treatment.

There was a proactive approach to bed management and discharge planning began from the moment the patient arrived in hospital. Services were responsive to patient needs and medical outliers (medical patients placed on surgical wards) received appropriate care and treatment that reflected their condition.

There were positive stroke and cardiac pathways to improve access to treatment times and discharge.

Summary of findings

There were systems and processes to manage risk and quality assurance, including local and clinical audits. Staff at all levels took ownership and responsibility for quality assurance.

Leadership was visible at all levels of the service. Leaders were aware of issues affecting service delivery and passionate about their staff. Staff felt supported and there was an open, honest patient centred culture.

There was a robust incident reporting procedure. Staff knew and demonstrated how they could report incidents. We saw that there was learning from incidents.

Nursing and medical staffing levels were safe. Nursing and medical staff received support from managers and senior clinicians and received regular supervisions.

However, we also found:

Staff did not assess all patients appropriately on their arrival to hospital. We saw evidence of risk assessments not completed or dated, and deteriorating patients not treated in a timely manner.

Staff compliance with infection control policies and procedures were inconsistent, particularly on the acute medical unit (AMU). Hand hygiene audits for AMU were poor and staff did not always ensure a safe environment for patients.

The environment presented a challenge to staff and service delivery. Despite the trust having a bed escalation plan additional beds were kept open in the clinical decisions unit while patients waited for medical beds.

Staff did not always follow procedures around assessing patient capacity and applying for deprivation of liberty safeguards (DoLS) authorisation.

Surgery

Good



Overall, we rated surgical services as good, however safety required improvement.

Patients, carers and families were positive about the care and treatment provided.

They felt supported, involved and staff actively engaged with patients whilst providing kind compassionate care.

Summary of findings

We observed positive interactions when staff obtained consent. Staff supported patients and relatives with their emotional and spiritual needs. Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. However, there had been two never events in the reporting period, one in May 2015 and one in November 2015. We found that the World Health Organisation (WHO) five steps to safer surgery checklists were not completed consistently.

There was inconsistent practice in the checking of resuscitation trolleys.

Staff were aware of current infection prevention and control guidelines. Equipment was available, clean, safe and well maintained.

Controlled medicines were managed and stored correctly, however we found some medicines stored incorrectly and inconsistent practice in the checking of medicines fridges.

Staff attended mandatory training, and staffing levels were sufficient to meet the needs of patients. Staff were aware there was a documented strategic business continuity and internal major incident plan within surgical services.

Staff provided care and monitored compliance in line with national best practice guidelines.

The surgical care group participated in a number of local and national clinical audits and acted upon any recommendations. Data from the audits was positive and the trust had action plans in place. Patients were assessed individually for pain relief and for their nutritional requirements.

Staff were competent and supported by managers. Multidisciplinary team working was established and effective within the surgical wards and theatres. Service planning and delivery took into account the needs of local people.

Patients were assessed appropriately and provided with treatment plans based on clinical priority. Discharges were planned with the multidisciplinary team, however due to community pressures these were not always timely.

Bed occupancy was low; however NHS England data showed that the national 18 week referral to treatment targets were not being met. Progress towards meeting targets was being made.

Summary of findings

The number of cancelled elective operations as a percentage of elective admissions was consistently above the England average, however, of the 701 cancelled operations all but 14 have been rebooked within 28 days which was consistently lower than the England average.

There were clear governance structures in place and lines of accountability. Leaders were visible and staff were positive about local leadership.

Values of the trust were understood by staff and embedded in appraisal documentation.

Information on how the public could provide feedback was displayed in the departmental areas.

The trust celebrated the achievements of staff with an annual event. The Musgrove Awards for Tremendous Achievement.

Critical care

Good



Overall critical care at this hospital was rated as good.

Safety of critical care was rated as requires improvement. There was limited assurance about safety. Overnight, we could not be assured medical assistance would be immediately available to provide advanced airway management before the consultant arrived. This did not meet Core Standards for Intensive Care 2013.

The environment did not meet national standards and this had not been highlighted on the critical care risk register. Guidelines for the Provision of Intensive Care Services (GPICS) state existing facilities that do not comply with HBN 04-02 should identify a program of work/time-line to establish when national standards will be met and, should note this as part of their risk register.

Infection prevention and control was not always given sufficient priority. During our inspection, we noted peeling paint, rust on radiators and broken and stained ceiling tiles in various areas across ITU and HDU.

Where daily checks were required for cleaning, storage of medicines and checking of resuscitation equipment, staff had not always signed to indicate this had been done.

However, patients were protected from abuse. Staff had an understanding of how to protect patients from abuse.

Summary of findings

We judged that the effectiveness of this service was good. Patients received effective care and treatment that mostly reflected current evidence-based guidance, standards and best practice. Patients had a comprehensive assessment of their needs, which included pain management, nutrition and hydration and physical and emotional aspects of their care. Outcomes for patients were routinely collected and monitored, and were mostly positive.

The care provided to patients in critical care was outstanding. Patients were truly respected and valued as individuals and were empowered partners in their care.

We found the responsiveness of critical care to be good. Services were tailored to meet the needs of the individual patient with a proactive approach to understanding the needs of different groups of people.

The leadership of critical care was good. This was an innovative service with a clear vision and a strong focus on patient centred care. Staff were engaged and demonstrated commitment to delivering high quality patient-centred care.

Maternity and gynaecology

Good



Overall, maternity and gynaecology services at Musgrove Park Hospital were rated as good. The safety of maternity and gynaecology services were rated as requires improvement, with effectiveness, caring, responsiveness and leadership rated as good.

The maternity service provided an average ratio of one whole time equivalent (WTE) midwife to 31 births, which was below the national standard of one midwife to 28 births.

Anaesthetic staffing out of hours did not meet the guidance of the Association of Anaesthetists of Great Britain and Ireland (AAGBI); this states that a duty anaesthetist must be immediately available on Labour Wards 24/7 and that there should be a minimum of 12 consultant anaesthetist sessions per week.

Where daily checks were required for cleaning and checking of emergency and resuscitation equipment, staff had not always signed to indicate this had been done.

Summary of findings

Rates of compliance with appraisals, safeguarding and mandatory training including skills and drills training for midwives were below the trust targets. Frequently occurring incidents were not always reported.

Midwifery staff had not received training in the care of the critically ill woman and anaesthetic recovery in line with current guidance, however systems were in place to ensure women having general anaesthetic received suitable care during recovery. Some maternity guidelines were not compliant with current evidence based guidance, however plans were in place to address this.

The normal birth, home birth, overall caesarean section and instrumental delivery rates were all better than the national average. The average waiting time for women waiting for epidurals was less than 30 minutes. The maternity service had achieved UNICEF Baby Friendly stage three accreditation, and breastfeeding statistics for initiation within 48 hours of birth were higher (better than) the trust target. The service had introduced a range of care initiatives that had been successful in reducing the still birth rate.

The care provided to patients in maternity and gynaecology services was good. Without exception, patients and their families said they had been treated with kindness and respect and described staff as caring.

Women were given a choice of place of birth in line with national guidance. Services were arranged to meet women's needs with a range of specialist clinics and midwives to support them.

There was no dedicated elective caesarean section list which could lead to patients facing delays.

The emergency gynaecology service was fragmented.

There was a clear vision and strategy in place for the development of the service. A staff leadership programme was available and staff worked well together.

The Head of Midwifery was not visible to more junior staff.

Summary of findings

Services for children and young people

Good



Senior midwives in maternity were aware of a difference in status to other staff of the same grade in the other parts of the hospital. Band seven staff were not always supernumerary in comparison to other hospital staff of the same grade.

Overall, the children's and young people's service was rated as good.

We found services for children, young people and their families were effective, caring, responsive and well led. However, improvements were needed for the service to be safe.

Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance.

A paediatric nursing community team of 10 children's nurses supported the children's and neonatal service throughout the Somerset region. Shortfalls in trained nurse provision on the neonatal unit and within children's services were managed through escalation pathways and through the support of an identified bleep holder.

The trust stated that funding for the two-bedded paediatric high dependency unit (HDU) was proportional to bed occupancy and monitored through the South West Specialist Clinical Network. The current funded staffing establishment was 4.7 whole time equivalent trained nurses. Eight band six nursing staff (not all of which were full time) worked in the HDU and were managed and supported by a band seven nurse who was HDU and advanced paediatric life support (APLS) trained. We were told that the majority of time the HDU was staffed by band six nurses who had completed the HDU course; however, there were occasions when an experienced band five nurse who did not have the HDU course would work in the HDU area. The service was not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing

Summary of findings

the Future 2015' funding was secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.

Neonatal staffing did not fully meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011) (BAPM) because they could not always provide 1:1 and 1:2 care for babies who required intensive care or high dependency care. The staffing report (1 April 2015 – 26 January 2016) confirmed that 32% of shifts were not compliant against the neonatal staffing toolkit. Because of this the neonatal caseload has been reduced by 0.34%. The failure to comply with the neonatal toolkit in respect of staffing and the potential risk to the neonatal intensive care service had been recognised as a risk on the women's and children's risk register.

The failure to comply with the neonatal toolkit in respect of medical cover overnight and the potential risk to the neonatal intensive care service had been recognised as a risk on the women's and children's risk register.

The South West Neonatal Network recorded neonatal daily staffing levels across the South West and the trust was comparable in terms of levels of neonatal staffing with other units in the South West. There was generally good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS). Monitoring records of resuscitation equipment and neonatal transport systems showed that monitoring of this equipment had not taken place daily.

There were shortfalls in the management and storage of some medication in the neonatal unit and child development centre.

Training shortfalls existed in some areas, for example in mandatory training, advanced paediatric life support (APLS) and European paediatric life support (EPLS) training. This meant that the service could not provide at least one nurse

Summary of findings

per shift in each clinical area trained in APLS or EPLS as identified by the RCN (2013) staffing guidance, although 79% of nursing staff did carry the PILS qualification for paediatric life support. Staff were caring, compassionate and respectful. Staff were positive about working in the service and there was a culture of flexibility and commitment. The service was well led and a clear leadership structure was in place. Individual management of the different areas providing acute children's services were well led. A governance system was in place and we saw clinical risks were identified. Feedback from staff, parents, children and young people had resulted in changes to aspects within the service.

End of life care

Requires improvement



We rated end of life care (EOLC) as requires improvement because:

Patients were protected from abuse and avoidable harm. Staff we spoke with understood their responsibilities to raise concerns and report incidents. Arrangements were in place to minimise the risk of the spread of infection.

Ward teams were supported to provide end of life care by the specialist palliative care team, the end of life care (EOL) nurse and a dedicated continuing healthcare (CHC) coordinator who supported the fast track discharge of patients wishing to be cared for in the community.

All patients were assessed to identify if there was a possibility that they were in the last year of life. If they were, then doctors had honest and open conversations with them about their condition and treatment wishes.

The bereavement team provided a timely and coordinated service for bereaved families and the chaplaincy service provided spiritual and emotional support. In addition, the trust had introduced Marie Curie companions, who were trained volunteers available to provide comfort and support to both patients and families.

Patients and relatives were treated with dignity and respect and were involved in their care.

The trust had a strategy and vision for the EOLC service and there was a trust board member with responsibility for EOLC. Senior leaders showed great passion, enthusiasm and commitment in

Summary of findings

developing the service in order to provide quality care for EOLC patients. The culture was such, that staff felt engaged and positive towards providing quality EOLC.

However, mental capacity assessments (MCA) and best interest discussions were not always recorded for those patients who lacked capacity and were unable to make and communicate decisions about cardiopulmonary resuscitation.

We found few local audits had been completed by the trust for EOLC. The National Care of the Dying Audit (2015) showed the trust performed worse than the England average in three out of the five clinical and seven out of eight key performance indicators. The trust had minimal data to demonstrate the responsiveness of the service for patients at the end of their lives.

The numbers of nurses within the Specialist Palliative Care Team (SPCT) and the number of palliative care consultants fell below the number recommended by the Commissioning Guidance for Specialist Palliative Care. The SPCT, were available five days a week, although the trust were looking at ways to extend this to seven days a week.

Systems for governance, risk management and quality measurement, were in place, but not fully developed, due to recent changes in management structure.

Outpatients and diagnostic imaging

Good



Overall, we rated outpatients and diagnostic imaging services at Musgrove Park Hospital (MPH) as good.

There was a positive incident reporting culture with sharing of information and learning taking place. Clinical areas appeared clean with infection control procedures followed. A new electronic patient record system had been introduced which, despite some problems was becoming accepted throughout the department.

Patient care and treatment was in line with current evidence based guidance, best practice and legislation. Staff could access information in appropriate formats in a timely manner when required to support their work. We saw good

Summary of findings

examples of cross community care with general practitioners and MPH working together to reduce outpatient attendances and improve patient's experience.

Staff in outpatients and diagnostic imaging displayed compassion and a caring attitude towards patients. The service received positive patient feedback. Patients and those close to them felt supported by staff and told us privacy and dignity was respected at all times. There were safeguarding policies and procedures in place of which staff were aware.

Patients and carers were provided with information and signposted to local support groups as appropriate.

Managers told us they were proud of the staff working within the department and their willingness to embrace change and positivity about the future. Staffing within outpatients was at agreed levels.

However, we identified issues with safe administration and storage of medication within the ear nose and throat clinic and the outpatient department did not have monitoring in place for the use of FP10SS, medication prescription pads. Imaging services experienced additional work pressures due to vacancy rates. Staff appraisal rates were below trust target across outpatients and imaging with levels falling below 90%.

The service did not consistently achieve referral to treatment targets within outpatients and diagnostic imaging; however, there was a clear vision and transformational plan to address identified issues.

Musgrove Park Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Detailed findings from this inspection

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Background to Musgrove Park Hospital

Taunton and Somerset NHS Foundation Trust operates mainly Musgrove Park Hospital, however some maternity and outpatients services are delivered from other locations in Somerset. This included outpatient services at community hospitals including Bridgwater, West Mendip, Minehead and Chard. Community midwifery services were only provided at Bridgwater Hospital. For the purpose of this inspection, we visited Musgrove Park Hospital only

Musgrove Park Hospital, located in Taunton, is the largest acute hospital in Somerset and provides a range of acute medical services and specialist services.

Taunton Deane was ranked 193 out of 326 districts in the 2015 Indices of deprivation. The Indices of Deprivation is a UK government qualitative study of deprived areas in English local councils. Somerset generally is better than the national average in terms of overall levels of deprivation. Depending on the methodology used,

Somerset is ranked as being between the 98th and 116th most deprived upper-tier local authority in England (of 152 local authorities). Somerset can therefore be considered to be within the 40% least deprived areas of the country overall.

Life expectancy at birth continues to rise for both males and females although inequalities persist between the most and least deprived areas. Screening rates for breast cancer (for women aged 53-64), cervical and bowel cancer are generally higher across Somerset compared to regional and national rates. However, cancer survival rates in Somerset are worse than the national average. Admissions for alcohol-specific conditions have increased in the last few years at a faster rate than nationally.

Two Health Profile indicators are significantly worse than England including incidents of malignant melanoma and hospital stays for self-harm, but are significantly better than England for obese children (year 6).

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: An end of life doctor, registered nurses, a student nurse, a critical care doctor, an allied health professional and a midwife.

We were also supported by one expert by experience who had personal experience of using, or caring for someone who used the type of services we were inspecting.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before our inspection, we reviewed a wide range of information about Taunton and Somerset NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the

clinical commissioning group (CCG), NHS England, Monitor, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

The announced inspection took place between the 26 and 28 January 2016. We held focus groups with a range of staff in the hospital, including nurses, junior and middle grade doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists and occupational therapists prior to the inspection. We also spoke with staff individually.

We held a listening event in Taunton, Somerset on 22 January 2016 where members of the public were able to share their views and experience of the trust with us. The feedback we received on most aspects was often conflicting depending on individual experience however; people reported that care was excellent.

Facts and data about Musgrove Park Hospital

Taunton and Somerset NHS Foundation Trust provide specialist and acute services to approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset. It has 576 Inpatient beds; 527 General and acute inpatient beds, 12 Critical care beds (of which six are ICU level three and six are HDU level two) and 37 Maternity beds. In addition there are two inpatient beds at the midwife led maternity unit at Bridgwater Community Hospital. It also has 81 day case beds.

The trust employs around 3,690 whole time equivalent (WTE) staff; this includes 457 WTE medical staff, 1055 WTE nursing staff and 177 WTE other staff.

The trust has a total revenue of £260.6 million and its full costs were £255.1 million. Whilst the trust currently had a reported surplus of £0.1 million, projections for the coming financial indicated that there was likely to be significant budget deficit.

There were 49,366 inpatient admissions, 329,413 outpatient (total attendances) and the A&E department saw 58,593 patients between 2014 and 2015.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

Before our inspection, we reviewed performance information from and about the hospital.

The emergency department based in the Queen building at Musgrove Park Hospital provides consultant-led emergency care and treatment 24 hours a day, seven days a week to a population of approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset.

The department has 12 “major” and six “minor” cubicles, a four-bedded resuscitation room, an eye treatment room, a see and treat area, plaster room and a designated paediatric area, including a paediatric waiting room.

There are seven beds and a flexible number of seats on Jowett Ward where patients could be admitted under the care of an emergency department consultant for short-term observation or whilst awaiting results of tests. Jowett Ward is open daily from 9.30am to 10pm.

In the reporting period April 2014 to October 2015, 94,891 patients attended the emergency department; 18,824 (18%) of these were children.

We visited all areas of the emergency department and Jowett Ward. We spoke with 21 patients, 10 relatives and 33 staff, including junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, administrative and housekeeping staff. We also spoke with four non-trust staff. We observed interactions between patients, relatives and staff and considered the environment.

We looked at 34 records of care and treatment including medication prescription charts.

Urgent and emergency services

Summary of findings

Overall, we rated emergency and urgent services as requires improvement.

The safety of emergency and urgent services was inadequate because patients were not protected from avoidable harm. Systems, processes and standard operating procedures were not always reliable or appropriate to keep people protected from avoidable harm, particularly around the assessment and management of the deteriorating patient. We saw staff were not adhering to the clinical response guidelines when patients were showing signs of deterioration, this meant patients were at risk of not receiving early interventions which could prevent further deterioration in their condition. There was not an effective system in place to ensure that patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of presentation to the department. Not all patients were screened for sepsis and we saw patients who had met two of the sepsis criteria were not screened for sepsis or commenced on the Trust's sepsis proforma; this put patients at risk of not receiving the correct treatment in a timely manner. Some essential lifesaving equipment was out of date or unchecked and medicines were not always stored safely. Arrangements were not in place to ensure suitable care and treatment was provided to children. Not all nursing staff had received the required training to care for children and facilities were not suitable for children. Staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times. However we also found emergency preparedness plans were in place. Openness and transparency about safety was encouraged. Where incidents were reported there was investigation and shared learning.

The effectiveness of emergency and urgent services was good. Patients using the service were receiving effective care and treatment, which met their needs. Patients care and treatment was planned in line with current evidence based guidance, standards and best practice. Patient needs were assessed throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and College of Emergency Medicine (CEM) guidelines. Information

about patients care and treatment and their outcomes were routinely collected and monitored. This information was used to improve patient care. However, staff did not consistently adhere to local guidelines, for example escalation of the deteriorating patient and sepsis screening.

The care provided to patients in emergency and urgent services was good. Patients were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients who used the service and those close to them was positive about the way staff treated them. The NHS Friends and Family Test (FFT) is a satisfaction data between August 2014 and September 2015 showed the emergency department consistently scored above the England average with scores ranging from 89% and 97%. Patients were treated with dignity, respect and kindness during all interactions with staff. Staff helped people and those close to them cope emotionally with their care and treatment.

We rated responsiveness of emergency and urgent services as good because patient's needs were mostly met through the way services were organised and delivered. Waiting times and delays were minimal and managed appropriately. Care and treatment was coordinated with other services and providers. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. However; Facilities and premises were not appropriately used for the delivery of care to children, whilst the department had a dedicated children's treatment and resuscitation area, we saw that adults were treated in these areas despite children requiring treatment being in the department at the time.

The leadership of the emergency and urgent services requires improvement. The leadership, governance and culture did not always support the delivery of high quality patient- centred care in relation to the care of children. Risks were not dealt with or escalated appropriately. Department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as the provision of paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register. However; candour, openness, honesty,

Urgent and emergency services

transparency, and challenges to poor practice were evident. Staff actively raised concerns verbally and felt listened to. There was a clear vision and strategy for the department. Medical and nursing staff appeared to work well as a team.

Are urgent and emergency services safe?

Inadequate



We rated safety of emergency and urgent services as inadequate because patients were not protected from avoidable harm.

We found;

- Systems, processes and standard operating procedures were not always reliable or appropriate to protect patients from avoidable harm, particularly around the assessment and management of the deteriorating patient. We saw staff were not adhering to the clinical response guidelines when patients were showing signs of deterioration, this meant patients were at risk of not receiving early interventions which could prevent further deterioration in their condition.
- There was not an effective system in place to ensure that patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of presentation to the department.
- Not all patients were screened for sepsis and we saw patients who had met two of the sepsis criteria were not screened for sepsis or commenced on the Trust's sepsis proforma; this put patients at risk of not receiving the correct treatment in a timely manner.
- Some essential lifesaving equipment was out of date or unchecked and medicines were not always stored safely.
- Arrangements were not in place to ensure suitable care and treatment was provided to children. Not all nursing staff had received the required training to care for children and facilities were not suitable for children.
- Low numbers of staff were trained in safeguarding children level 3.
- Staffing levels and skill mix were not appropriate to keep patients protected from avoidable harm at all times.

However we also found;

- Emergency preparedness plans were in place.
- Openness and transparency about safety was encouraged.

Urgent and emergency services

- Where incidents were reported there was investigation and shared learning.

Incidents

- There were 766 incidents reported in the reporting period January 2015 – December 2015. The top three incident themes related to treatment and care, documentation and medication.
- The strategic executive information system data (Steis) showed Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response (NHS England, March 2015). There had been a full investigation, learning from this incident had been recorded and agreed actions completed.
- Incidents giving cause for concern, or following a specific trend were discussed in the department meetings and through the safety briefing at handover. We saw evidence of this in the department meeting minutes and during handovers we attended.
- Staff we spoke to were aware of, and appeared knowledgeable and confident about reporting incidents. All trust staff had access to the online reporting system. Agency nurses did not have access to the electronic system but told us they would report the incident to the nurse in charge who would support them being able to do so.
- We could not be assured all staff were raising incidents appropriately. Staff told us they did not always report incidences of staff shortages unless this compromised patient care. Senior manager said staff did not always have the time to report incidents and one said they felt it was because they did not receive feedback. Staff told us they received acknowledgement of submitting the incident form but said they did not always receive feedback. Between August 2015 and November 2015, four incidents were reported under the heading unsafe or inappropriate staffing levels. The department leader was auditing staffing levels to create a case for additional staff.
- Staff gave us examples of when they might report incidents such as a pressure ulcer or falls. Staff said there was a non-blame culture in the department and they felt empowered to report incidents without fear of reprisal.
- We reviewed a set of medical notes for a patient who had been in the department. We saw that poor levels of care for this deteriorating patient had not been raised as a clinical incident.
- Mortality and morbidity meetings had not been held on the emergency department since September 2015. Staff were unable to obtain the information of patients who had died in the department following the installation of a new computer system. Mortality and morbidity meetings are a way of reviewing and learning from patient deaths. There was a risk learning from deaths in the department may not have been shared appropriately. Departmental leaders informed us there was a process in place to ensure any increases in mortality were reviewed at the directorate governance meeting. We reviewed the clinical governance meeting minutes and did not see any evidence that deaths in the emergency department were discussed.
- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. We reviewed an incident where duty of candour had been demonstrated. Staff we spoke with whilst not familiar with the terminology "duty of candour" knew their responsibilities to be open and honest with patients when things did go wrong. New employees were given awareness of Duty of Candour at the corporate essential learning element of their induction program. On an on-going basis, all employees completed a three yearly update on corporate essential Learning. Staff we spoke with confirmed this took place.

Cleanliness, infection control and hygiene

- The emergency department appeared visibly clean and staff were aware of the current infection prevention and control guidelines, however, on Jowett Ward we saw contaminated cotton wool and medical gauze, medicines pots and contaminated linen on the floor.

Urgent and emergency services

This increased the risk of the spread of infection. We brought this to the attention of staff within the department who acted immediately to ensure the ward was cleaned.

- In the children's waiting area the material on two chairs was ripped exposing the underlying foam, a cubicle in the minors area had a hole in the wall which had been covered with medical tape and a work surface in the resuscitation area had a large exposed broken edge. Effective cleaning of these areas could not be assured so the risk of infection was increased.
- On Jowett Ward, three boxes of cereals were unsuitably stored on the floor. On our unannounced visit, we saw that these had been removed.
- On Jowett Ward the kitchen area, which included the floor, and work surfaces were visibly dirty and the area untidy. We raised this with the senior team in the department who assured us this would be rectified; however, when we returned a day later the kitchen remained visibly dirty and untidy. On our unannounced visit, all areas of Jowett Ward appeared visibly clean.
- We saw that the emergency department did not submit environmental cleanliness data as part of the directorate infection control report in October 2015, which meant that we could not be assured that effective monitoring was always carried out in the department. Cleanliness scores between April 2015 and January 2016 ranged from 89% to 98%.
- Cleansing gel was available at the entrances to each area. Patients and visitors were encouraged to use it by staff.
- Staff were 'bare below the elbow' to allow effective hand washing, however we did observe one doctor treating a patient in the resuscitation area who was wearing a wristwatch.
- Protective equipment, such as gloves and aprons, were available and we observed staff using this appropriately. We also observed staff washing their hands between patients.
- Hand hygiene audit results for the period April 2015 to January 2016 showed a varied compliance rate between

73% in November 2015 and 100% in May 2015. No hand hygiene results were submitted for September 2015. Hand Hygiene results were mostly in the trust acceptable target range.

- Staff used green 'I am clean' signed and dated stickers to show equipment was ready for use however seven pieces of equipment and two commodes which were ready for use did not have these. We observed a nurse taking a patient into the resuscitation room to a trolley area that had not been cleaned. The nurse asked staff present if they had changed the sheet, and staff confirmed they had not, the nurse proceeded to clean this area prior to caring for the patient. This meant there was not a robust system in place for recording cleaning and decontamination of equipment or bed areas after patient use.
- We saw medical equipment for example central line insertion packs and neck collars were stored on the floor in an open equipment room. This was an infection control risk.
- Bed sheets and blankets were stored in an open cage and on shelves in an open area off the main corridor and there was a risk that the environment may contaminate this for example people brushing past it. This meant it might not be clean when required.
- A side room was available for treating those patients who may pose an infection risk had active infections or at risk of infection due to impaired immunity.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles. We saw staff adhering to these process and procedures.

Environment and equipment

- The emergency department lacked storage space and we found storerooms and clinical areas to be cluttered and untidy. The storeroom on the main corridor was cluttered and access to cupboards was restricted by boxes stored on the floor in front. This was a health and safety risk.
- In the resuscitation area, large pieces of equipment for example fluid warmers, were blocking access to a cupboard with breathing equipment in it.

Urgent and emergency services

- On Jowett Ward, the sluice room was small, the door remained open, and a commode was stored in the doorway. A further bay in the ward had a range of equipment for example a large cage of consumables. Walking frames were stored in the centre of the seating area. We informed the senior team of our concerns, and the following day some items were removed. We returned to Jowett Ward on our unannounced visit and found that the area was much improved, equipment had been removed and the area painted.
- The designated children's waiting area was visible from the main adult waiting area this was not compliant with Intercollegiate.
- In January 2015, the Department of Health issued an alert to NHS trusts requiring action to reduce the risk of strangulation in children and vulnerable adults from loop cords and chains on window blinds. There were window blinds with loop cords in the children's waiting area and treatment rooms; these posed a risk to children. The blinds had not been risk assessed. We escalated our concerns to the directorate manager who removed the one in the waiting area immediately. We were assured the remaining blind would be removed immediately, once the treatment room was no longer in use. On our unannounced visit, this blind had been removed.
- An area used as an additional triaging area was cluttered with computers and medical equipment. This was not a suitable environment to triage patients.
- We saw four bags of patient's lost property stored in the corner of an open area off the main department corridor. This was not an appropriate storage area for patient property.
- Resuscitation and emergency equipment for adults and children was available in all areas and staff were aware of its location in the event of an emergency.
- There was not a robust system in place for checking availability and suitability of life saving equipment. There was no checklist for contents or evidence of regular checks being carried out on the resuscitation equipment in the main department area or the emergency transfer bag within the resuscitation room. Nursing staff told us the contents of each drawer were listed inside the drawer; however, when we opened the seals on the resuscitation trolley two drawers did not have a contents list. We could not be assured all of the lifesaving equipment required was present.
- We found resuscitation equipment had not been checked in line with trust policy and could not be assured it was safe and ready for use in an emergency. Several single-use items in an emergency transfer bag were not sealed and some were out of date and on one resuscitation trolley, we found an out of date piece of airway equipment. We informed the nurse in charge immediately of this. We returned the next day, found this piece of equipment was still on the resuscitation trolley, and had not been replaced. It is unacceptable for life saving equipment to not be ready for use.
- During our unannounced visit, we could not be assured that the resuscitation equipment in the main corridor had been checked in line with trust policy. The checklist for the resuscitation trolley had not been signed for four out of the previous nine days.
- A logbook for an anaesthetic machine in the resuscitation room had not been completed for 12 out of 26 days in January. Nursing staff told us it was the anaesthetist or operating department practitioner's job to do this and the anaesthetic team prior to each use would check it. We were not assured this would be the case.
- There was a safe and effective system for the repair, servicing and maintenance of medical equipment. We checked 14 different pieces of medical equipment in the department and with the exception of one piece found them to be in date with routine servicing. We informed the nurse in charge of the out of date piece of equipment, it was removed immediately and sent for maintenance.
- The department did not have a secure room available to assess patients with mental health needs.
- During our inspection we saw a child being treated in an adult resuscitation bay. There was no equipment in the adult resuscitation bays for the care of children and these bays were not child friendly, we saw a consultant constantly moving between the adult and child resuscitation bays to obtain equipment to deal with a sick child.

Urgent and emergency services

Medicines

- Medicines were not always securely stored. We found two oral medicines cupboards in the minor's area were open; we informed nursing staff of this, who immediately locked them. On a further four occasions during our inspection, we found these cupboards were unlocked. During our unannounced inspection, we found one medicine cupboard was unlocked; we escalated this to a doctor who locked the cupboard immediately.
- The medicines fridge in the minor's area was not locked during our inspection. Staff said that the key had been lost for the fridge and we did not see any actions to mitigate the risk of it being left unlocked. We escalated our concerns to department leaders. During our unannounced visit, this fridge remained unlocked.
- In the resuscitation area, we found the medication fridge unlocked on two occasions.
- We saw there were several items of oral and intravenous medicines left unattended on the work surface in the children's resuscitation bay. A child was present in the bay at the time. We immediately informed the nurse in the area, who arranged for this to be locked away.
- Eye drops were not stored in a locked cupboard and were left out in the eye treatment room
- During an evening visit we observed a non-registered nurse on Jowett Ward was holding the keys to the medicines cupboard, although these were handed over to a nurse once they arrived, this was against hospital policy. Non-registered staff should not hold keys to the medicines cupboards.
- Medical gases were stored in an open area in a cylinder trolley. Empty and full cylinders were stored in the same trolley. A label was present on each side of the trolley for "empty" and "full" cylinders. Five out of six cylinders in the full section were empty and three out of six in the empty section were full. This meant there was risk an inappropriate cylinder would be selected. We escalated our concerns to staff. When we returned the following day cylinders in the trolley were stored in the correct positions. During our unannounced visit we took the opportunity to check the medical gas trolley, all of the cylinders present were full, with empty cylinders stored elsewhere.
- We saw an oxygen cylinder with a mask attached was stored on the floor in the children's treatment area; we escalated this to staff who told us it would be removed. The mask was removed however; the cylinder remained in the room through the inspection. The cylinder was not secure and was a health and safety risk.
- Staff carried out checks on controlled drugs in line with the trust policy. Checklists we reviewed confirmed this.
- Staff in the department were responsible for maintaining minimum stock levels of medicines and checking expiry dates. We saw there was a process in place for stock rotation. On the safety board, a message was present reminding staff of the need to replace a specific fridge medication at the end of the month.
- Medicines requiring storage between two and eight degrees celsius were appropriately stored in medicine fridges. Records confirmed fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- Storage arrangements and disposal records for controlled drugs did not always follow the Trust's Controlled Drugs Policy. Controlled drugs are medicines that need additional security. Staff used one controlled drugs cupboard to also store other injectable medicines; this was not in line with Trust policy. Some patients were prescribed variable doses of controlled drugs. Staff had not recorded the amount, if any, that was unused and been disposed of.
- Staff kept supplies of some medicines labelled for patients to take home, so they could start their treatment quickly. We saw records of the use of these medicines, as required by the trust's policy. However, we checked the stock records of two medicines and found that the recorded stock balances kept with the medicines were wrong. An audit trail for the use of these medicines was therefore not possible and not all medicines could be accounted for.
- Where medicines were prescribed, we saw these were mostly administered and recorded safely and appropriately. We saw a patient on Jowett Ward had an hour and half delay to the administration of medicines. We escalated this to the nurse on the ward who said they were just starting the medication round.

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- Qualified nurses working in the triage, minors and 'see and treat' areas were working under patient group direction (PGD) for the prescription of simple pain relief. Patient group directions provide a legal framework allow some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. We reviewed three PGDs were all correctly completed, authorised and in date. Staff signatures were present to confirm they had read these.
- Policies outlined the processes for safeguarding vulnerable adults and children. Staff followed specific guidelines and care pathways where concerns around safeguarding children and young people were identified, such as instances of self-harm.
- The department were expected to complete a safeguarding children's checklist for all children presenting to the department. We found seven out of 11 children's records we reviewed did not have this completed and one was only partially completed. This meant safeguarding concerns might not always be identified.

Records

- Staff used paper patient records and these were not always securely stored in the emergency department. Children's records were printed on different coloured paper so children in the department could be easily identified. During our unannounced visit, we saw approximately 26 boxes of patient records were stored by the reception desk in the main waiting area. Reception staff said they were awaiting collection to go to an offsite storage facility. This was not a suitable place to store patient records, as they were easily accessible to the public. We raised our concern with the site manager who assured us they would be removed immediately.
- On Jowett Ward, we found 30 discharged patient records stored behind the nursing station. Staff informed us they were filed daily by the reception staff. We reviewed some of the cards and found records present were for patients discharged the previous week. This was not a suitable way of storing records and was a risk to a patient's confidential information.
- On three occasions, we saw unattended computers were not locked. This meant there might be unauthorised access to patient information.
- We looked at 34 records of care and found where entries were present these were structured and legible.
- When required, patient records included risk assessments, such as for falls, pressure care and nutrition; these were reviewed and updated on a regular basis. We found six out of eight patient records showed nursing and medical assessments were not always carried out in a timely manner for example a pressure ulcer risk assessments were not completed.
- Data for the emergency department in December 2015 showed 76% of nursing staff and 63% of medical staff had received level two safeguarding training. This did not meet the trust target of 90%.
- Three out of 27 (7%) medical staff had received level three safeguarding training. Medical and nursing staff in the department were expected to complete four local e-learning safeguarding modules, which the trust classed as enhanced safeguarding children training. The modules were domestic abuse, fabricated or induced illness, sexual exploitation and female genital mutilation. Data we received from the trust showed 10 out of 54 (18%) nursing staff and eight out of 27 (30%) medical staff had completed these modules. This was significantly lower than the trust target of 90%.
- The trust told us that some senior doctors and trainee doctors had received level 3 safeguarding but this wasn't recorded. We were therefore unable to assess how significant this impacted on overall levels of training.
- Staff were aware of the female genital mutilation policy and female genital mutilation training was included in level two safeguarding training for registered professionals.
- Reception staff checked the demographic details of children attending the department and the next of kin and who was accompanying the child or young person, which is considered good practice. Although there was a flagging system for identifying children with known vulnerabilities, this was not always effective.
- Children who attended the department who needed further investigation around potential safeguarding

Safeguarding

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concerns were noted in a diary or if posed a serious safeguarding concern admitted to the children's ward. For children who were noted in the diary a member of the safeguarding children team reviewed the diary each working day. The safeguarding team said that any concerns would be referred to children's social care or discussed with the child's health visitor or school nurse. At the time of our inspection, arrangements were that the safeguarding team would review those attendances by infants under five and there was a reliance on the team in the department identifying needs and recording it in the diary. There was no opportunity for attendances of children and young people over five to be reviewed to ensure that any safeguarding or child protection concerns had not been missed.

- There were procedures in place for adults and young people over the age of 16 who may be at risk of domestic abuse and staff were aware of their responsibilities in relation to this.

Mandatory training

- Mandatory training for all groups of staff was delivered through a face-to-face or electronic learning system. Modules included moving and handling, infection control, fire safety and resuscitation.
- Mandatory training data for nursing staff showed a completion rate of 74% and for rate for medical staff was 63% against the trust target of 90%.
- Staff within the emergency department received children's resuscitation training such as immediate life support and advanced paediatric life support. Records for nursing staff showed completion rates for paediatric life support were 88% and European Advanced Paediatric Life Support (EPLS) was 34%. This number was low when considering the number of staff required to complete the course. The department told us there had been a problem accessing the EPLS course. They were now in the process of allocating staff to attend and expected to see an increase in the number of staff completing this over the next few months.

Assessing and responding to patient risk

- An escalation policy was in place and bed management meetings took place up to three times per day to address and escalate risks could affect patient safety, such as low staffing and bed capacity issues.

- Patients attending the department were first seen by the receptionist who took details and then placed their record in the triage box. A qualified nurse saw patients in arrival order unless the receptionist identified their condition required immediate review. Depending on the severity of their ailment, the nurse streamed patients to the appropriate route such as the minor or major injuries areas. Reception staff told us they had no specific medical training. They told us if a patient was bleeding heavily or if they had chest pain this would warrant an immediate review. We did not see any standard operating procedure of how or when the receptionists should escalate any concerns.
- We spoke with a consultant who informed us, there was no rapid triage of children and they had concerns about the current triaging system especially in relation to children.
- There was not an effective system in place to ensure that patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of presentation to the department in line with best practice. Four out of six adult patients were not triaged within 15 minutes of arrival and one patient was waiting 33 minutes. Not all patients had triage times recorded therefore we could not establish how long they had waited for triage.
- Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 state that children should have an initial clinical assessment within 15 minutes of arrival to the department. Four out of 11 children presenting to the department during our inspection did not have a clinical assessment within 15 minutes of arrival and one did not have a triage time recorded. During our unannounced visit, we saw that one child had waited 48 minutes to be triaged.
- During our inspection, we found four patients had not been triaged, prior to being brought into the department. Minutes from the emergency department seniors meeting for November 2015 showed the triage process had been discussed. The minutes stated "In times of peak demand it was agreed that we should not triage in detail as this creates a greater queue for nurse assessment". Failing to triage a patient, not triaging

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patients in detail, or delays to triage meant that patients may not have their condition assessed appropriately, there is a risk of urgent needs being missed, and treatment delayed.

- We asked the trust to provide us with data on triage times for patients self-presenting to the department. The trust were unable to provide this data as it was not routinely collected. The trust were working to address this.
- Observations such as blood pressure and respiration rate were not recorded or some observations such as a pulse rate were missing in seven triage cards we reviewed. We reviewed the medical records of a child in the department, despite the medical history suggesting that a routine blood sugar test may be required we could not see that this had been carried out. We discussed this with a senior nurse who informed us that given the patients' medical history this should have been carried out by the nurse during triage. This meant the condition of the patient had not been appropriately assessed.
- A nurse received and assessed patients arriving by ambulance through a separate entrance. We observed handovers of patients from the ambulance staff to the hospital staff. These were discreet and dignified. Patients were allocated to the appropriate area when a bed was available for example minors or majors, staff said that patients arriving by ambulance would not be seated in the waiting area. We spoke to one parent of a sick child who arrived by ambulance. They said they were sat in the main waiting area for over two hours before being seen by a doctor. Once reviewed by a doctor they were immediately transferred to the resuscitation room. This meant staff had not followed the department policy.
- The department did not operate a rapid assessment and treat (RAT) process, which meant at times when the department was busy and ambulance patients were awaiting a bed there might be a delay to treatment. RAT typically involves the early assessment of 'majors' patients in emergency departments, by a team led by a senior doctor, with the initiation of investigations and or treatment. Evidence has shown outcomes and the patient experiences are greatly improved when a RAT process is used. Senior leaders told us they were considering piloting a RAT process, although they had no firm date when this would start.
- Observation charts included the national early warning score (NEWS) for adults and paediatric advanced warning score (PAWS) for children. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. Early warning scores were not recorded during triage and therefore the severity of a patient's condition was not established at the earliest opportunity.
- Early warning scores were not always completed on patient's observation charts. On seven out of 11 children's observation charts, there were no PAWS and three out of five adult charts, there was no NEWS completed.
- We reviewed one set of records for a patient and found despite a documented deterioration in the patient's condition the junior doctor did not escalate the care in line with the trusts clinical response guidelines, there was no evidence of senior doctor review despite an increasing early warning score.
- During our unannounced visit, we saw staff were not adhering to the clinical response guidelines for two adult patients who were "triggering" a NEWS of eight. The trust clinical response to a NEWS score of eight requires specific interventions to be carried out for example an immediate review by a doctor and continuous monitoring of vital signs such as blood pressure and heart rate. One patient who had triggered a NEWS of eight, was not having continuous monitoring of vital signs and had not been reviewed by a doctor an hour later. A further patient although having continuous monitoring of vital signs did not have their care escalated to a doctor and did not have an immediate doctor review despite a second NEWS score of eight. We informed the nurse caring for the patients of our concerns who told us they would get a doctor to review the patients.
- There was no system for displaying early warning scores for all patients in the department, so staff could see where closer observation was required. We asked the

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nurse in charge to tell us where the sickest patient in the department was. The nurse told us they hoped they were in “resus” but could not be assured, as they did not know the up to date early warning scores of all patients in the department. This meant a deteriorating patient may not be allocated to the appropriate area or receive the correct level of escalation.

- Sepsis screening was not recorded as part of the triaging process; this meant that there might be a delay in a patient receiving timely treatment for suspected sepsis.
- We saw that eight patients who had met two of the sepsis criteria were not screened for sepsis or commenced on the sepsis proforma; this put patients at risk of not receiving the correct treatment in a timely manner for example commencement of “Sepsis Six”. The “Sepsis Six” is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis if given within an appropriate period. There is strong evidence that swift delivery of ‘basic’ aspects of care prevents treatment that is much more extensive.
- One of the fundamental aspects of the ‘sepsis six bundle’ is to administer antibiotics within an hour of suspecting sepsis. Data provided to us by the hospital for the reporting period January 2015 to December 2015 showed that between 40% to 100 % of patients who were diagnosed with sepsis received the antibiotic within one hour. An action plan was in place to address the variation in treatment times and we saw that some of the actions had been completed such as raising awareness of sepsis amongst doctors and nurse in the department.
- A credit card sized card had been created by the trust called the Neutropenic Sepsis Alert Card this was for patients on chemotherapy to carry with them at all times. Patients presented this card to the emergency department if they became unwell, or hypo- or hyperthermia developed. This card gave authority for intravenous drug trained nurses to administer the first dose of antibiotics to patients presenting with suspected Neutropenic sepsis at Musgrove Park Hospital without prior medical review, this meant there would be no delay in treating this patient group. Although we did not see any patients with this card during our inspection, nursing staff demonstrated an awareness of this.

- We saw clinical stress pathways in place for example a major haemorrhage protocol and staff gave us examples of when they may be used.
- We saw a pre intubation verbal checklist carried out by the medical and nursing teams during an emergency in the resuscitation area. Staff were engaged in this process. The checklist is a process recommended by the National Patient Safety Agency (NPSA) for every patient undergoing this procedure. The process involves a number of safety checks before proceeding to carry out the intervention in an attempt to avoid errors.
- There was no screening tool to assess risk of physical abuse in children. We spoke with the paediatric lead and they told us they were redesigning the paediatric care record and this would be included in the new pathway. There was no date set for when this would be commenced.
- There was an onsite paediatric team to support the medical team in the care of children if required. During our inspection, we saw the team supporting a doctor with one sick child in the resuscitation area.
- The trust paediatric team led and supported all investigations in to the sudden, unexpected deaths of children in the department.

Nursing staffing

- Staffing assessment tools were not used in the emergency department. Staffing assessment tools allow decisions on safe staffing levels to be made based on patients’ levels of sickness and dependency. It also includes quality indicators linked to nursing care to help ensure staffing levels achieve best patient care. Not using staffing tools means staffing levels may not always be appropriate to deliver safe patient care. The department lead informed us that staffing numbers were based on clinical judgment.
- There were approximately two nurse vacancies within the department in December 2015 and plans were in place to recruit into these posts.
- The expected and actual staffing levels were displayed on notice boards in the waiting area. This had not been updated for two days.
- Nursing staff of differing grades were assigned to each of the patient areas within the department. The aim was

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for at least one nurse for every four patients in each area and one nurse to every two patients in the resuscitation area. Staff told us they were often pulled from their allocated areas to assist colleagues in other areas leaving other areas short.

- Shortfalls in staffing levels were usually met by using in-house bank staff or external agency staff. In-house staff were always contacted first for any cover required and agency staff were used as a last resort.
- The use of agency nurses was low ranging between 0.7% and 2.1 % over the period January 2015 to December 2015.
- We found there were insufficient numbers of trained nursing and support staff in the department, and nursing staff told us there was not always an appropriate skill mix to ensure patients were safe and received the right level of care. During our inspection we saw a non-registered nurse was left in Jowett Ward for over 20 minutes whilst waiting for a nurse to come from another ward, another non registered member of staff told us they were often allocated to Jowett Ward on their own and would call the nurse in charge if there was a problem. During an evening visit to the department, there was one band 6 shift unfilled and two agency nurses working on the shift. We spoke with one nurse who was caring for a child in the resuscitation room, they told us their European Paediatric Life Support (EPLS) qualification had expired. We escalated this to the nurse in charge who told us they were not aware of this, there were two agency nurses on shift, and they were not aware of the competencies of other staff on shift. The nurse told us this was a regular occurrence. We escalated our concerns to the site manager who said they might get some support from the paediatric department but this would depend on their capacity. When we returned, the next day department leaders told us that there had not been any help from the paediatric department overnight.
- Jowett Ward was established to be open from 9.30 am to 10pm. Nursing staff told us this would often remain open overnight and nursing staff were taken from the majors area to provide the staff required. This meant there was not sufficient staffing to cover the emergency department and Jowett Ward. Department leaders told

us they tried to avoid Jowett Ward remaining open overnight however; the ward was used when the trust required additional bed capacity. The department was open for three nights during our inspection.

- The Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and Royal College of Nursing Standards 2013 state that a minimum of one paediatric trained nurses should work on each shift. There was one trained paediatric nurse employed in the emergency department. This was not sufficient to meet this standard. We escalated our concerns to the trust at the time of our inspection. Following our inspection, we received a letter from the trust outlining the action they had taken to address this concern. The letter stated that the trust had put additional paediatric cover in place the weekend immediately following our announced inspection and would continue to do so. During our unannounced visit there was one paediatric nurse working in the see and treat area, although they were not directly involved in the care of children in the department at the time. There was no paediatric nurse working on the night shift.
- Registered nurses, health care assistants and assistant practitioners in the department undertook paediatric resuscitation training; however, the majority of staff, 63 out of 67 staff were not trained in other areas of care and treatment of children. The Royal College of Nursing guidance recommends emergency departments, urgent care centres and minor injuries units maximise existing resources and at the same time invest carefully into the existing nursing workforce to enhance their paediatric skills. The guidance recommends a number of competencies staff should be trained in. The Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings also provide clear guidance. Nursing staff in the emergency department had not received any additional competency based training to care for children. Department leaders told us there were no paediatric competencies for nurses in the department to work towards, however new staff spent a day working in the children's wards to see how the area worked. The department had run an in-house minor skills day in 2014 where a consultant had delivered training session on paediatric presentations in ED (1 Hour). During our

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inspection, we observed a nurse caring for a child did not know how to apply a neck brace, a consultant demonstrated this to the nurse to ensure it was applied correctly.

- Assistant practitioners worked in the department to support nursing staff. An assistant practitioner is a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The assistant practitioner delivers elements of health and social care and undertakes clinical work under the supervision of a registered nurse.
- An emergency nurse practitioner (ENP) team operated between 8 am and 11 pm seven days per week. ENPs worked in the see, treat, and minor injuries area. The department was currently developing experienced nurses in the department to take on this role. Three ENPs had completed management of minor illness and injury in children qualification.
- The senior nurses (band six and seven) had allocated management days when they did not form part of the staffing establishment to allow them time to carry out management duties. On three occasions during our inspection, nursing staff had been taken off the allocated management days to fill staffing shortages. One member of staff said this was a regular occurrence.
- Nursing staff handovers occurred at each shift change and included discussions about patient needs and any staffing or capacity issues. One to one handovers were done by the patient's bedside nurse to nurse.
- There were inconsistencies in the way that agency staff were inducted. We spoke with one agency nurse who reported being orientated and inducted to the area when they first came on shift, however we did not see the department had kept a record of this. During our unannounced visit we saw that an agency nurse on Jowett Ward had been inducted using a checklist so that this was recorded, however in the majors area we spoke to an agency nurse who reported being inducted to the area, but no formal checklist or record had been kept of this. The senior nurse in the majors department said they would complete the record at the end of the shift.
- The department employed a higher proportionate of consultants than the England average. The proportion of junior, middle career and specialist registrar doctors was lower than the England average this meant there was a shortage of registrar grade doctors within the department. Consultants had to review more patients without the support of junior and middle grade staff.
- There was approximately 25 whole time equivalent (wte) medical staff within the emergency department of which approximately nine were consultants.
- Consultant cover was provided between 8am and 12am seven days per week. A local agreement was in place to ensure there was consultant presence 16 hours per day 365 days of the year.
- Middle grade doctors covered the 24-hour period between Thursday and Sunday. Variable cover was available Monday to Wednesday, however we saw a full 24 hours per day seven days per week middle grade doctor rota was due to commence in February 2016.
- A junior doctor rota provided 24-hour cover, which aimed to match the increasing attendances during the late evening and night.
- A number of General Practitioners (GPs) worked as part of the emergency department team to support management of patients in the ambulatory stream with primary care problems; this meant there were more senior medical staff working to see patients in a timely manner especially at weekends.
- There were two consultants in the department who had dual accreditation for emergency medicine and paediatrics.
- We saw a structured clinical standardised approach to handover.
- In the reporting period, January 2015 to December 2015 there was variable, but low locum usage of between 0.3 % to 1.9%.
- Nurses and junior doctors in the units told us advice and support from consultants was readily available, including out of hours.

Medical staffing

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- During our inspection, we saw a consultant induct a new locum doctor to the department there was no formal process followed and it was not documented. The lack of formal process could lead to inconsistency in the information during this induction.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place and readily available.
- All staff spoken with were aware of and knew their roles in the event of a major incident.
- The departments had clear guidelines and action cards for major incidents and copies of these were in a folder at the nurses' station. Nursing staff knew how to access these.
- Staff were familiar with how the chain of command worked in the trust for major incidents.
- The department had access to decontamination facilities and equipment to deal with patients who may be contaminated with chemicals, exposure to nuclear and other hazardous substances.
- There was 24 hour seven days per week security cover and the emergency department had priority to this service. Nursing staff told us the security team were highly effective and supportive. During our inspection, we saw security called to the department and they responded in a timely way.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated the effectiveness of emergency and urgent services to be good because patients were receiving effective care and treatment, which met their needs.

We found;

- Care and treatment was planned in line with current evidence based guidance, standards and best practice

and patient needs were assessed throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and College of Emergency Medicine (CEM) guidelines.

- Information about patients care and treatment, and their outcomes was routinely collected and monitored. This information was used to improve patient care.
- Staff could access information they needed to assess, plan and deliver care to people in a timely way.
- Consent to care and treatment was obtained in line with the legislation and guidance.

However;

- Staff did not consistently adhere to local guidelines, for example escalation of the deteriorating patient and sepsis screening.

Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines, and were aware of recent changes in guidance. Clinical guidelines were available in line with National Institute for Health and Care Excellence (NICE) Guidance and College of Emergency Medicine (CEM) guidelines, however during our inspection we saw that some guidelines for example escalating the deteriorating patient and sepsis screening were not consistently adhered to.
- Staff in the emergency department used a range of care pathways for adult and children, in line with national guidance, such as for fractured neck or femur, trauma and paediatric head injury.
- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of nursing care were based and aligned to best practice guidance. For example, use of pressure ulcer and nutrition risk-screening tools.
- The department was part of the Severn Trauma Network and clear protocols were in place for the receipt, treatment and transfer of patients suffering from traumatic injury.
- We saw a local audit regime was planned. Audits scheduled to be carried out included a re-audit of renal colic management (based on CEM standards) this was following introduction of new departmental guidelines. Audits were discussed at clinical governance meetings.

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- Staff told us procedures and policies reflected current guidelines and were easily accessible through the trust's intranet. We looked at four policies and procedures on the trust's intranet and these were up to date and reflected national guidelines.

Pain relief

- A pain passport was given to children when they checked into the department. Parents and children were encouraged to describe their pain using pictorial expressions.
- Patients and relatives we spoke with had been asked about their pain and given pain relief where appropriate at regular intervals. This was not always documented in records we reviewed.
- We saw the older person's assessment and liaison (OPAL) team used a pain recognition score for patients with cognitive impairment.
- A protocol had been created to ensure effective pain relief for patients presenting to the department with a fracture neck of femur (broken hip). We saw a special kind of nerve block called the Facia Iliac Block was immediately initiated for a patient with a fracture hip in the department. This meant the patient was receiving the best pain relief possible.
- There was access to the pain management team for support and guidance.
- For the two questions on pain relief in the Care Quality Commission (CQC) Accident and Emergency (A&E) survey for 2014 the department scored above the England average for the question staff did all they could to help patients with pain and scored about the same as the England average for the question how quickly pain relief was given.

Nutrition and hydration

- The department had facilities for staff to make drinks and snacks. We observed patients being offered snacks and drinks when they had been in the department for extended periods of time, however staff told us they often relied on prompts from patients as there was no formal comfort rounding. Comfort rounding is a scheduled check on patients comfort each hour and to establish if a patient requires anything at that given point for example a drink. One patient and relative who

had small children had been in the department for six hours and had not been offered anything to eat or drink, we mentioned this to staff and they immediately offered this to the patient and their relative.

- Patients staying overnight on Jowett Ward were offered a choice of meals. Snack boxes from the kitchen were available at all times.
- In the CQC A&E survey for 2014, the department scored in line with the England average for the question were you able to get suitable food or drinks when you were in the A&E Department?
- Water fountains and vending machines were available in the department.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national CEM audits so they could assess their practice and performance against best practice standards.
- Audits included severe sepsis and septic shock, paracetamol overdose, asthma in children, cognitive impairment in older people, mental health in the emergency department and initial management of the fitting child.
- The severe sepsis and septic shock 2013/2014 audit showed the department to be performing in line with the England average for seven indicators, better than the England average for four but worse than the England average for one indicator. We saw actions in place to address the poor performing indicator by way of a sepsis care pathway. The aim was to help staff identify when to provide treatments in line with best practice guidelines. However, during our inspection this was not always used.
- The paracetamol overdose 2013/14 audit showed the department performed worse than the England average for two indicators and in line with the England average for the remaining three.
- The asthma in children 2013/14 audit showed the department performed worse than the England average for four indicators, in line with the England average for five and better than the England average for one. We saw a local action plan with five actions had been completed.
- The assessing for cognitive impairment in older people 2014/2015 audit showed the department to be performing better than the England average for three out of the six indicators, two were in line with the

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England average and one was worse than the England average. Following on from this audit the department had employed acute care of the elderly practitioners who supported the department with geriatric assessments

- In the CEM audit, mental health in the emergency departments 2014/2015 results showed the department to be performing in line with the England average for five indicators, better than the England average for one but worse than the England average for two. During our inspection we saw that an action plan had been completed in December 2015 and staff were going to complete a local audit re assess themselves.
- In the CEM audit for the initial management of the fitting child 2014/15, the department performed in line with the England average for all of the five indicators.
- In the CEM consultant sign off audit 2013, the department performed in line with the England average for all of the four indicators. The consultant sign off audit standard states patients falling into certain groups for example patients returning to the emergency department with the same condition within 72 hours of discharge should have been seen by or discussed with a senior doctor
- In the reporting period October 2014 to September 2015 396 patients presented with suspected Neutropenic sepsis. This showed 370 patients (93%) received their first dose of intravenous antibiotics within one hour of arrival into hospital, this was a significant improvement (compared to 116 out of 178 patients (65%) presenting between October 2013 and June 2014).
- We saw the audits had been reviewed and action plans had been developed to improve where shortfalls had been identified.
- The rate of unplanned re-attendance to the emergency department within seven days was consistently above the five percent target set by the Department of Health, but was better than the England average between April 2013 and May 2015.
- Information about the outcomes of care and treatment for major trauma patients was collected and submitted to the trauma audit and research network (TARN).

Competent staff

- Newly appointed nurses had an induction to their role in the department and had a supernumerary period, however a member of staff told us they did not have a supernumerary period when they first started in post and they just had to “learn as they went on”.
- Nursing and medical staff received an annual appraisal. The figures for December 2015 showed 81% of nursing staff and 65% of medical staff had received an appraisal in the last 12 months.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council; this was carried out by the trust.
- A revalidation process was in place with good training opportunities for medical staff.
- The trust had put plans in place to support nurses to revalidate. The library was supporting staff to develop skills in reflections for inclusion in revalidation portfolios.
- A senior emergency department nurse was allocated 15 hours per week as a practice development nurse; they were responsible for co-ordinating staff training and development. The practice development nurse also worked alongside new staff to orientate them to their role.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. We saw good teamwork between an intensive care consultant and emergency department consultant when caring for a critically ill patient in the emergency department.
- There was an MDT approach which enabled care to be delivered in a coordinated way. Allied health professionals such as occupational therapist and physiotherapists worked well with the nursing and medical teams
- There was effective daily communication between multidisciplinary teams within the emergency department. Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks and concerns. Staff had good relationships with each other. A health care assistant said it was nice to be able to talk to the doctors and they felt empowered to be able to raise concerns about patients directly with them if they needed to, they said doctors were approachable and supportive.

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- There were routine multidisciplinary meetings involving the nursing staff, therapists and medical staff as well as social workers and safeguarding leads (where required) to ensure the patient's needs were fully assessed. This included identification of the patients' existing care needs, relevant social or family issues, mental capacity as well as any support needed from other providers on discharge, such as home care support or alcohol rehabilitation.
- Staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers, mental health liaison, and alcohol liaison as well as diagnostic support such as for x-rays and scans.
- An alcohol liaison team was available on site between 9am and 5pm.
- The joint emergency therapies team (JETT) comprising of physiotherapists, occupational therapists and therapy technicians worked in the emergency department. The JETT team worked closely with the nursing staff to identify patients who may require input to facilitate discharge directly from the emergency department and avoid hospital admission.
- JETT had dedicated links to community services and priority access to community hospital beds, which could avoid hospital admissions.
- The older person assessment and liaison team (OPAL) were based in the department. OPAL worked closely with the JETT team and staff in the department to screen patients over 75 who attended the department. The team carried out functional assessment, cognition, mood and behavior assessments in order to support timely discharge from hospital. OPAL had direct access to a consultant specialising in the care of the older person and other specialist services.
- A cardiac nurse specialist was available to support review of patients in the emergency department seven days per week.
- A stroke nurse specialist was available to support review of patients in the department. They facilitated transfer to the computerised tomography (CT) scanner then direct admission to the stroke unit when required. CT uses x-rays and a computer to create detailed images of the inside of the body.
- There were good links with other departments in the hospital for example theatres, imaging and pathology.
- The emergency department was consultant led, offering a service 24 hours a day, 365 days a year.
- X-ray and CT scanning diagnostic services were available in the emergency department 24 hours a day. Staff said they did not have problems accessing these when required.
- Support services for example OPAL, JETT and the cardiac assessment nurses worked in the department seven-days per week.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There was a formal handover for patients transferred from the department to the wards, which included a summary of the patient's care and treatment in the department. We saw on one occasion where the handover had failed between the emergency department and acute medical unit. This resulted in a 45-minute delay to a patient with suspected sepsis receiving antibiotics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with demonstrated understanding of the issues around consent and capacity for adults and children attending the department. Staff told us if they were unsure in any circumstances, they would seek guidance from senior staff or from the safeguarding lead.
- We saw from records and from our observations, the older people's assessment and liaison team (OPAL) completing abbreviated mental testing to establish a patient's memory status. If a patient showed memory function a two stage mental capacity assessment would be carried out to establish if the patient had the capacity to consent.
- When a patient was considered to lack capacity to make decisions staff sought the support of appropriate professionals so decisions could be made in the best interests of the patient.
- Staff asked for consent from patients before their treatment; however, consent was not recorded in all of the records we reviewed.

Seven-day services

Urgent and emergency services

Are urgent and emergency services caring?

Good



We rated caring in emergency and urgent services as good because patients were treated with dignity and respect, and were involved in partners in their own care.

We found;

- Feedback from patients who used the service and those close to them was positive about the way staff treated them. The NHS Friends and Family Test (FFT) is a satisfaction data between August 2014 and September 2015 showed the emergency department consistently scored above the England average with scores ranging from 89% and 97%.
- Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff helped people and those close to them cope emotionally with their care and treatment.

Compassionate care

- We spoke with 21 patients and 10 relatives. They were all positive regarding the care provided, they told us they or their relative were cared for in a kind and compassionate manner by staff. Our own observations supported this.
- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. We saw patients' cubicle curtains were drawn and staff spoke with patients in private to maintain confidentiality.
- We saw people treated as individuals and staff spoke to patients in a kind and sensitive manner.
- Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed.
- The seating area on Jowett Ward was not suitably positioned and faced a patient bed area. Patient's privacy and dignity was at risk. We told nursing staff of our concerns and when we returned the following day privacy screens were in place.
- The NHS Friends and Family Test (FFT) is a satisfaction survey measures patients' satisfaction with the healthcare they have received. The test data between

August 2014 and September 2015 showed a response rate between 87% and 89%. Low response rates are common for A&E. FFT scores for this reporting period showed the emergency department consistently scored above the England average with scores ranging from 89% and 97%, indicating patients were positive about recommending the hospital to friends and family.

- The CQC A&E survey 2014 showed the department was performing the same when compared with other trusts for 13 questions and was performing better than the England average for 11, these included being treated with dignity and respect whilst in the department and patients feeling reassured.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were involved and kept up to date with the care and treatment of the patient. They said the staff took time to make sure the patients and relatives understood the care and treatment and the options available.
- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand, however we did observe one doctor communicating with a relative whose first language was not English, and they did not check the patient had understood the information.
- We saw good interaction between a child and the medical team. The child was shown their x-ray and scan pictures to help them understand their injury. A skeleton was used to give a more in depth explanation. Explanations were given in a way to ensure the child understood the information.

Emotional support

- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.
- Patients told us the staff were understanding, calm, reassuring and supportive and this helped them to relax.
- A child was distressed when having observations carried out; we saw an agency nurse caring for the child use a mobile phone to play the child a song from their favourite television programme to ease their distress.

Urgent and emergency services

- The hospital had a chaplaincy service and staff told us they could request support from the chaplaincy team if this was necessary.
- Patients could access a range of specialist nurses, for example; cardiac nurses and OPAL nurses. We saw these staff providing specialist support to patients and those close to them in relation to their psychological needs.

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

Good



We rated responsiveness of emergency and urgent services as good because patient's needs were mostly met through the way services were organised and delivered.

We found;

- Waiting times and delays were minimal and managed appropriately.
- Care and treatment was coordinated with other services and providers.
- There were systems in place to support vulnerable patients.
- Complaints about the service were shared with staff to aid learning.

However;

- There was not sufficient consideration paid to the flow of children in the department. Facilities and premises were not appropriately used for the delivery of care to children, whilst in the department. Despite a dedicated children's treatment and resuscitation area being available, we saw that adults were treated in these areas despite children requiring treatment being in the department at that time.

Service planning and delivery to meet the needs of local people

- During 2014 /15, approximately 60,000 patients, including children attended the emergency department. This was an increase of 10% from the previous year

- The emergency department was a receiving centre for major trauma patients. Staff followed a trauma pathway which provided guidance for staff on the process for stabilising patients prior to transferring them to the regional major trauma centres.
- An escalation policy provided guidance for staff when dealing with periods where there was significant demand for services and staff demonstrated an awareness of what to do in these circumstances.
- Older Persons Assessment and Liaison (OPAL) and Joint Emergency Therapies Team (JETT) worked in the department to provide a service to those patients 75 years old and over to avoid unnecessary hospital admissions.
- Jowett Ward was not suitably equipped for patients who remained in the ward overnight.
- Patients requiring a place of safety were transferred to a nearby location with suitable facilities to provide appropriate care.

Meeting people's individual needs

- Care plans demonstrated patients' individual needs and were taken into consideration before delivering care.
- Staff had access to a language interpreter if needed to communicate with patients where English was not their first language.
- The OPAL team used a dementia-screening tool to identify patients who may be living with dementia so any additional needs could be met.
- Nursing staff told us they used the learning disability passport and the "This is me" document. These documents help staff to understand the needs of patients living with dementia and learning disabilities.
- Relatives were encouraged to support patients in the department living with dementia or learning disabilities.
- The department had a dementia link nurse who attended regular meetings and updated the team on any pertinent issues.
- Staff told us patients living with dementia or learning disabilities would be placed close to the staff base when space was available in order to observe and support them. We saw this happen during our inspection.
- Dementia support workers could be accessed at the trust and could sit with patients living with dementia in the department if required.
- Distraction therapies such as twiddle gloves were available for patients living with dementia.

Urgent and emergency services

- The trust had a learning disabilities lead attend the department to advise on the care and treatment of patients with learning disabilities. A flagging system had been developed on the trust electronic system to identify patients with a learning disability
- There was a designated room for relatives. Patient and visitors had access to a Wi-Fi internet connection.
- Patient information leaflets were available for a wide range of injuries and illness these were only available in English. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff had access to services for patients who had, or may be, suffering from a mental illness. The clinical site team had direct access to the psychiatry out of hour's team.
- Children and young people who attended the department following an incident of self-harm or needing urgent support for their mental health were cared for appropriately. Young people were admitted to the paediatric ward as advised by NICE and were seen the next working day by the mental health team.
- The unit had a chaperone policy in place. A chaperone is a person who accompanies a patient during an examination for example a female would be accompanied by a female member of staff when being examined by a male member of staff. Staff we spoke with told us every time a chaperone was required they assisted.
- The children's play area was not well equipped we saw a few toys and books but no television or games for older children. On our unannounced inspection, we saw that a television and games console was present in the children's play area.
- On Jowett Ward, we found there were not; sufficient arrangements to ensure patients were cared for in single gender facilities or had access to single gender washing and toilet facilities. During our inspection we saw a male and female patient were cared for in beds opposite each other. The department leaders told us Jowett Ward should not be used for patients staying in the hospital overnight, however during our inspection male and female patients remained in Jowett Ward overnight.
- We saw a wheelchair user have difficulty using the busy waiting area. It was difficult for them to place their wheelchair in the waiting area due to the location of the current fixed seating area.
- The Department of Health (DH) target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The trust had achieved the 95% target between January and July 2015. The trust failed to meet the target in August 2015 (94%) September 2015 (94%) and October 2015 (89%), however these figures still remained above the national average. We saw a joint action plan between the trust and local clinical commissioning group had been created to address the failing target. We saw that some of the actions had been completed and other actions were on schedule to be completed by February 2016. Directorate and department leaders told us this was a priority.
- We saw a patient flow escalation plan in place and staff were aware of when they would need to use this. However although the department had a dedicated waiting area for children, the needs of delivering the service to children using had not been fully considered in relation to co-ordinating flow of children to the appropriate children to treatment areas. During our inspection on three occasions, we saw adults were being cared for in the designated children's treatment area, despite there being children in the department. On two occasions during our inspection; we found adult patients were being treated in the designated children's resuscitation bay, and children were being treated in the adult bays. When we spoke to nursing staff about this, they said it could not be helped when all the other resuscitation bays were in use. On a further occasion, an aggressive intoxicated adult patient who was being observed by security was placed in a major's cubicle next to a young child. There was not sufficient consideration paid to the flow of children in the department.
- The total time spent in the emergency department (average per patient) was 124 to 153 minutes between January 2013 and September 2015, which was similar to the England average of 124 to 145 minutes during this period.
- The percentage of emergency admissions via the emergency department who waited between four and 12 hours from the decision to admit until being admitted was better than the England average. Between September 2014 and August 2015 there were 268 people waiting four to 12 hours.

Access and flow

Urgent and emergency services

- In the period September 2014 to August 2015 the department was not meeting current DOH guidelines relating to trolley waits. Two patients waited more than 12 hours on a trolley.
- The percentage of patients leaving the department before being seen was better than the England average between January 2014 and July 2015.
- The DH target is handovers between ambulance and emergency department must take place within 15 minutes with no patients waiting more than 30 minutes.
- The trust was not meeting this target. In the period June 2014 to May 2015 on average 88% of ambulance handovers took greater than 15 minutes and 28% over 30 minutes. Less than 1% of ambulance handovers took greater than 60 minutes to complete; this was low when compared to other trusts; however, this number was seen to be increasing.
- For the period November 2014 to November 2015, there were 79 black breaches. Black breaches are those cases where it has taken over one hour from the time the ambulance arrives at a hospital, until the clinical and patient handovers have taken place. These 'black breaches' were mainly caused by an increase in the numbers of patients attending the department and also by ambulances arriving together. A joint action plan was in place with the local clinical commissioning group to address this, and we saw that some of the actions were complete.
- The JETT team saw all patients presenting to the department over the age of 75. In the reporting period April 2015 to January 2016 the JETT team prevented on average 96% of avoidable admissions to the hospital.

Learning from complaints and concerns

- There was a formal policy for managing concerns and complaints. Staff were aware of the policy and how to access it.
- During our inspection we did not see any information displayed to inform patients on how to raise a concern or make a complaint.
- In the reporting period, January 2015 to November 2015 there was a low number (17) of complaints about the department. Complaints and concerns were discussed at monthly clinical governance meetings. Actions to address concerns and make improvements were noted. Most complaints related to communication, attitude of staff and privacy and dignity.

- Senior nurses told us they openly addressed any concerns or complaints raised in the department and instantly entered into open discussions with patients and relatives in order to come to a prompt resolution.
- All staff we spoke with was aware of their responsibilities if a complaint was raised.

Are urgent and emergency services well-led?

Requires improvement



We rated well-led in emergency and urgent services as requires improvement because the leadership, governance and culture did not always support the delivery of high quality patient- centred care in relation to the care of children.

We found;

- Risks were not dealt with or escalated appropriately. Department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
- Leaders were not always clear about their roles and their accountability for quality in relation to paediatric care.
- That was lack of nursing leadership within the department.

However;

- Candour, openness, honesty, transparency, and challenges to poor practice were evident.
- Staff actively raised concerns verbally and felt listened to.
- There was a clear vision and strategy for the department.
- Medical and nursing staff appeared to work well as a team.

Vision and strategy for this service

- The Trust had a strategic aim to provide first class, 24 hours a day-seven days per week emergency, urgent and planned care for patients at all stages of life. Particular emphasis had been placed on ensuring the

Urgent and emergency services

appropriate services were in place, either 24 hours a day-seven days per week or a seven-day per week basis, in respect of emergency care services however we noted that paediatric care provision in the emergency department was not part of this strategy.

- The emergency care strategy approved in 2008 set out the case for prioritising the needs of emergency patients and had formed the basis of investment in 24 hours a day seven days per week working. The strategy had resulted in investment in the emergency department workforce, which included a consultant presence until midnight seven days a week.
- The department's leaders had a clear vision for staff development and service development, which was ongoing. The clinical lead acknowledged the national and local challenges the department faced with medical staffing. The week following the inspection, a rota that ensured 24-hour middle grade cover was due to start.
- Staff were aware of the trust values, which were to put patients first by working as one team; leading and listening; and striving for the best and together, we make the difference. We observed staff delivering care and demonstrating behaviours in line with the hospital values.

Governance, risk management and quality measurement

- Governance meetings were held as part of the acute medicine directorate. We saw minutes from September 2015 until November 2015. Department leaders told us that it was an open invitation for all staff, however, we saw that in practice attendees were mostly senior staff. Agenda items included the departmental risk register, urgent patient safety issues, incidents and audit.
- We reviewed the department risk register for November 2015 and noted there were five risks on the register which were lack of 24/7 middle grade doctor cover in the department, ambulance handover delays greater than 15 minutes, failure to meet the four hour target, increase in adverse patient safety issues, breaches in standards of care due to inadequate nursing to patient ratios once ED extra capacity opened and radiology reports have significant delay. We could not see evidence the register had been reviewed regularly. One risk on the register had no date; another two risks were dated February 2013 and December 2014 with the final risk being present since November 2015. During our inspection, we requested the most up to date department risk register whilst we were on site. We received a copy of the risk register dated January 2016 and could see that this had been reviewed and updated with target dates, actions and progress of the five risks, no additional risks had been identified.
- Nursing leaders were not aware of all of the current risks affecting the department and the delivery of safe care nor were these risks proactively escalated. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
- We spoke with the department leaders about the risk register. The nursing leader was only aware of the risk in relation to nursing staff, when asked if there were other risks, they said they did not know but said they could find the register to establish other risks. We asked the nursing leader if there was any support from the children's ward in relation to children's nurses we were told there was no policy in place for this to happen and the nursing leader felt that they did not need it. The nursing leader told us they felt that all staff in the department were able to look after children. This meant the nursing leader did not have an overall view of the risks in the department.
- The clinical director told us the top two risks for the department were recruitment and flow and were working on plans to address this. We noted there had been an increase from seven to nine consultants. The clinical director was working with local GPs to try to encourage them to work in the department. The clinical lead had also been working on non-national contracts to try to provide more consultant presence in the department.
- During our interview with the directorate leadership team (general manager, lead consultant, lead nurse and associate medical director), we established that the department had not considered recruitment of paediatric trained nurses to the department. The department were not meeting the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and we could not see this risk had been mitigated. This meant there was no clarity in relation to roles and accountability for quality in relation to paediatric care.

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- The department measured themselves against both the Royal College of Emergency Medicines standards and the Severn trauma network service specifications.
- Throughout our inspection we raised several of our concerns with the department leaders especially in relation to the lack of competencies of nursing staff taking care of children in the department, but no attempt was made to address the issue whilst we were on site. We also raised our concerns about the lack of checking and recording of the resuscitation equipment, despite this when we returned the following day the out of date equipment remained, and during our unannounced visit we did not see evidence that all resuscitation equipment had been checked on a daily basis.
- Following our inspection, we received a letter from the trust outlining the action they had taken to address the concerns we raised in relation to the skills of nurses caring for children in the department. They told us a meeting had been scheduled following our announced inspection to discuss a full pathway review, led jointly with the paediatric team, using national guidance as a benchmark. On our unannounced inspection, we spoke with the practice development nurse who confirmed that the meeting did take place, and that further meetings were to be scheduled. Minutes for this meeting showed that department leaders and the paediatric team discussed some of the issues identified in our feedback to the trust such as the environment and lack of paediatric nurses in the department. Minutes from this joint meeting did not discuss how the department would go about ensuring current nurses in the department would be supported to develop paediatric skills in line with the Royal College of Nursing guidance 2013.
- The lead nurse and some senior nurses had completed the leadership course. This is an in-house leader led programme which uses the knowledge, skills and experience from staff across the trust, to support and enable leaders to lead change and drive performance through earning commitment, demonstrating candour and compassion. Some nurses told us they were due to complete the course but this had been cancelled due to poor staffing levels. Minutes from the department's senior meeting in November 2015 supported this.
- Nursing leaders were unaware of national guidance from the Royal College of Nursing (2013) which advises that there must be a minimum of one-registered children's nurse available at all times in emergency departments, therefore we were not confident that the nurse leaders were clear about their roles and their accountability for quality in relation to paediatric care and therefore nursing leadership in the department was not strong.

Culture within the service

- Staff told us they felt frustrated they were not always able to go the extra mile for patients, as the department was so busy. Some staff told us they felt "under pressure" and "stressed". One consultant told us the morale was low from "top to bottom".
- Staff told us there was a friendly and open culture and they were most proud of the teamwork within the department.
- Junior doctors and nurses also told us they received a good level of support from their peers and line managers.
- The medical and nursing staff appeared to work well as a team.
- In the 2014 / 2015 NHS staff survey 63% of staff would recommend the trust as a place to work, this was above the England average of 58%.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Patient feedback forms were available on reception for patients to complete.
- The trust created "Musgrove Matters". This newspaper-style publication was sent to local GPs, members of the public on the hospital's members list,

Leadership of service

- The emergency department formed part of the acute medical directorate. The overall lead for the emergency department was the clinical director, who was supported by the directorate manager and the lead nurse.
- There was a senior shift coordinator on each shift managed the day-to-day running of the services.
- The nursing and medical staff told us they felt the clinical director was approachable, visible and provided them with good support.

Urgent and emergency services

all colleagues, and was available for patients and visitors throughout the hospital site. We saw copies of this in the department during our visit and staff told us they could also view this on the intranet.

Staff engagement

- A staff pulse check was carried out on a quarterly basis and asked 11 questions to measure colleague engagement. We saw staff in the department were encouraged to complete this and a reminder was placed on the team notice board. Pulse check data could not be broken down at department level so gave a sense check of the hospital as a whole.
- In the 2014/2015 NHS staff survey the trust scored 3.8 above average compared to the benchmark for the sector of 3.7. However, the response rate for the survey was only 26% compared to an England average of 44%. The trust recognised they had sent the questionnaire electronically to employees rather than paper copies, which they had done in previous years. The plan was to send a mixture of both for the 2015 /2016 survey. We were unable to break this information down by department.
- Staff had access to “Share with Sam” this was access to the chief executive. Staff were encouraged to share their

feedback of the hospital openly, honestly and easily. There were a variety of direct and confidential communication channels with the chief executive provided through the intranet, email and paper forms. Staff we spoke with said they had used this service and had received a good response.

- We were told the JETT team had been nominated for the 'Musgrove Awards for Tremendous Achievement' (MAFTA) in recognition of their hard work in the department

Innovation, improvement and sustainability

- General Practitioners (GPS) worked in the emergency department. GPs supported management of patients in the ambulatory stream with primary care problems.
- The department told us GP rotas were not constrained by employment law, allowing the department to increase the number of shop floor senior decision makers at weekends. We were told the GP service had reduced cost, provided ongoing stability, and improved efficiency within the department.
- The JETT and OPAL teams worked with the emergency department to prevent avoidable admissions.

Medical care (including older people's care)

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

Information about the service

Musgrove Park Hospital serves a population of approximately 350,000. There were just over 39,000 admissions to medical care services between July 2014 and June 2015, 55% day case, 41% emergency and 4% elective. Specialities include gastroenterology, stroke, clinical oncology, respiratory and cardiology. Two directorates manage medical care services; acute medicine and haematology, oncology and palliative care (HOPE). There are 13 medical wards including a 51 bed acute medical unit (AMU), four care of the elderly wards and an additional winter pressures ward. In addition, there is coronary care unit with a cardiac catheter laboratory, discharge lounge, medical day case and ambulatory care units.

We used a variety of methods to help us gather evidence in order to assess and judge the medical care services based at Musgrove Park Hospital. During our inspection, we visited 13 wards, the coronary care unit, cardiac catheter laboratory, ambulatory care and discharge lounge. We spoke with 67 patients or their relatives and 103 staff including; junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, nursing and medical students, bank and agency nursing staff, pharmacy staff, administrative and clerical staff and volunteers. As part of our inspection we used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who could not speak with us.

We observed interactions between patients, their relatives and staff, considered the environment and looked at 21 medical and nursing care records. Before our inspection we reviewed performance information from and about the hospital.

Medical care (including older people's care)

Summary of findings

Overall, we rated medical care services, including care of older people at Musgrove Park Hospital as good, but safety requires improvement.

We found:

Patients received evidenced based care and treatment and we saw policies based on national guidance. Staff assessed and managed patient's hydration, nutrition and pain appropriately.

The trust took part in local and national audits to assess patient outcomes and the quality of care. Results from these audits were mostly positive. There was evidence of some seven day working particularly from diagnostic imaging and reporting.

The service had very positive friends and family test results with an average of 100% and 98% for HOPE and Acute Medicine directorates respectively. This meant almost all patients would recommend the service to others.

Staff treated patients with compassion, dignity and respect and we saw staff going the extra mile for patients. Patients were positive about their care and we saw that they were involved in their care and treatment.

There was a proactive approach to bed management and discharge planning began from the moment the patient arrived in hospital. Services were responsive to patient needs and medical outliers (medical patients placed on surgical wards) received appropriate care and treatment that reflected their condition.

There were positive stroke and cardiac pathways to improve access to treatment times and discharge.

There were systems and processes to manage risk and quality assurance, including local and clinical audits. Staff at all levels took ownership and responsibility for quality assurance.

Leadership was visible at all levels of the service. Leaders were aware of issues affecting service delivery and passionate about their staff. Staff felt supported and there was an open, honest patient centred culture.

There was a robust incident reporting procedure. Staff knew and demonstrated how they could report incidents. We saw that there was learning from incidents.

Nursing and medical staffing levels were safe. Nursing and medical staff received support from managers and senior clinicians and received regular supervisions.

However, we also found:

Staff did not assess all patients appropriately on their arrival to hospital. We saw evidence of risk assessments not completed or dated, and deteriorating patients not treated in a timely manner.

Staff compliance with infection control policies and procedures were inconsistent, particularly on the acute medical unit (AMU). Hand hygiene audits for AMU were poor and staff did not always ensure a safe environment for patients.

The environment presented a challenge to staff and service delivery. Despite the trust having a bed escalation plan additional beds were kept open in the clinical decisions unit while patients waited for medical beds.

Staff did not always follow procedures around assessing patient capacity and applying for deprivation of liberty safeguards (DoLS) authorisation.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



Overall, we rated the safety of medical care services at Musgrove Park Hospital as requires improvement.

We found:

- Staff did not complete all Waterlow assessments for pressure ulcers appropriately or within six hours of admission as per National Institute for Health and Care Excellence (NICE) guidance
- Infection control practices on the acute medical unit (AMU) did not meet trust requirements or standards.
- Staff did not check resuscitation trolleys regularly in line with trust policy. One trolley had out of date equipment and another had equipment with no clear expiry date.
- Sharps boxes were not sealed and left open presenting a risk of injury and infection to patients and staff.
- Medicines were not always stored securely and checked to ensure they were stored at the right temperature.
- Staff left some records unsecured in open cupboards or left out in corridors.
- Mandatory training completion rates did not meet the trust standard for acute medicine directorate.
- Staff did not always identify and record patient risk in a timely manner. This included sepsis diagnosis and management.

However:

- There was a robust incident reporting procedure. Staff knew how, and what, to report as an incident. There was evidence of learning from incidents.
- Medical care services checked and maintained equipment regularly.
- The pharmacy team provided a well-established and comprehensive service.
- Staff knew about trust safeguarding policies and procedures. Staff gave us examples of when they had used these procedures.
- Nursing and medical staffing levels reflected patient needs.

Incidents

- The trust incident reporting policy stated staff should report incidents through the trust's electronic reporting

system. We spoke with a range of staff across the service and all were aware of how to report incidents. All of the staff we spoke with told us they were encouraged to report incidents.

- Staff provided us with examples of when they had reported incidents, and understood what constituted an incident. This included reportable incidents such as pressure ulcers, medication errors, slips, trips and falls. The majority of staff we spoke with said they had received feedback on the incidents they reported. Staff who reported incidents usually received feedback by email. Senior nurses fed back general learning from incidents at handovers and safety briefings.
- Medical care service reported 2,177 incidents for the reporting period January 2015 to December 2015. There were six serious incidents for the same period. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Five incidents related to pressure ulcers (damage to the skin) and one was a fall incident. Fielding Ward and acute medical unit (AMU) reported the most incidents. The most common incident types were patients admitted with pressure damage and a patient slip, trip, or fall.
- Senior nurses carried out the management of incidents. Incidents were analysed to identify themes and trends, which contributed to a comprehensive review. We saw root cause analysis undertaken by incident investigators with actions and learning identified. Directorate governance groups also discussed incidents and monitored the action plan until completion.
- The trust policy was to report pressure ulcers of grade one or above. Staff we spoke with said they reported all pressure ulcers. This demonstrated staff documented pressure ulcers as a local clinical incident in line with Royal College of Nursing (RCN) management of pressure ulcers.
- Each medical speciality held monthly mortality and morbidity meetings. We saw evidence clinicians discussed deaths, and any issues were actioned. Discussion referred to best practice and NICE guidelines where applicable. We saw from minutes of mortality and morbidity meetings reviews led to changes in service improvement.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of

Medical care (including older people's care)

health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person'. Staff we spoke with knew about the duty of candour, demonstrated how they were open, transparent and provided support to the patient. The trust shared duty of candour compliance data monthly and quarterly with directorates and staff discussed any relevant issues at their morning safety briefing.

- One member of staff gave an example of a medicines incident in which the senior nurse informed the patient's family straight away, because the patient did not have capacity. The senior nurse invited the family on to the ward and shown what had happened. The senior nurse ensured the family had the opportunity to ask questions.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The trust collected data on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers, falls, patients with a catheter associated urinary tract infections (CAUTIs), and blood clots or venous thromboembolism (VTE).
- The trust monitored safety information on a monthly basis and the results displayed using a safety cross. The safety cross was a chart displayed on all of the medical wards we visited. It highlighted when patient harm had taken place and how long wards had been harm-free.
- There were 23 reported hospital acquired pressure ulcers, nine falls, and 15 CAUTIs reported between September 2014 and September 2015. Data showed the number of hospital acquired pressure ulcers and falls were decreasing. The number of CAUTIs remained constant except for spike between August and September 2015.
- The service had positive results treating VTE. Between April 2015 and October 2015 an average 96% of patients received VTE assessments on admission to hospital and we saw re-assessment within 24 hours in all medical records. Patients at risk of falls all had up to date falls risk assessments. At the time of our inspection the trust were rolling out a new initiative to manage falls. This involved a member of staff remaining in a ward bay at all times to monitor patients at risk of falls.

- Staff used the Waterlow assessment tool for identifying and assessing the risk of pressure ulcers developing. Patients admitted to hospital should receive a risk assessment for pressure ulcers within six hours of admission in accordance with NICE QS89 guidance. However, we could not see evidence of Waterlow assessments completed within six hours for some patients. Data from the trust between January and December 2015 showed 88% of Waterlow charts had evidence of completion on admission. Somerset Clinical Commissioning Group (CCG) had also raised this in a recent peer review of pressure ulcer management. We raised this with the trust tissue-viability leads who said they were looking at changing the pathway and Waterlow document so staff could evidence the time of assessment.

Cleanliness, infection control and hygiene

- The trust audited their performance on infection control. The audit showed between April 2015 and December 2015 the trust were around 90% compliant on average with hand hygiene policies and procedures. Results varied between 89% and 97% across this period. The same audit showed cleanliness across acute medical wards had dropped from 96% to 92% between July 2015 and December 2015. Senior managers monitored an action plan to address any poor performance. Work was ongoing to improve performance on infection control.
- Data from the trust showed between April and December 2015 there were 19 Clostridium Difficile (CDifficile) cases in the trust. C.Difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics. The 19 cases of C.Difficile was above the trusts projected annual target of 12 cases and seven of these cases occurred between November 2015 to December 2015.
- We saw from trust audits the environment on AMU was not always clean, and staff did not always wash their hands. Data from the December 2015 hand hygiene audit showed 80% of staff had washed their hands before and after contact with patients (in line with trust policy). We observed staff on AMU and saw out of 14 staff, 11 washed their hands in line with trust policy. Therefore, poor practices presented an infection risk to staff and patients.
- Minutes from the increased incidence meeting (a meeting discussing C-Difficile incidents, themes and

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trends) on 18 January 2016 highlighted there were ongoing concerns regarding the infection control practices in AMU. We saw the meeting identified actions; however, it was too early during our inspection to know whether these actions had an impact.

- Directorate managers said a new environment, leading to an increase of 29 beds, and several temporary and new staff were factors in infection control standards not being what they should be on AMU. In response to these issues managers said they had increased the frequency of infection control audits and a full review of the C-Difficile cases. We saw from the minutes of the increased incidence meetings managers identified immediate actions. The acute medicine directorate had an action plan to address poor performance and there was an increase in infection control and hand hygiene audits. These were ongoing at the time of our inspection. Nursing staff on AMU said senior nurses mentioned infection control at every safety briefing.
- Staff mostly demonstrated a good understanding of infection prevention and control. Data from the trust showed 81% of staff had completed their infection control training. This was worse than the trust target of 95% and some new members of staff told us they had not yet received infection control training. Staff who had not received training in infection prevention and control measures posed a risk to patients and staff.
- The trust had higher rates of Methicillin-Susceptible Staphylococcus Aureus (MSSA) than the trust projected. MSSA can cause infections called Septicaemia (blood poisoning) if it gets into the bloodstream. The trust reported 16 cases of MSSA between April and December 2015 against an annual target of nine.
- The trust reported zero incidents of Methicillin Resistant Staphylococcus Aureus (MRSA) between April 2015 and December 2015. MRSA is an infection that can cause problems if it gets into wounds or into the bloodstream. This was better than the England average.
- Trust audits showed there were not always catheter care plans in place. Four wards in November 2015 and five wards in December 2015 did not meet the required standards for documenting catheter care. Not having catheter care plans meant staff might not identify risk to patients with catheters in a timely manner.
- On Wordsworth Ward, we saw a used air mattress un-bagged (not decontaminated and sealed) waiting for collection stored with clean linen. Patients who are at risk of developing pressure ulcers use air mattresses as

part of their care and treatment. There was no evidence the mattress was clean and therefore this presented an infection control risk. We raised this with a senior nurse who said staff cleaned mattresses immediately after use before collection. However, the senior nurse acknowledged there was no evidence of this, and shortly after the mattress was collected.

- There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms, and staff used aprons when serving meals. However, we observed staff on two wards leaving bays without taking off the gloves they had worn to assist with personal hygiene and then returning to the patient. These practices increase the risk of the spread of infection.
- All wards had cleansing gel dispensers inside their entrances and by each patient bed space. Appropriate signage regarding hand washing for staff and visitors was on display. Staff placed patients in side rooms when considered an infection control risk; for example, those with diarrhoea. There was clear signage outside the rooms to ensure staff and visitors knew about the increased precautions they must take when entering and leaving the room, and side room doors remained closed.
- All sluices we checked were clean and tidy.
- A sharps box is a container filled with used medical needles and other sharp medical instruments. We saw a sharps box on AMU was full and left open. It was possible to reach inside the bin and pull items out. This meant a risk of injury and possibly infection to staff and patients. Sharps boxes should always be sealed and disposed of when full. Regulation 7(6) (c) of COSHH requires systems to be in place to dispose contaminated waste safely. We raised this with the senior sister and she removed the box immediately.
- However, on our unannounced visit we saw five sharps boxes open and not sealed. Staff left the boxes on trolleys unattended. This meant patients or visitors could access the boxes and their contents.
- We saw two cardboard bedpans full of urine left unattended in a toilet in AMU. One bedpan had been sitting in the toilet on top of the waste bin for 40 minutes without staff collecting or disposing of it. We spoke to the nurse in charge who told us staff sometimes asked

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patients to leave samples of urine for testing. However, she acknowledged staff should not have left the urine there so long. After we raised this issue staff removed them immediately.

Environment and equipment

- There were systems to maintain and service equipment as required. The service maintained and checked equipment regularly to ensure it continued to be safe to use. We saw labelling on equipment to show when electrical testing had been undertaken. All of the equipment we looked at was in date for its testing period.
- There was an equipment library for stocks of specialist mattresses and other equipment. Staff told us they had no problems accessing specialist equipment from the equipment library for example equipment to reduce the incidences of pressure ulcers and falls.
- All wards had access to resuscitation equipment. Adjoining wards shared resuscitation trolleys. Some ward staff we spoke to expressed concerns about sharing because if a trolley was in use staff had to try to find a trolley from a ward further away. Staff we spoke with said at times wards borrowed trolleys to use antidote boxes. Therefore, sometimes wards could return trolleys without replenishing equipment. During our inspection, we saw one resuscitation trolley not sealed because it was waiting to be re-stocked. A senior nurse said the trolley would be stocked later that day. We returned to check the trolley and saw it restocked and sealed. There were no risk assessments for sharing trolleys but despite this there had been no reported issues.
- The trust had systems to record the daily and weekly checks required to ensure it was complete and ready for use. However, staff did not always follow these systems. We checked six resuscitation trolleys and saw staff had not checked three trolleys daily and weekly in accordance with trust policy.
- One resuscitation trolley had out of date equipment. Another trolley had Magill forceps and a bag valve mask (a self-inflating bag used in resuscitation) with no clear expiry date. We raised this with the resuscitation officer who escalated the issue. The resuscitation officer ordered replacement equipment.
- Medicines were not always stored securely on medical wards. On many wards, staff kept medicines and intravenous fluids (IV) in treatment rooms without doors. Although most medicines were in locked cupboards within these rooms, several were not. This included medicines delivered from the pharmacy and sometimes those stored in refrigerators. Storerooms were not locked securely, therefore there were not suitable arrangements in place to prevent medicines being stolen or tampered with.
- We could not be certain medicines were stored at suitable temperatures to maintain their quality and ensure they were fit for use. Staff did not consistently record refrigerator temperatures or maintain them within a suitable range. We saw gaps in recording temperatures on five occasions in January 2016 on AMU. Staff on Fielding and Eliot Ward had recorded temperatures outside of the required range with no evidence of action. Staff did not measure room temperatures in any of the treatment rooms we inspected.
- A trust wide audit of medicines security had recently identified the need to improve security of storage of medicines, and staff had completed appropriate risk assessments. The trust planned to introduce lockable cupboards during refurbishments where possible, and a ward based medicines management audit piloted, however the trust had not fully rolled this out when we visited. We were not confident staff took sufficient, timely action to ensure medicines were stored safely.
- Controlled drugs (CD) are medicines requiring additional security. We saw controlled drugs were stored and recorded appropriately. We noted from records staff checked them twice weekly and the CD check records were complete. However, on one ward staff kept the CD key inside another medicines cupboard and not with an identified key holder. This was not in line with the trust's policy.
- There was a pharmacy top-up service for stock medicines on most wards, and other medicines were available to patients quickly and efficiently through a nurse-led ordering system. Staff kept patient's own medicines in lockers by their bed and were readily available to take away avoiding delays in medicines supply at discharge. This meant people were not kept waiting for their medicines.
- We found the pharmacy team provided a well-established and comprehensive clinical service to

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ensure people were safe from harm from medicines. The pharmacy team visited all wards each weekday, and although they did not provide the clinical service at weekends, an on-call pharmacist was available and could access the dispensing robot to supply required medicines. We saw pharmacy staff reviewed and confirmed the prescriptions for people on first admission to hospital, and we saw evidence that over 90% of patients' medicines were reconciled by pharmacy staff to reduce the risk from discrepancies in medicines prescribed. Pharmacists recorded medicines interventions on the prescription charts to help guide staff in their safe administration.

- We observed good practice on wards during medicines preparation, and patients told us staff looked after their medicines well. Patients on wards were encouraged to bring in their own medicines for use during their stay in hospital. On some wards, staff reported supporting patients to continue to administer their own medicines. However, this was not taking place often, and staff said the trust's self-medication policy was currently under review. We did not see staff encouraging patients to self-administer during the inspection.
- On some wards, staff reported keys were not available for patients to access their own medicines in their bedside lockers, reducing the opportunity for self-medication. Staff we spoke with said where there were no patient locker keys, available self-medicating patients would have to keep medicines in their bags, on a table, or leave their cupboard open. However, we did not see any medicines left out of lockers or in view.
- We looked at the prescription and medicine administration records for 43 patients on 13 wards. Staff fully and legibly completed prescription charts and documented all where necessary. Administration records showed people received their medicines as prescribed, including those medicines required at specific timings outside of usual medicine rounds. There was a specific group managing insulin errors, chaired by the medicines management nurse. Staff recorded all episodes through the trust incident reporting system and investigated appropriately.
- The trust had effective medicine ordering and dispensing systems. Nurses ordered medicines needed for patients, and pharmacy staff were involved in medicines supply top-ups to maintain supplies on the wards. This ensured that medicines were supplied quickly when needed, and improved the speed of

patient discharge. Staff we spoke with said the pharmacy department provided a good medicines supply service. The average daily prescription turn-around time for the last 12 months at the trust was 19 minutes, which was considered to be quick.

Records

- The majority of the medical records we looked at were legible, clear, and staff were dating and signing all entries. This was in accordance with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance.
- Records were stored in notes trolleys in ward areas. We saw most of the trolleys locked securely. The majority of unlocked trolleys were under the supervision of nursing and medical staff.
- However, patient records requiring collection by consultant secretaries for discharge letters were not stored securely. On one ward, we saw records left on the floor in a corridor next to the nurses' station. On another ward, records were stored in unlocked cupboards. This meant there was an increased risk of unauthorised persons accessing records.
- Staff used electronic patient records alongside paper records. The trust had not yet fully implemented the electronic system. Medical staff we spoke with said the electronic system was good for investigations and discharges.

Safeguarding

- We spoke with staff about protecting patients from abuse. Most staff told us they had received training in safeguarding adults and children and were aware of the trust's safeguarding policy. Data from the trust showed us an average of 86.5% of nursing and 79.5% of medical staff across the acute medicine and HOPE directorates had completed their safeguarding adults training.
- Staff in both directorates also took part in safeguarding children training levels one and two. An average of 87.5% of nursing and 81.5% of medical staff had completed level one safeguarding children training. Seventy percent of medical staff and 81% of nursing staff had completed level two safeguarding children training.
- All the staff we spoke with could describe types of abuse and what constituted abuse. Staff were confident in

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escalating any concerns they had and gave us examples of when they had followed safeguarding procedures or escalated an issue. This meant staff raised safeguarding concerns appropriately.

- There was a safeguarding lead for the trust. However, most staff we spoke with could not tell us who the safeguarding lead was. The majority of staff said they would escalate to a sister or matron if they had concerns. This was in line with the trust's safeguarding policy.
- In 2011, the trust undertook an assessment against the Safeguarding Adults Self-Assessment and Assurance Framework for Health Care Services (2011) this was updated in 2012. The trust used the framework to provide assurance against safeguarding procedures. No further updates had been undertaken, and therefore no present performance against the framework was available. However, at the time of inspection the trust developed, with partners, a self-assessment tool for regional adoption which was in the process of being agreed. The trust said as soon as it was agreed work would commence to apply this tool to assess current processes.

Mandatory training

- The trust delivered mandatory training over a three-year period using online software. Mandatory training included safeguarding, health and safety, infection control and manual handling. Managers and the trust monitored which staff were and were not up to date with their mandatory training. It was a manager's responsibility to ensure staff were booked on to training and were up to date.
- Data from the trust showed as of December 2015, 80% of staff in acute medicine and 90% of staff in HOPE were up to date with their mandatory training. The trust standard for mandatory training was 90%. The majority of medical wards were below 80% compliance meaning they were worse than the trust standard. Most staff we spoke with said they had undertaken their mandatory training, however data showed that 16% of staff were three months or more late with their mandatory training.
- Seventy-five percent of medical staff across medical specialties were up to date with mandatory training. Twenty out of 115 medical staff (17%) were three months or more late.

- Managers received workforce reports, which identified staff not up to date with training. Managers had a system to notify and remind staff to refresh their training. We saw they maintained detailed training records for staff.

Assessing and responding to patient risk

- Nursing staff throughout the trust used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- Risk assessments for the majority of patients for venous thromboembolism (VTE), pressure ulcers, and falls, were undertaken appropriately. Risk assessments identified required actions to minimise any potential risk to patients. However, it was not always clear if staff had undertaken risk assessments in a timely manner.
- Staff demonstrated a good knowledge of the risks associated with sepsis. Staff recognised sepsis as a clinical emergency. The majority could tell us the actions they would take if they suspected a patient was deteriorating and showed signs of sepsis. If not recognised and treated early sepsis can lead to death. The trust used a 'sepsis six' tool to detect whether a patient was experiencing sepsis. The tool outlined the steps to follow in the event of a patient developing sepsis.
- Early warning score proformas documented the vital signs which would alert staff to the possible signs of sepsis. Other medical wards did not use sepsis-screening templates and instead used EWS charts, to identify possible symptoms. This may result in a delay to screening and treatment of patients with suspected sepsis.
- Staff did not screen all patients for sepsis on arrival to hospital. The trust policy stated staff should screen all patients for sepsis when referred to AMU by a GP. Sepsis is a life-threatening condition occurring when the body's response to an infection harms its own tissues and organs. Audit data from January 2016 showed staff screened 86% of patients for signs of sepsis.
- Guidance on treating sepsis states that patients should receive antibiotics and/or intravenous (IV) fluids within an hour of staff identifying symptoms. Data provided by

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the trust for the reporting period January to December 2015 showed on average, half (50%) of patients referred to AMU did not receive antibiotics within the recommended first hour. Forty four percent of patients received IV fluids within the same hour.

- The data for treating sepsis in AMU was worse than the medical average with 33% of patients receiving antibiotics and 31% receiving IV fluids within an hour respectively. This meant despite staff identifying symptoms relating to sepsis they were slow to respond to manage the condition, this places patients at risk.
- In response to the sepsis performance data the trust sepsis committee had an improvement programme. This included the introduction of sepsis champions, teaching sessions on AMU and one to one training for staff. The sepsis committee would monitor and audit the completion of the sepsis proforma. The committee said that the numbers relating to patients receiving treatment within the hour related to very small numbers (average of five per month). They also said, due to the expansion of AMU, they had to reintroduce many of the measures to protect patients from sepsis because of an expanding workforce.
- We reviewed medical records for one patient on Wordsworth Ward. The patient arrived in ED unresponsive following a seizure. The patient was transferred to Wordsworth Ward via AMU after being treated in ED. The records showed no evidence that staff acted on poor and deteriorating vital signs appropriately and promptly. We did not see evidence of records showing what action was taken to address low blood oxygen levels and deteriorating NEWS scores. There was also no record of the patients transfer from the emergency department to AMU. This meant staff treating the patient on the ward would be unaware of what treatment the patient had received and whether the treatment received was appropriate.
- On Conservators Ward we saw two members of staff turning a patient despite the patient record stating it needed four people to turn them. This presented a risk of harm to the patient and staff, as the recommended number of staff were not turning the patient.
- Staff were required to attend hospital life-support training yearly. All staff we spoke with said they had received hospital life-support training. As of December 2015, 131 out of 450 nursing and non-nursing staff (29%) were not up to date with hospital life support training. This presented a risk to patients if staff were not up to

date with life support training. As of January 2016, all nursing staff required to complete advanced life support (ALS) training had completed it and 58% of medical staff were up to date. However, the trust responded to this stating some medical staff who were new to the trust had completed their ALS certificate elsewhere (ALS training is valid for four years). Therefore, they were conducting an exercise to review these figures.

- A critical care outreach team (CCOT) was available 24 hours a day, seven days a week to support staff with patients who were at risk of deteriorating. The hospital at night team was available overnight and could access specialist support from staff on the critical care unit.
- Patients receiving chemotherapy had a card, signed by a consultant, identifying them as being at risk of infection. If patients felt unwell and presented the card to other health professionals, it enabled them to receive fast treatment of antibiotics without having to see a consultant first. Audits between December 2014 and January 2015 showed over 90% of patients received antibiotics within an hour.
- We observed a medical emergency on one ward we visited. Staff acted in a calm manner and dealt with the situation quickly and professionally.
- Nursing handovers occurred at every shift change, during which staff communicated any changes to ensure staff took actions to minimise any potential risk to patients.

Nursing staffing

- The trust used the safe care tool to determine numbers of staff required to care for patients. Senior nurses based staffing on the number of patients and their needs; we saw wards managed this flexibly. The tool allowed staffing updates and rotas to be changed and updated in real time ensuring managers were always aware of the staffing requirement. The ratio of nursing staff to patients on the majority of the wards we visited were in line with the recommended guidance of one nurse to eight patients.
- All the wards we visited displayed the number of staff (registered nurses and healthcare assistants) planned for each shift, and the numbers actually present on each shift. During our visit, there was the planned number of staff on duty.
- Data from the trust showed overall that the majority of wards had enough staff to fulfil rota requirements. When more staff were required to provide one to one support

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for complex patients, we saw ward managers could use extra staff. Bank and agency staff were used to fill gaps in rotas. Nurses already employed by the trust worked on the bank meaning the majority of bank staff were inducted and familiar with the trust. Bank and agency staff we spoke with said they had been welcomed and inducted onto the ward. We saw examples of ward welcome packs and completed inductions for agency and bank nurses.

- Most wards had between two and seven nursing or non-nursing vacancies. Data from the trust showed there were almost 20 whole time equivalent (WTE) vacancies on AMU in November 2015. To address staffing shortages managers seconded nursing staff from other wards. The service had increased leadership presence on the ward and introduced incentives for bank staff to increase the amount of staff available to work on the ward. During our inspection, we saw the trust had recruited additional staff and there were eight WTE vacancies for AMU. There were newly recruited nurses from overseas recruited to fill vacancies. This demonstrated vacancies were being managed and recruitment processes working.
- The numbers of staff (excluding junior doctors) had increased from 677 in January 2015 to 777 in December 2015. During this period, the turnover in staff had decreased from 12.9% to 10.5%. This meant the number of staff leaving the trust was reducing. This would contribute to better consistency of care and treatment to patients and more staff to meet rota requirements.
- Staff absence due to sickness in the acute medicine directorate was above the trust average between March 2015 and November 2015. The trust average was 3.6% and the acute medicine was 4.2% for November 2015. However, this was an improving picture.
- Staff conducted nursing handovers every shift change at 7am and 7pm. There were smaller handovers for staff arriving for afternoon shifts to ensure all staff had up to date information about patients. Staff discussed new and existing patients, their medical history and care plans highlighting any key information including potential risks to the patient.
- However, senior nurses conducted handovers at the nurse's station, which presented a risk of other patients or visitors overhearing confidential information in the surrounding area.
- The trust had increased its establishment of stroke nurse practitioners to three. This meant there were

more staff available to attend the emergency department to treat patients having a stroke more quickly, for example, the administering of thrombolysis treatment. Thrombolysis treatment is a medicine given to stroke patients to help break down the blood clot causing the stroke. The nurse practitioners could also support stroke staff on the ward to support the care and treatment of stroke patients.

- The majority of patients we spoke with thought there was enough staff.

Medical staffing

- Data from the trust showed the trust had 215 whole time equivalent (WTE) medical staff in post against a planned 219 WTE. We saw medical staff were mostly available when required on wards. Nursing staff said there was always a doctor available when needed and doctors were approachable.
- There was a good skill mix of medical staff. There was a slightly higher proportion of junior doctors and middle grade doctors and similar percentage of consultants to the England average. The use of locum doctors was low for both HOPE and the acute medicine directorates.
- Medical staffing was planned according to demand and the days of the week. For example, extra doctors were on shift on a Friday and Monday, which were busy days. On weekdays, a base team; a minimum of two junior doctors and a specialist consultant were allocated to review new arrivals and sick patients as well as regular planned ward rounds. There was extra medical staffing attached to AMU due to the number of patients and the demand.
- There was a consultant on call out of hours and at weekends; two consultants worked overlapping shifts until 10pm on AMU. At night, there was a mix of different doctor grades and specialities. The trust had a resident on call consultant at night. Both nursing and junior doctors said the on-call consultant was always available when needed. There were some exceptions when services were busy.
- On weekends and bank holidays, there were cardiology and gastroenterology consultants available for ward rounds and consultations. Consultants would see new patients arriving onto the wards at the weekend.
- Most junior doctors said they felt supported and consultants were around when they needed them. However, a small number of junior doctors said there was a lack of support at weekends and out of hours.

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One junior doctor said they had to “make important decisions because the on call consultant was really busy” or unavailable. If junior doctors had concerns about medical staffing capacity, junior doctors had an escalation plan to raise staffing capacity concerns. If staffing issues were escalated, consultants would ‘act down’ to support the work of other doctors. Junior doctors had used the escalation process and felt that it worked.

- Medical staffing handover arrangements were both verbal and electronic. We observed a medical staff handover. Staff identified patients requiring further examination, patients who were deteriorating, and the status of patient treatment and care. There were clear actions and medical staff starting shifts aware of their responsibilities.

Major incident awareness and training

- There were arrangements to respond to emergencies and major incidents. A trust-wide major incident plan was in place to guide staff in responding quickly and effectively to any major incident.
- The trust had escalation and critical capacity plans to deal with high demand, seasonal pressures and major incidents. The escalation process and criteria for escalation were clear. The plan identified key roles and responsibilities. The trust used action cards for staff so they knew their responsibilities. Staff were aware of the plans and their role should there be severe pressures on medical services. The trust identified additional capacity on some wards so when demand for services increased extra beds and staff were deployed to cope with demand.

Are medical care services effective?

Good



The effectiveness of medical care services at Musgrove Park Hospital was good.

We found:

- There was evidence-based care and treatment. Policies and practices were based on National Institute for Health and Care Excellence (NICE) guidance.
- Staff appropriately assessed and managed patient needs around pain.

- Staff assessed patient nutrition and hydration needs and managed them appropriately. The majority of patients were positive about the food they received.
- The trust took part in audits to measure the quality of services. Performance in the audits was overall positive. The trust had action plans identifying improvements.
- Staff were well supported and received regular one to one supervisions.
- Staff were positive about training opportunities and were receiving support for planned revalidation of professional registrations.
- There was positive and robust multi-disciplinary working.
- Urgent diagnostic imaging and reporting was available out of hours during the week and at weekends.
- Staff received timely access to information in order to deliver care and treatment.
- We saw appropriate use and documentation of patient consent. Staff were overall aware of the mental capacity act and the trust policy.

However, we also found:

- Staff did not always follow trust procedures for documenting patient capacity.

Evidence-based care and treatment

- Policies based on guidelines enable staff to work to the very latest guidelines and best practice. There were policies based on National Institute for Health and Care Excellence (NICE) guidelines. The trust reviewed and assessed their policies regularly against NICE guidelines to ensure policies were up to date.
- Staff could access information about trust policies, pathways, and available support services on the trust's intranet. Staff showed us where they would find relevant guidance and information. Agency and bank staff could access these policies.
- Staff used evidence-based guidance to plan care and assess needs of patients. The trust audited respiratory medicine and found most readmissions (60%) were avoidable. The trust implemented actions to improve patients care and treatment because of the findings. The aim was to make discharge more effective and to prevent readmission of patients. This included increase in consultant ward times, an improved pulmonary rehab service, and improved home oxygen provision.

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- The medical specialties provided care and treatment in line with guidelines from the NICE and Royal College guidelines. An example of this was staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE).
- Generic care plans were in use on wards. These contained general and specific instructions on care delivery and reflected patients' individual needs and preferences. This meant it was possible to establish the care needs of each patient from the care plans in place.
- Some wards kept a vulnerable adult information folder on the ward, which included guidance on the mental health act, mental capacity act and other key policies.
- Staff used cognitive screening tools to assess patients in a confused state. Patient records had actions, recommendations and care plans as a result. We saw from patient records staff followed up and reviewed actions. This supported to staff to provide individualised care to patients living with dementia.
- The medical lead for intravenous (IV) fluids was the author of the trust policy on IV management. This was in line with NICE guidance QS66 Intravenous fluid therapy in adults in hospital.

Pain relief

- We observed nurses monitoring the pain levels of patients, recording the information, and taking appropriate action to manage patient's pain. Staff assessed pain levels as they were undertaking physiological observations. Staff recorded pain scores on the patient observational charts.
- Medical staff prescribed pain relief for patients who required it, and patients we spoke with told us they were given pain relief when they needed it. Carers accompanied some patients. Where possible, carers supported nursing staff in pain assessments.
- During both the nurse handover and, the multidisciplinary ward round we observed staff assessing and reviewing patients pain requirements as required.
- Where further advice or support was required, staff told us they could access the trust acute pain team. Staff could contact the pain nurse via a bleep or make urgent referrals through an electronic referral system.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used throughout the acute medical and care of the

elderly wards. MUST is a screening tool to identify adults, who are malnourished or at risk of malnutrition. Staff used MUST to inform care planning and identify any specific dietary requirements. Staff used food and fluid balance charts if patient risk assessments indicated they required them.

- Dieticians had input into patient care and treatment where there was an assessed need. We saw in medical records reviews and recommendations by dieticians. We saw patients receiving meals appropriate to their medical and diet needs.
- Patients had access to drinks. Staff placed drinks within reach of patients and where required, staff supported patients to drink. Staff regularly offered patients tea, coffee, and water and where appropriate staff thickened drinks according to care plan requirements.
- A colour-coded tray and was used on all medical and care of elderly wards to identify patients who needed help with eating and drinking. We saw patients who were nutritionally at risk or required support with eating had their meals served on a red tray.
- Protected meal times were used to allow time for patients to eat in an unhurried manner. However, where relatives or visitors supported people to eat, they were encouraged to continue this.
- Percutaneous endoscopic gastrostomy (PEG) is a medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding. Staff worked to all relevant PEG feeding guidance. The trust had processes in place for patents admitted with a PEG feed.
- Medical services had one standard emergency feeding procedure, which was nasogastric tube feeding (a tube passed through the nose into the stomach). There were separate guidelines for the intensive care unit.

Patient outcomes

- The endoscopy unit at the hospital was Joint Advisory Group on GI Endoscopy (JAG) accredited in July 2013. JAG Accreditation is the formal recognition an endoscopy service has demonstrated it has the competence to deliver against the measures in the endoscopy Global Rating Scale (GRS) Standards.
- The trust took part in the majority of available national audits to review the effectiveness of care and treatment. This included the national inflammatory bowel disease and chronic obstructive pulmonary disease audits. Each speciality had an audit lead to monitor information.

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Where required the trust produced action plans to meet areas for improvement. However, the trust had not updated some action plans and therefore made it difficult to review progress.

- The trust took part in the national Heart Failure Audit. Data showed that between 2013 and 2015 trust performance had significantly improved. Improvements in performance included inpatient mortality rate and the percentage of patients seen by specialists.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. The trust were better than the England average in two of the three measures in the 2013/14 MINAP audit. The trust performed worse than the England average (77.9%) for patients referred for or had angiography (including after discharge) scoring 71.6%. However, this was improvement on previous year's results (52%).
- In December 2015 the trust had participated in a pressure ulcer peer review undertaken by Somerset Clinical Commissioning Group (CCG). The findings were mostly positive and highlighted "strong governance, ownership, transparency and organisational learning for pressure ulcer (PU) prevention and reduction". There were some recommendations regarding better documentation of risk assessments. The peer review had only just taken place an action plan had not yet been finalised.
- Between June 2014 and May 2015, the trust performed in line with the England average for standardised relative risk of readmission for elective patients. There was a higher risk of readmission to hospital for haematology patients. However, measures were in place to help reduce the risk of readmission, including all patients requiring any form of treatment were discussed at the Haematology multidisciplinary team meeting (MDT). Haematology had recruited a full complement of three Haematology Clinical Nurse Specialists, who worked together to prevent unnecessary admissions, both elective and non-elective.
- Between June 2014 and May 2015, the trust performed better than the England average concerning the standardised relative risk of readmission for non-elective patients. However, respiratory medicine was worse than the England average and therefore

there was a higher risk of readmission for non-elective patients. The trust had identified through audits of the service improvements, including increased staffing levels.

- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. SSNAP scored the trust at level D between July and September 2015, which is poor on a scale where level E is the worst possible. The trust in most areas demonstrated average performance with mostly C ratings. The stroke steering group reviewed audit data monthly and revised action plans on an ongoing basis.
- The trust submitted data to the National Diabetic Inpatient Audit (NaDIA). The trust performed worse than the England average in 11 out of 21 measures. This included visits by diabetes teams, prescription errors and medications errors. The trust produced an action plan to meet areas for improvement identified from the audit.
- The trust performed worse than England average for two out of three measures on the 2014 Lung Cancer Audit. The trust performed worse in the percentage of patients discussed at multidisciplinary team (MDT) meetings and the percentage of patients receiving a CT scan before bronchoscopy. The trust had an action plan to address pathway improvements for patients. The service worked towards making improvements and was on course to complete the majority of actions.
- In the trust Lung Cancer Audit 2014 (165 cases were submitted for audit) results were worse than the England average for two out of three measures. These included, being discussed at multidisciplinary team meeting 94% (target 95%) and percentage of patients receiving computerised tomography scan (special x ray) before bronchoscopy 77% (target 95%).

Competent staff

- There was a preceptorship programme for newly qualified nurses, which included competencies relating to the ward they were working in.
- All new staff attended an induction. Staff we spoke with confirmed they received adequate inductions. Newly appointed staff said the trust planned and delivered inductions well.
- The majority of staff said they had received an appraisal. Data from the trust showed 81% of staff in the Acute

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Medicine directorate had received an appraisal in the last year. A further seven percent of staff had appraisals were out of date by 18 months or two years. The coronary care unit had achieved 42% of staff receiving an appraisal in the last year, which was the lowest in the directorate. Seventy four percent of medical staff had an up to date appraisal.

- Staff we spoke with told us their appraisals included discussion about their learning and development needs. Staff received a six-month review of their progress against their learning objectives.
- The majority of staff in the HOPE directorate (96%) had received and appraisal in the last year.
- All staff we spoke with said they received regular one to ones and supervision from their managers. Some managers kept records of these and used them in appraisals and some did not. Some managers used one to ones as an informal chat as part of ongoing support. Therefore, there was not a standardised approach to supervisions.
- All nursing staff were up to date with their revalidation and all medical staff had job plans in place. Medical and nursing staff told us they had sufficient support relating to revalidation and job plans. Revalidation is a process by which doctors and nurses can demonstrate they practice safely. The trust reviewed and monitored job plans.
- Most junior doctors said consultants and the trust supported them. Junior doctors could find time to undertake their mandatory training and additional learning.
- All wards we visited had staff in link roles. The staff in link roles had the responsibility of keeping up to date with and informing staff of specific subjects, for example dementia, learning disabilities, and safeguarding. Where possible all nurses and health care assistants undertook link roles. Each link role was allocated a study day to learn and research and to impart information to the rest of the ward.
- There was additional in-house training for nursing staff. The trust provided additional training on neurology, endocrine and tissue viability staff provided extra training to staff.
- The trust had recently recruited a number of nursing staff from overseas. Overseas nurses we spoke with said colleagues and the trust had welcomed and supported them. Senior nurses provided new overseas nurses with at least one mentor they could shadow and support

them to achieve the competencies they were required to meet. New overseas nurses took part in training for one month prior to starting on the wards and supernumerary on wards until deemed competent.

- Three practice development nurses (PDM) worked to support newly recruited overseas nurses. The PDMs provided supervision and identified training needs for the new nurses. The PDMs set up a language club for overseas nurses to help the nurses improve their English. This helped improve their communication with patients and other members of staff.

Multidisciplinary working

- Ward teams had access to the full range of allied health professionals, which included physiotherapists, dieticians, and occupational therapists, and team members described good, collaborative working practices. There was a joined-up approach in assessing the range of patient needs. Staff regularly reviewed assessments and kept them up to date.
- Multidisciplinary team (MDT) working was evident throughout acute medical wards and care of the elderly wards. There was daily communication between members of the multidisciplinary team with daily board rounds taking place.
- There were regular MDT meetings for all specialties. Consultants, discharge facilitators, social workers, nurses, doctors and allied health professionals (occupational therapists, physiotherapists, dieticians) all attended MDT meetings. Meetings were consultant led and focussed on the best interests of the patient. Family engagement and discharge planning were included in MDT discussions with clear patient led goals.
- We saw evidence of multidisciplinary teamwork within patient records. Nurses, doctors and therapies staff all made entries on a single patient record used by all staff.
- There was a wide range of specialist nurses, for example; heart failure nurses, we noted their presence on the wards. Staff told us they knew how to contact these specialists and felt supported by them. The heart failure nurses ran clinics every weekday for inpatients.
- Wards could access psychiatric input and there was a community psychiatric nurse (CPN) available on site during normal working hours Monday to Friday and via a county-wide team 24 hours a day, seven days a week. We saw referrals had been made and CPN input in medical notes.

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- Heart failure nurses worked with community health providers to provide care and treatment to patients in the community. The nurses held six meetings a year in the community with different healthcare providers.

Seven-day services

- There were additional cardiology and gastroenterology consultant rotas at weekends in addition to medical staff already rostered to work.
- Patient could access urgent diagnostic imaging and reporting out of hours, overnight during the week, and at weekends. Magnetic resonance imaging (MRI) scans were available 24 hours, seven days a week for spinal cord compression and interventional radiology was available for urgent and critical patients. Ultrasound, computerized axial tomography CT and MRI departments all ran extended days for routine and urgent work. Junior doctors said they found the extended working day and seven day service to be excellent and there was timely reporting of imaging
- There was consultant delivered upper gastro intestinal (UGI) endoscopy for all urgent and critical patients (normally UGI bleeding and bolus obstruction) out of hours. There was an on-demand service for occasional lower GI urgent/critical patients, for example, severe colitis or bleeding. Some routine services were available at weekends in exceptional circumstances in order to facilitate patient discharge.
- Cardiology provided angiography (medical imaging) and percutaneous coronary intervention (PCI), a treatment for patients who had suffered a heart attack, for critical and urgent patients at weekend. Patients could access echocardiography on discussion with a cardiology consultant.
- Respiratory medicine had plans to move to seven-day ward rounds by June 2016.
- The stroke service ran consultant led rapid access clinics for patients over the weekend. Stroke consultants reviewed new patients arriving over the weekend to ensure there were no delays in diagnosis or starting care and treatment. Patients could access physiotherapy services out of hours if required. We saw physiotherapy staff on some wards on rosters for evening and late shifts.

Access to information

- Staff could access information needed to deliver effective care and treatment in a timely and accessible

way. This included care and risk assessments, care plans, case notes and test results. The majority of care plans were robust and reviewed, which meant staff could look at the latest information about patient treatment and care.

- When staff transferred patients between wards, we saw nursing staff handing over patient records as well as providing a verbal handover to nursing staff on the receiving ward.
- Heart failure nurses used an electronic patient record system to identify patients with established heart failure. This meant heart failure nurses had instant and up to date access to information about ill patients requiring specialist care and treatment.
- Medical staff used three separate electronic databases to view clinical letters, x-rays and investigations. This meant patient information was easily transferable and available. While medical staff were not frustrated with using three separate systems, they did say it could be better.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up-to-date Mental Capacity Act 2005 (MCA) policy, which included the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to make advance decisions and statements to plan ahead in case they are unable to make important decisions in the future. DoLS are part of the Mental Capacity Act 2005. They aim to make sure people in care homes and hospitals are looked after in a way not restricting their freedom inappropriately.
- We looked at seven patient records where there was an assessment of the patients' capacity and DoLS procedures. Five out of the seven patients were assessed as requiring a DoLS authorisation and we saw that in all cases the ward had put urgent authorisations in place. Wards had applied for extensions for four out of five patients.
- However, trust policy stated that staff should complete a two-stage mental capacity assessment prior to seeking a DoLS authorisation. Documentation relating to this was missing in two out of the five patient records containing DoLS authorisation.
- On our unannounced visit, we saw a patient's movement restricted by lowering the head end of the

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bed. As a result, this prevented the patient from getting out of bed and leaving the ward. Staff we spoke with said this was due to the patient displaying aggressive behaviour. We saw the patient attempting to harm staff. The patient was also unable to walk therefore; staff said the action was in the best interest of the patient. However, we looked at the patient's record and saw staff had not completed a capacity assessment or best interest decision. We escalated this to the senior nurse who had taken appropriate steps to assess and provide appropriate support to the patient.

- Staff asked patients for consent appropriately and correctly, where patients consented to care and treatment we saw this documented. Where necessary, for example if a patient required an invasive procedure, staff explained risks and consent documented in medical notes. Where patients did not give consent, staff respected and documented their decisions to refuse treatment. In most of the patient records, patient capacity was documented and recorded.
- Medical photographers asked patients for consent when taking pictures of wounds or pressure ulcers.

Are medical care services caring?

Outstanding



Overall, we found caring in medical care services to be outstanding.

We found:

- Throughout our inspection, we saw numerous examples of staff responding to patients with kindness, dignity, respect and compassion.
- The service had consistently very positive friends and family test results with an average of 100% and 98% for HOPE and Acute Medicine directorates respectively. This meant almost all patients would recommend the service to others.
- Patients were positive about their treatment and care with the majority of patients expressing their care and treatment was excellent.
- There were examples of staff understanding patient needs and going the extra mile to improve the service provided to their patients.
- Staff escorted and supported patients with walking, eating and with daily routines.

- Staff involved patients in their care and treatment and patients said staff ensured they understood what was happening to them. Patients were regarded as individuals and staff showed an understanding of patient's personal and social needs.
- Patients could access a range of specialist nurses for emotional support. Patients could access other services to support their emotional needs including the chaplaincy and bereavement service.

However, we also found:

- We saw two examples of staff not treating patients with dignity and respect.

Compassionate care

- Throughout our inspection, we saw numerous examples of staff responding to patients with kindness, dignity, respect and compassion. Staff smiled, used humour and we saw positive patient-staff relationships. All staff we spoke with highlighted the importance of the patient and stated patients were the main reason for doing their job.
- The majority of patients felt their care and treatment was excellent. Patients said they were welcomed on to the wards; staff were friendly and always introduced themselves. One patient said care had been "unbelievably good" and another patient said care was "absolutely fantastic". Relatives said if they needed anything staff would do their best to help.
- Staff understood patient personal and social needs and put patients first. Staff gave examples of bringing patients preferred foods if the patient requested them. Patients living with dementia or end of life could drink a small amount of alcohol if staff considered it part of their normal, daily routine and not harmful to the patients. Where possible patients were encouraged to feel 'at home' and follow their daily routines as much as possible. Two patients said, "They treat us as humans and as individuals".
- Staff on a care of the elderly ward gave us an example of compassionate care. Staff enabled an elderly man to stay on the ward with his wife at New Year. They had never been apart at New Year therefore staff made this possible. Another ward gave us an example of taking a visually impaired patient's guide dog for a walk because they were too ill.
- Although wards had enough equipment we saw examples of where staff had purchased items for wards

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to make small improvements to patient life on the ward. This included coloured beakers and plates for patients living dementia, toasts racks, and eggcups for breakfast time. Staff were passionate about creating the best possible environment for their patients.

- We saw staff escorting and helping patients who had mobility issues. We observed many positive interactions between staff and patients creating a friendly, relaxed atmosphere.
- Therapy staff were supportive and we observed them encouraging and supporting patients during their rehabilitation. We saw an example of a physiotherapist preserving patient dignity by adjusting their dressing gown. They ensured the patient felt warm, comfortable, and their slippers were secure.
- Staff remained calm and positive even when faced with challenging patients. We observed examples of staff engaging in challenging interactions with patients. Staff spoke in a calm manner, using humour where appropriate. Staff did not discourage patients living with dementia who wanted to walk around the ward.
- We undertook a Short Observational Framework for Inspection (SOFI) on Coleridge Ward and Conservators Ward (SOFI is a specific way of observing care to help us understand the experience of people who use the service, including those who are unable to talk with us). The majority of our observations were positive. We observed positive interactions between staff and patients. Staff re-assured patients and displayed empathy. Staff used dignity curtains and responded quickly to patient needs. Staff supported and assisted patients to the toilet or with eating.
- However, we saw two interactions on Coleridge Ward where staff had conversations over the patient, rather than with the patient. The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey asking patients whether they would recommend the NHS service they had received to friends and family, who needed similar care or treatment. Between May 2015 and October 2015, for the HOPE directorate 100% of patients would recommend the service to others for every month of this period. The acute medicine directorate averaged 98% with many wards scoring consistently 100%. This meant the majority of patients were happy with the care and treatment they had received.
- The trust was in the top 20% of trusts in 12 out of 24 indicators on the cancer experience survey in 2013/14.

The trust was performing similar to other trust in all the other indicators except one. These meant patients' were generally happy with their treatment and care provided by cancer services. The results showed overall, there were improvements on the previous year scores.

- The trust scored better than the England average in all four categories of the PLACE survey in 2015. The scores were between one percent and five percent better than the England average.
- The trust were performing in line with other trusts in all areas of the CQC in-patient survey except for four where they were better performing. The areas where they were performing better than other trusts were; patients given help at meal times, being able to talk about worries and fears, delayed discharge and length of discharge delays. This meant patients overall were happy with their care and treatment provided by the trust.
- We saw one example of staff not treating a patient with dignity. A patient wearing an incontinence pad and net underwear had no cover or sheet over them, leaving them exposed. The patient remained in this state for over five minutes in full view of patients and visitors until staff arrived to cover them up. One patient on this ward said, "you have to queue for attention" because the ward was busy.

Understanding and involvement of patients and those close to them

- Staff involved patients in their care and treatment. We observed staff discussing care plans with patients and ensuring they understood their treatment and condition. Patients and those important to them we spoke with told us staff gave them enough information about their care and treatment.
- We saw in patient records and on patient information boards that staff identified and recorded communication difficulties. Staff communicated with patients who were severely deaf by writing on pieces of paper and staff recorded their responses in medical notes. This demonstrated staff understanding and involving patients in their own care and treatment.
- Staff were helped to get to know patients by those who knew them (relatives and carers). This supported the provision of person-centred care. It included providing information such as social history, care preferences, and any special memories the person may have.
- Staff recognised when patients required additional support to enable them to be involved in their care. We

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saw in one set of records staff had requested an advocate for a patient. We saw in the majority of medical records discussion between staff and family regarding additional communication needs.

- Staff asked patients if they understood what staff had said to them. Patients were encouraged to ask questions and all staff spent time with the patient answering them. The majority of patients said they felt informed and they could ask questions if needed. Patients said staff described what was going to happen and why. One patient said "they told me what was happening" and another said, "I understand what is needed".

Emotional support

- Staff understood the impact care and treatment in hospital would have on the patient's wellbeing. We saw, through observing handovers, MDT meetings and patient records, staff consider the impact of care and treatment on patients and how they could support patients.
- Patients and those close to them told us staff were approachable and they could talk to them if they needed to. Staff told us they would initially provide emotional support for patients and those who were close to them. One patient said, "Staff are very good at reassuring me".
- Staff used private rooms to deliver bad news to patients and their families. We observed staff taking relatives into private rooms so they could have a private space in which to talk and reflect.
- The stroke service ran weekly carers meetings for relatives or those who care for patients. Staff organised meetings in partnership with the Stroke Association charity. Staff explained pathways and, what patient care and treatment might involve. Carers and relatives were able to ask questions and receive emotional support from other carers and staff. This also allowed relatives and carers to access social networks who understood their particular needs and issues.

Are medical care services responsive?

Good



The responsiveness of medical care services at Musgrove Park Hospital was good.

We found:

- The trust had an escalation policy to manage the increase in demand for beds, which included triggers, and actions for staff.
- Bed management meetings were comprehensive and there was a dedicated patient flow team managing and responding to bed capacity.
- Bed occupancy rates were better than the England average
- There was proactive discharge planning from the moment patients arrived in hospital. Discharge facilitators liaised with wards and partner organisations supported patient discharge.
- The trust performed better than the England average for referral to treatment times and for patient length of stay.
- Patients requiring urgent scans had less than half a day wait.
- Patients who were medical outliers received consistent care and treatment by appropriate clinicians due to a buddy ward system.
- There were positive stroke and cardiac pathways to improve access to treatment times and discharge.
- Staff could access translation or interpretation services when required. Written materials and information was available in other languages.
- Care and treatment was personalised to meet the needs of patients living with dementia and patients with learning disabilities.
- The trust had a specialist diabetes nursing team to care for patients with diabetes. The team held daily podiatry clinics for inpatients.
- Information was available to patients informing them how to make a complaint or the PALS service.

However, we also found:

- The environment on some wards presented a challenge to staff and delivery of services.
- The MRI services were not achieving their target waiting times for scanning patients.

Service planning and delivery to meet the needs of local people

- The acute medicine directorate had introduced new acute admissions services to meet the needs of local people and deal with increasing demand. This included

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the development of a unit consisting of ambulatory emergency care centre, a nurse-led medical day unit, an acute medical admissions unit and an Older Persons Assessment and Liaison (OPAL) unit.

- As part of the project to improve admissions services, the trust relocated neurological rehabilitation to a more appropriate environment to enhance the patient experience and was fundamental in the success of the project.
- In addition to the above, the directorate had opened escalation wards and extra beds to deal with the demand of winter pressures.
- The trust had four care of the elderly wards. Care of the elderly was the largest medical speciality and therefore reflected the population of the local area.
- All wards had seated waiting areas for visitors and relatives. The size and location of the waiting area varied from ward to ward. There were separate showers and toilets for male and female patients. Refreshments were available to visitors and relatives and situated on the ward.
- The Beacon Centre delivered specialist inpatient and day oncology, haematology, and radiotherapy services. The environment was modern, clean and bright making patients, and those supporting them, comfortable. Patients told us they valued the beacon centre and its environment.
- Doctors could refer patients to a heart failure nursing service. The heart failure service ran weekly clinics to follow up care and treatment of patients in the community.
- The environment on some of the older wards presented challenges to staff. Store rooms were small and were in short supply and therefore storage of equipment became difficult and we saw store rooms were overcrowded. On one ward, equipment was stored in the staff room because there was nowhere else to store them. The lack of space on some wards meant patient bays were smaller and therefore patient beds were closer together. The lack of space on some wards also affected the number of toilet and shower facilities available to patients. Some patients said the environment was “drab” and “old”, one patient said, “We need more toilets” and two patients said their ward needed more showers and there were queues.
- The clinical site manager and patient flow coordinator were responsible for allocating patients to beds across the site. Staff including senior nurses and bed managers met three times each day. These meetings looked at how safely and quickly, staff managed the flow of patients through the hospital. Staff matched up patients waiting for beds on the wards with the beds available, and made suitable arrangements for patients waiting to go home. We attended and observed a bed management meeting. Staff identified patients ready for discharge and future risks to capacity. The meeting reviewed bed management processes against the current state of bed occupancy.
- The trust had a bed management and escalation policy. The policy supported managers to identify bed capacity issues early. It identified triggers and actions needed to cope with increased demand for services. The policy clearly identified which wards and departments could open up extra beds and what staff were required to make the ward safe.
- There was a dedicated team to coordinate the movement of patients, bed allocation and patient discharge across the hospital. This central team worked with senior nurses, allied health professionals, medical staff and discharge facilitators, using real time information, to manage patients and work to discharge them quickly. Staff told us they constantly monitored discharges.
- The trust had opened an additional ward to deal with the demands during winter pressures. Exmoor Ward was a 22 bed escalation ward staffed by seconded, bank and agency staff. The ward had appropriate equipment and medical staff cover. Patients on the ward were all stable and almost medically fit to return home. There were no direct admissions and patients arrived from ambulatory care or acute medical unit (AMU).
- Bed occupancy rates were consistently better than the England average. Bed occupancy rates during the winter months of January to March 2015 were at 85% compared to the England average of 90%. Between April 2015 and June 2015, the bed occupancy rate fell to 78.3% against the England average of 87%. Data from the trust showed between October 2015 and December 2015 the average bed-occupancy levels had risen to 87%. However on discussion with the trust these figures did not present an accurate picture as the tally was

Access and flow

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taken at midnight each day and the figure included patient areas that were not utilised 24 hours each day. At inspection we found the trust reported capacity issues as demand had grown.

- There were occasions when capacity meant additional beds on the Clinical Decisions Unit were kept open overnight while patients waited for medical beds. Data from the trust showed that between August 2015 and January 2016, Jowett Unit was open 94 days out of 181 including the majority of September and October 2015.
- There was a small discharge lounge, which consisted of five chairs. Wards moved patients to the discharge lounge when they were ready to go home. Five patients were waiting in the discharge lounge, all of whom had their medication, and were waiting for transport home.
- The wards had discharge co-ordinators to support the ward teams. Discharge co-ordinators had responsibility for patient flow and discharges in their ward areas. We saw discharge co-ordinators on the wards we visited.
- Discharge planning for patients began early on admission to hospital. We saw evidence of discharge planning by medical, nursing and therapy staff. There were key actions and goals set for the patient in order to be medically fit for discharge.
- Early supported discharge was available for stroke patients. Early supported discharge enabled wards to discharge patients earlier so they could receive care and treatment at home.
- The trust performed better than the England average for the management of delayed transfers of care. For example, 3.5% of patients experienced delays in waiting for residential home placements compared to the national average of 10.9%. The England average for patients experiencing delays in waiting for care packages in their own homes was 12.7% compared to the trust figure of 3.5%. This meant where additional patient support was required from social care organisations patients experienced fewer delays than other areas of the country.
- However, the trust were performing significantly worse regarding patients needing further NHS non-acute care. Most delayed discharges (59%) were due to needing NHS non-acute care compared to 20% England average. Staff told us waiting for non-acute care did cause delays to patients leaving hospital.
- The trust had significant challenges with delayed discharges due to a reduction in community bed provision and in care homes. The trust were aware that

the rurality of the area meant that public transport was not always available to allow elderly partners to visit loved ones if they were placed out of their home area. The delay in awaiting further NHS care was predominantly waiting for physiotherapy and occupational therapy support. This issue combined with the increase in emergency attendances meant that the hospital capacity was challenged.

- The trust had a community in reach team to support patients finding beds in non-acute NHS care. The community in reach team worked with discharge facilitators, nursing and therapy staff to identify suitable placements for patients.
- Data from the trust showed between April 2015 and October 2015 an average of 39% of patient discharges were before 2pm in the HOPE directorate. Despite this average, the directorate did exceed the trust target of 40% in April, July and August. In acute medicine, the average for the same period was 30% of patients discharged before 2pm. Most staff we spoke with told us discharges did not always happen in a timely way. They told us delayed discharges were often due to suitable community bed placements and care packages not being in place.
- The trust performed consistently better than the England average for referral to treatment times. Between March 2015 and August 2015, 95% and 100% of patients during this period accessed consultant led treatment within 18 weeks. The England average was 95%.
- Between July 2014 and June 2015, the trust performed better than the England for elective and non-elective patients for most specialties. Only Gastroenterology (4.1 days) and Respiratory Medicines (8.7 days) had longer average length of stays than the England average (3.3 and 7 days respectively.)
- The MRI services aimed to scan all inpatients within 24 hours but this target at times was not being achieved with an average wait of between two and three days. Some patients were waiting over one week, and staff felt this contributed to delays in discharge. This was mainly due to capacity issues in the MRI department and managers were addressing the issues through outsourcing work, and extended day and weekend working.

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- Radiology arrangements for inpatients were good, with set times arranged between staff for inpatients. Patients had quick access to urgent scans. Patients waited less than a day for routine scans.
- Data from the trust showed that between April 2014 and March 2015, 11% of patients had one or more ward moves per admission. This was an improvement on the previous year with 13% of patients having had one or more ward moves. One percent of patients had four or more bed moves. This meant the majority of patients were not required to move wards meaning patients received consistent treatment and care by the same team of staff.
- Moving patients at night presents a risk to patients in terms of continuation of care as well as disturbing their rest and causing confusion for patients and their relatives. We reviewed the number of bed moves after 10pm between October and December 2015. The total number of bed moves after 10pm increased from 20 in October, 41 in November, to 57 in December. These figures represented 3.7% rising to 10.8% of the overall acute inpatient bed space. The increase in figures represent the service getting busier due to winter demands. This meant only a small number of patients were being moved after 10pm and were not being moved unnecessarily.
- Medical outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space. The number of outliers fluctuated between 16 and 27 patients per day in the period between 15 January 2016 and 21 January 2016. At the time of our inspection, there were 22 medical outliers. Despite not being on the correct ward, we saw an appropriate medical consultant saw patients.
- Wards operated a buddy system meaning outlying patients on a surgical ward received treatment from medical and nursing ward staff. This provided continuity and consistency of care for patients. We saw information on staff boards containing which patients were situated on buddy wards. When beds became free, the patient flow team would move patients from the buddy ward to the appropriate ward.
- The cardiac catheter laboratory developed a pathway for patients requiring day case treatment, which led to an increase in the number of day case patients. They reviewed the procedure schedules and reorganised them to enable procedures requiring a longer recovery time to take place in the morning. This meant some patients did not have to stay overnight because they attended afternoon procedures. Patients needing an overnight stay in hospital were transferred to the cardiology ward where staff, trained in nurse led discharge, ensured patients went home when medically fit the next day.
- Primary percutaneous coronary intervention (PCI) is a procedure used to treat coronary heart disease. Primary PCI within 90 minutes of arrival reflects the ability of hospitals to provide timely treatment. Data from the trust for the reporting period July to December 2015 showed 96.5% of patients received treatment within 90 minutes.
- The stroke service had implemented a pathway enabling patients with a suspected stroke to go straight to a computerised tomography (CT) scan; this was the most efficient pathway to diagnosis allowing rapid and appropriate treatment. A stroke specialist nurse and consultant met and examined patients upon arrival to the emergency department. Data from the trust showed for the period June 2015 and October 2015 an increased number of patients, (71.1% to 77.5%) were reaching the stroke ward within four hours of arrival to the hospital.
- The stroke service had step down beds on Triscombe Ward. Staff would move patients to these beds if the patient had clear plans. Patients remained under stroke consultant care while in these beds.
- In response to meet increasing demand, the trust had increased the number of endoscopy sessions across the local areas. The trust increased sessions from eight to ten at a local hospital and the trust had introduced Saturday morning sessions at Musgrove Park Hospital.

Meeting people's individual needs

- Patients had their individual needs assessed by both medical and nursing staff and where required we saw input from other members of the multidisciplinary team.
- Staff told us they could access translation services. Patients who required a British Sign Language interpreter were required to let staff at the trust know. Staff knew about the service. Interpretation and translation services were available to staff 24 hours a day. Large print and easy materials were available on request. Some wards had information printed in other languages for patients to read or take away.
- The trust had an electronic alert system to identify patients living with dementia. Staff would add a

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'forget-me-not' flower symbol to patient electronic records so staff could easily identify patients living with dementia in future. The trust had an older person's mental health liaison service when the needs of patients require extra assessment.

- Care of the elderly wards had dementia champions who took the lead on appropriate adjustments for each patient. Staff used information about the patient to personalise care, allowing for patient routines and habits. We saw staff evidenced information collected about the patient in medical records, in-patient risk documents, and in 'This is me' documents. 'This is me' was a document used to collect personal and social information about the patient including their likes and dislikes; these were completed by friends and relatives of the patient.
- Staff used pictorial menus for patients living with dementia and patients with learning disabilities. This enabled staff to communicate with patients and allowed patients to choose what they wanted to eat.
- Tissue viability staff used pictures to help patients with learning disabilities understand why they needed to be treated. The tissue viability service was developing easy read material for patients at the time of our inspection.
- Care of the elderly wards had social areas for patients and families to spend time together rather than congregating around hospital beds. Wordsworth Ward had a well-used reminiscence room. Wards had activity boxes and 'twiddlemuffs' so patients could be stimulated or occupy their hands. Twiddlemuffs are knitted hand muffs or bands that have additional textures, buttons, and material attached. Staff used them to help patients living with dementia to keep their hands busy rather than pulling at catheters and cannulas. Wards had trolleys stocked with finger foods and tea/coffee so patients and relatives could help themselves when required.
- Care of the elderly wards brought in pets as therapy (PAT) 'dogs for patients to spend time with. Staff used PAT dogs for patients to help them remain calm, for comfort and as an activity.
- The trust had a learning disabilities nurse available four days a week. Staff used communication forms to inform the nurse of admissions on arrival. Staff also used an electronic alert system to identify patients with a learning disability. The learning disability nurse visited

patients daily and worked with carers to deliver care and treatment for patients. One carer we spoke with said they could have their own planned activities for the patient during the day.

- Staff supported patients with learning disabilities to develop individual hospital passports. Hospital passports provide staff with information about the patient for example, their individual needs. We saw patients with learning disabilities had completed passports and care reflected their individual needs for example extra staff support or single rooms.
- The trust had a specialist diabetes nursing team to care for patients with diabetes. The team received daily reports, which highlighted patients identified as having diabetes and visit the patient. There was a daily diabetes podiatry service for inpatients and if required the service visited the patients on the wards.
- There was a range of information for patients and their relatives/carers. Information was clearly visible outside entrances to wards. Information included; support services, how to manage illnesses such as diabetes and mental health services. Information available to patients related to the ward speciality meaning there was appropriate information available.
- Patients could order whatever food they wanted and whatever time they wanted and therefore patients were not restricted to eat just at mealtimes. Patients had a wide range of menu choices but could order whatever they wanted. We saw patients requesting and eating fried breakfasts if they were medically able to do so. The majority of patients were happy with the quality and choice of food.
- The Older Persons Assessment and Liaison (OPAL) unit offered comprehensive assessments of older people. The unit cared for patient who were frail, elderly and had complex needs. A dedicated team of nurses and doctors staffed the unit. This allowed staff to focus care on some of the most ill elderly patients.
- Patients could access a range of specialist nurses, for example in palliative care and diabetes care and these staff could offer appropriate specialist support to patients and those close to them in relation to their psychological and emotional needs.
- The hospital had a chaplaincy service and staff told us they could request the chaplaincy team if this was necessary for patients who needed emotional or spiritual support. Patients and visitors could access the chapel at the hospital. Wards provided wheelchair and

Medical care (including older people's care)

escort services for those who needed it to attend the chapel. In addition, chaplains and their volunteers were available to listen and support in the chapel quiet corner or on the unit as required.

- Staff worked with other charities to offer befriending services, timely information, and support for relatives.

Learning from complaints and concerns

- We saw posters explaining how to make a complaint within the ward areas throughout the trust. Contact information for the Patient Advice and Liaison Service (PALS) was available. We also observed comment cards where patients and those close to them could give feedback. However, on some wards information about complaints was not clearly visible.
- Senior nurses were involved in investigating complaints in their areas. All staff we spoke to said knew how to deal with complaints and concerns. Nursing staff told us they would try to resolve complaints quickly and locally whenever possible. Managers for the appropriate speciality produced actions plans and identified learning. Staff we spoke with said managers shared learning from complaints and concerns. Managers shared learning through team meetings, safety briefings, newsletters and emails. We saw an example of a ward newsletter sharing learning with staff.
- Staff on Fielding Ward gave an example of stopping the use of wrap-around incontinent pads following a complaint. This demonstrated learning and making changes because of a complaint.
- Patients we spoke with felt comfortable raising complaints and concerns with staff. Patients said staff were approachable and therefore it was easy to raise issues. When asked, patients could identify where complaints information was. Patients said they would ask ward receptionists or a member of staff if they could not find it.

Are medical care services well-led?

Good



Overall, we rated well led for medical care services as good.

We found:

- Directorate plans supported and worked towards the trust mission statement.
- Senior nursing staff had clear visions for their wards and specialities.
- There were clear governance structures with clear roles and accountabilities.
- There were systems and processes to manage risk and quality assurance, including local and clinical audits. Leaders were working towards tackling key performance issues and risks. Staff at all levels took ownership and responsibility for quality assurance.
- Leadership was visible at all levels. Leaders were visible, aware of issues affecting their services and passionate about their staff.
- There was an open, honest, patient centred culture within medical care services.
- Staff felt listened to and were involved in helping to shape medical care services.

Vision and strategy for this service

- There was a clear vision and strategy for the service. Strategic objectives and directorate plans supported the trust mission statement of "Working together for a healthy Somerset". Staff could not tell us about the trust strategy and mission however, we saw staff working to the trust values and strategic objectives. Staff demonstrated a person centred approach was an example of this.
- Senior nursing staff had very clear objectives and strategies regarding their own wards and departments. Staff we spoke with could tell us about the vision and plans for their own wards and departments.
- We saw directorate plans to help achieve the strategic goals of the service. Managers recorded progress against the plan and reviewed this regularly. Directorate plans reflected key strategic issues, including financial sustainability and cost effectiveness. Managers updated the board regularly on their progress against the directorate plans.

Governance, risk management and quality measurement

- There was a clear structure for both acute medicine and HOPE directorates. Clinical service leads in each speciality had a specific manager to report to therefore there were clear lines of accountability. Senior nursing staff reported to clinical service leads as well as provide oversight to wards, nursing and non-nursing staff.

Medical care (including older people's care)

- Staff were clear about their roles and what they were accountable for. We saw staff taking responsibility for quality and assurance of services at ward and at management level.
- There were systems and processes to review governance arrangements and quality assurance systems. The trust conducted self-evaluation exercises to identify improvement in governance and quality systems. Governance meetings reviewed quality assurance. Managers showed us a new performance-monitoring tool, which would enabled managers to monitor real time performance data. This was an example of a direct change resulting in self-evaluation.
- There was a programme of internal and clinical audits to monitor quality and identify actions where required. We saw from action plans and audit activity the service continually reviewed and tried to improve quality of services.
- Medical care services had an intravenous (IV) fluids lead who had overall responsibility for training, clinical governance, adult and review of IV fluid prescribing, and patient outcomes.
- Every ward had an individual risk register. The ward risk registers combined to form the directorate risk register. The directorate risk register formed part of the trust corporate risk register. This meant managers and staff could take ownership of their own risks; there were common themes and trends in terms of managing risk, and risks escalated through the trust if necessary.
- Staff and managers could identify the key risks to their services. They reflected both what we found and what staff and managers identified on risk registers. These included, staffing, infection control, environmental concerns and sepsis management. We saw the trust had action plans to manage and continue to address key areas of risk including infection control. Work was ongoing at the time of the inspection to improve these areas.
- Senior managers and clinicians attended monthly governance meetings. Governance meetings discussed and reviewed risks each month as well as identifying new and emerging risks. Managers recorded and reviewed actions, complaints and policies. This ensured there was clinical input into strategic and operational issues.
- Each speciality held quarterly multidisciplinary speciality meetings and produced action logs. We

reviewed minutes of the care of older persons meetings in April, July and September 2015. Senior nurses, doctors, and therapy representatives attended the meetings. The meeting discussed performance around infection control, serious incidents, and complaints for all care of the elderly wards. The meeting reviewed actions with clear roles and responsibilities identified.

- The trust had steering groups to review practice and quality about specific topics such as falls or pressure ulcers. We saw performance was audited and reported on against policies and guidance with clear actions identified.

Leadership of service

- Most wards had a number of different leaders. We saw leadership from consultants and senior managers driving best practice and change, from Healthcare Assistants (HCAs) in link roles or sepsis champions, and ward leadership from senior nursing staff. All leaders were passionate about what they did and this was encouraged throughout the majority of wards we visited.
- Leaders knew about the issues affecting their services. They could describe and pinpoint to the inspection team what needed to improve and how their services could develop.
- Leaders were visible on wards. Staff and managers could give examples of when senior managers including the chief executive had 'walked the floor' and visited wards. All staff we spoke to said local leaders were visible and often seen on wards. We heard examples from staff of matrons and managers supporting staff on wards and working shifts.
- The trust carried out a quarterly pulse check of how staff felt about leadership capability in the trust. The overall trust average between April 2015 and October 2015 was 70% felt there was capable leadership. The percentage of staff in both directorates felt there was capable leadership was 74% (HOPE) and 72% (acute medicine).
- Staff we spoke with knew about the trust whistleblowing policy and were comfortable raising concerns with senior nursing or medical staff. All staff we spoke with said leaders were approachable.

Culture within the service

- The trust carried out a monthly pulse check of how staff felt about how staff felt about the hospital as a place to work. The overall trust average between April 2015 and

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October 2015 was 78%. The average percentage of staff felt the hospital was a great place to work was 83% for both acute medicine and HOPE directorates. The majority of staff we spoke with said the trust was a good place to work and they were proud to work there.

- Nursing and medical staff spoke positively about the service they provided for patients. Staff reported positive working relationships and we observed staff being respectful towards each other, not only within their specialities but also across all disciplines. They spoke positively about the culture within their own areas and throughout the trust as a whole.
- The culture at the hospital encouraged candour, openness and honesty. All staff said they could be honest with colleagues and with managers. Managers had an 'open door' policy meaning staff could approach them any time if they had queries or concerns.
- Medical, nursing and non-nursing staff were happy to challenge others, and be challenged where appropriate. The majority of staff said they felt respected and valued.

Public engagement

- Foxes Academy is a local centre for learning and training for people with learning disabilities. The trust worked with Foxes Academy to provide feedback and reflect on the experiences of patients with learning disabilities. The feedback highlighted staff talked to carers rather than patients, there needed to be better use of hospital passports and easy to read maps. The trust used this feedback to improve signage and wayfinding in the hospital. The trust planned to work foxes students as part of the assessment team for the forthcoming Patient Led Assessment of the Care Environment (PLACE) assessment.
- The trust conducted quarterly patient experience surveys and these were individualised to each ward. Information about patient feedback was clearly visible on all wards. This allowed ward sisters to discuss with their teams about patient feedback and possible improvements as a result. Staff gave us examples of when practice had changed because of patient feedback.
- Fielding Ward had set up a working group to support the refurbishment of the ward. The working group included patients and carers. Patients had contributed ideas to the proposed development including new wet rooms, new television and an improved reception area.

Staff engagement

- The trust engaged a sample of staff on a quarterly basis known as a 'pulse check'. This enabled the trust to have a snapshot of how staff were feeling about working at the trust on a regular basis. By engaging staff on a regular basis, the trust managers could respond quickly to any concerns or issues raised by staff.
- All staff we spoke with said they felt engaged by the trust and could contribute to the way services worked. Staff felt communicated with by sisters and senior managers.
- Both leaders and staff understood the value and importance of raising concerns. All staff we spoke with said they could approach their ward sister or matron about any issues on the ward. Managers and ward sisters demonstrated to the inspection team their desire and willingness to listen to staff.
- Managers communicated regularly with staff. Senior nurses held safety briefings each day with ward staff to discuss any pertinent issues, learning or patients on the ward. Staff said they appreciated and liked the safety briefings. Some wards held regular team meetings and some produced newsletters for staff.
- Junior doctors we spoke with told us about registrar meetings. They said the meetings were useful because registrars could discuss and raise issues. Consultants always invited one registrar to the acute physicians meeting to represent the views of registrars. One registrar said consultants always listened to them at these meetings.
- Staff on Eliot Ward had a closed Facebook page monitored and managed by a junior sister. Staff could share information, best practice and swap shifts. Staff we spoke with liked having the page because it enabled a flexible channel of communication.

Innovation, improvement and sustainability

- The hospital was named as one of the top hospitals in the 2015 CHKS awards, (CHKS is a provider of healthcare intelligence and quality improvement services), and was highly commended for patient experience. The CHKS awards commended the cancer care team, in the International Quality Improvement category, for their work.
- Investors in People awarded the gold standard to the whole Haematology, Oncology and Palliative Care Directorate (which included the Beacon Centre), one of only 7% of accredited organisations to win this.

Medical care (including older people's care)

- The trust celebrated success by giving staff 'going the extra mile' (GEM) and, the 'Musgrove awards for tremendous achievement' (MAFTA). All staff nominated received GEM awards and staff were appreciative of the recognition. There was a culture amongst staff and managers of continuous improvement and development. Staff gave us examples of ongoing work to improve services. This included a discharge improvement group to improve the discharge process and better use of the trust electronic patient record system.
- The trusts financial position had caused some concern for stakeholders. This meant financial stability was a key priority across all wards and departments. Staff had been actively involved in contributing ideas as to how wards and departments could save money.

Surgery

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

Information about the service

Surgical services are provided at Musgrove Park Hospital (MPH), a large acute hospital comprising all acute services. This hospital is the largest in Somerset.

The hospital provides emergency inpatient surgical treatment, elective (planned) inpatient surgical treatment and day surgery across a range of specialities; ophthalmology, head and neck, bariatric, gastrointestinal, orthopaedics, vascular, colorectal, urology and general surgery. There are 15 operating theatres including a surgical day unit and eight surgical wards.

Between July 2014 and June 2015 there were 31,300 surgical episodes of care carried out at MPH. Emergency cases accounted for 24% of all episodes, day cases 60% and elective cases 16%.

We visited the following surgical wards; Barrington (vascular, bariatric and gastrointestinal), Blake (head and neck, ear, nose and throat and ophthalmology), Gould and Portman (trauma and orthopaedics), Hestercombe (elective orthopaedics and women's health), Montacute (colorectal and urology), Parkside (private), Surgical Assessment Unit and Day Surgery Unit, Pre-operative assessment clinic, the operating theatres and recovery suites.

We spoke with 22 patients and 19 relatives, observed staff giving care and reviewed ten patient records and nine medication charts. Staff records and trust policies were considered alongside performance information from, and

about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

We also spoke with 55 members of staff at different grades including nurses, doctors, ward managers, theatre managers, the director and lead nurse of infection prevention and control, and designated consultants and matron leads for the surgical directorate.

Surgery

Summary of findings

Overall, we rated surgical services as good, however safety required improvement.

Patients, carers and families were positive about the care and treatment provided.

They felt supported, involved and staff actively engaged with patients whilst providing kind compassionate care.

We observed positive interactions when staff obtained consent. Staff supported patients and relatives with their emotional and spiritual needs.

Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. However, there had been two never events in the reporting period, one in May 2015 and one in November 2015.

We found that the World Health Organisation (WHO) five steps to safer surgery checklists were not completed consistently.

There was inconsistent practice in the checking of resuscitation trolleys.

Staff were aware of current infection prevention and control guidelines. Equipment was available, clean, safe and well maintained.

Controlled medicines were managed and stored correctly, however we found some medicines stored incorrectly and inconsistent practice in the checking of medicines fridges.

Staff attended mandatory training, and staffing levels were sufficient to meet the needs of patients.

Staff were aware there was a documented strategic business continuity and internal major incident plan within surgical services.

Staff provided care and monitored compliance in line with national best practice guidelines.

The surgical care group participated in a number of local and national clinical audits and acted upon any recommendations. Data from the audits was positive and the trust had action plans in place.

Patients were assessed individually for pain relief and for their nutritional requirements.

Staff were competent and supported by managers. Multidisciplinary team working was established and effective within the surgical wards and theatres.

Service planning and delivery took into account the needs of local people.

Patients were assessed appropriately and provided with treatment plans based on clinical priority.

Discharges were planned with the multidisciplinary team, however due to community pressures these were not always timely.

NHS England data showed that the national 18 week referral to treatment targets were not being met.

The number of cancelled elective operations as a percentage of elective admissions was consistently above the England average, however, of the 701 cancelled operations all but 14 have been rebooked within 28 days which was consistently lower (better) than the England average.

There were clear governance structures in place and lines of accountability. Leaders were visible and staff were positive about local leadership.

Values of the trust were understood by staff and embedded in appraisal documentation.

Information on how the public could provide feedback was displayed in the departmental areas. The trust celebrated the achievements of staff with an annual event. The Musgrove Awards for Tremendous Achievement.

Surgery

Are surgery services safe?

Requires improvement



Safety in surgery was rated as requires improvement.

We found:

- Emergency resuscitation equipment was available in all the areas we inspected, however; staff did not complete the daily check of equipment consistently across the service.
- Staff reported incidents and mostly lessons learned were shared widely in practice. However, there had been two never events in the twelve months prior to the inspection. The first occurred in May 2015 and involved a wrong site nerve block. Incident investigation showed the World health Organisation (WHO) five steps to safer surgery and the stop before you block checklists had not been used. The second occurred in November 2015 and also involved a wrong site nerve block. Incident investigation showed the stop before you block checklist had not been used correctly.
- Mortality and morbidity meetings did not occur within all of the surgical specialities a hospital wide mortality and morbidity meeting did not take place.
- Some medicines were seen to be stored outside of lockable cupboards and could be accessed by unauthorised people.
- Medicines fridge temperatures were not monitored and recorded consistently.

However we found :

- There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour regulation
- Mandatory training, and staffing levels were sufficient to meet the needs of patients
- Staff were aware of current infection prevention and control guidelines. Equipment was available, clean, safe and well maintained.

Incidents

- Staff reported incidents on an electronic system. Staff we spoke with were aware of how to report an incident

and gave examples of changes that had happened following incidents. For example, patients who were identified at risk of falls were nursed in a bed visible to the nurses work station or one to one in single rooms.

- The trust reported five serious incidents for surgery between October 2014 and September 2015, three of which were slips, trips and falls, one surgical invasive procedure and one pressure ulcer.
- The top three incident themes reported between June 2015 and November 2015, were health and safety, medication, treatment and care.
- The trust reported two never events between April 2015 and December 2015 within surgery. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The two never events were the same involving an anaesthetic nerve block being given into the wrong leg. The first event occurred in May 2015 and was investigated, the trust identified that 'Stop before you block' and the World Health Organisation (WHO) five steps to safer surgery checklist had not been followed. Learning was identified and shared across the trust surgical teams. The second event occurred in November 2015. This indicated that learning and change in practice from the first event had not been fully embedded.
- We saw a copy of the trust incident policy which clearly outlined the process for reporting and managing incidents. The policy recommended that patients and relatives were supported and informed of the outcome of investigations in accordance with the duty of candour regulation. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- We reviewed a number of incidents and found investigations were appropriately conducted using a root cause analysis process to identify any contributing factors and actions were assigned as necessary. Learning from incidents had been shared at meetings and changes in practice had been made where required. We saw evidence of a communication book used on Blake ward used to disseminate such learning.

Surgery

- Morbidity and mortality (M&M) meetings were taking place in three areas; ear nose and throat (ENT), trauma and orthopaedics, and breast care. Highlights of these meetings were reported to governance meetings. Although we were informed that M&M meetings were taking place in other specialties, including general surgery (colorectal/UGI), vascular and urology, we did not see documented evidence of meetings taking place in these specialties or an overarching M&M meeting.
- A web based central alerting system (CAS) received patient safety alerts. Alerts available on the CAS website included safety, medical device, and drug bulletins. There was a nominated officer responsible for sharing central alerts, appropriately and in line with agreed timescales, according to local policy. We saw patient safety alerts on staff notice boards.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).
- Not all wards displayed safety thermometer information in the clinical area. This meant staff, patients and relatives could not see the level of harm free care that was provided.
- Between January 2014 and January 2016 the safety thermometer data reports the following rates of harm free care: Barrington 96.6%, Parkside 96.9%, Gould 96.3%, Montacute 95.1%, Portman 91.5%, Hestercombe 97.3%, Surgical Admission Unit 96.4% and Blake 93%. These figures include all identified harm events whether or not they occurred whilst in the hospital. The national average for harm free care in the same period was 94.1%.
- Between September 2014 and September 2015, surgery services reported a low prevalence of grade two to four pressure ulcers, 13 were reported. They also had a very low prevalence of falls; three reported with harm, and one catheter acquired urinary tract infection.
- The trust had implemented a protocol to ensure that urinary catheters were used appropriately and removed

as soon as possible in order to reduce the chance of catheter related urine infections. We checked the notes of one patient who had a catheter and saw that the protocol was being used correctly.

Cleanliness, infection control and hygiene

- The surgical wards were uncluttered and appeared visibly clean. 'I am clean' stickers were seen on equipment such as commodes, blood pressure machines, hoists, walking frames and wheelchairs to indicate that equipment was ready to be used.
- Clinical areas displayed infection prevention and control information, which was visible to patients and visitors.
- There had been no hospital attributed episodes of methicillin resistant *Staphylococcus aureus* (MRSA) in the service up to November 2015.
- Information submitted by the trust showed there had been 19 hospital attributed episodes of *Clostridium difficile* (C difficile) in the service up to November 2015. All cases had already undergone a root cause analysis in order to identify where improvements needed to be made. Root cause analysis suggested that there was a link with Medical Admissions Unit (MAU) and C difficile cases; an action plan was in place for the MAU.
- We observed that all staff were compliant with key trust infection prevention and control (IPC) policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- We saw completed cleaning schedule check lists for anaesthetic and scrub rooms. This provided assurance that staff completed daily cleaning, flushing of water systems and monthly deep cleaning of the areas.
- Staff told us rapid response cleaning was available in theatre. This enabled theatres to re-open in a timely way keeping operations on schedule.
- Pre-operative assessment staff completed MRSA screening on elective surgical patients. This helped reduce the risk of surgical wound infection.
- Mandatory infection control training was attended by 73% of medical and dental staff, and 84% of nursing and midwifery staff. This was lower than the trust target of 90%.
- All surgical wards had infection prevention and control (IPC) link nurses who provided cascade training and carried out hand hygiene audits using the World Health Organisation's (WHO) five moments of hand hygiene at the point of care tool.

Surgery

- The trust had an infection prevention programme for hand hygiene to ensure transparency of reporting. All wards scoring 90% and above for three consecutive months were validated by an independent representative and a patient representative. Wards reporting accurately were provided with a certificate of achievement. The IPC link nurses delivered focused hand hygiene awareness sessions for nursing and medical staff on wards that were underperforming in the hand hygiene audits.
- The IPC team and link nurses had training meetings three times a year where approximately 40 to 50 of the 60 link nurses attended.
- We observed good hand hygiene practices and compliance with the bare below the elbow policy.
- The microbiology and the pharmacy teams performed antimicrobial ward rounds weekly. This was in line with Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use NICE guidelines (NG15). Antimicrobial stewardship is the practice of minimizing the emergence of antimicrobial resistance by using antibiotics only when necessary and, if needed, by selecting the appropriate antibiotic at the right dose, frequency and duration to optimize outcomes while minimizing adverse effects. We saw evidence of this on nine medication charts we reviewed.
- On the surgical assessment unit there was a number of fabric covered chairs which would not be possible to ensure they could be cleaned sufficiently to limit the risk of the spread of infection.

Environment and equipment

- Surgical services were delivered in two distinct areas of the hospital. One area was the original old building and the other a very new and modern building; the Jubilee Building.
- Equipment appeared visibly clean and well maintained in the wards and theatre areas. Equipment was appropriately checked, and decontaminated regularly with checklists in use for daily, weekly and monthly monitoring.
- Clinical areas had limited storage for equipment; however an equipment library was available. This stocked and repaired regularly used items. The trust carried out preventative planned maintenance on all equipment stocked in the equipment library. This included items such as, syringe pumps, pressure relieving mattresses and infusion pumps. We saw that

all the equipment had annual service stickers attached, which were in date and signed. We were told by library staff that the pressure relieving mattresses were cleaned by ward staff before being returned to the library. In addition, they were sent away annually for a 'deep clean'.

- We checked 20 pieces of equipment, for example; blood pressure monitors and hoists; all had been appropriately tested and were within their service date. Electrical equipment we checked had been checked annually as per portable appliance test recommendations.
- Bariatric wheelchairs were available and there was an overhead bariatric hoist on each ward of the Jubilee building (3 wards) one ward. However, specialised beds were ordered in as required. Bariatric equipment is specially designed for larger or obese patients.
- Emergency resuscitation equipment was available in all the areas we inspected however, staff did not complete the daily check of equipment consistently across the service and inconsistent procedures were used for the checks. We checked eight resuscitation trolleys four of which had incomplete checks or out of date equipment. Staff we spoke to were unsure about the resuscitation trolley checking policy. During our unannounced visit we saw that consistent check lists for completing the daily check of the resuscitation trolleys had been introduced.
- The ward and theatre areas were well maintained, free from clutter and provided a suitable environment for treating patients.
- Staff in the theatres told us they always had access to the equipment and instruments they needed to meet patients' needs and confirmed any faulty equipment was either repaired or replaced promptly.
- The trust used single-use, sterile instruments where necessary. The single use instruments we saw were within their expiry dates. The service had arrangements for the sterilisation of reusable surgical instruments.
- There was sufficient storage space in the theatres and items such as surgical procedure packs were stored in a tidy and well-organised manner.
- We looked into three ward kitchens. The kitchens appeared visibly clean, well equipped and well stocked with additional food and drink items and equipment to aid patients eat and drink independently.

Medicines

Surgery

- Medicines management was overseen by the medicines governance committee chaired by the chief pharmacist. The medicines governance committee reported to the quality assurance group which in turn reported to the board.
- A medicines review group was in place which specifically looked at medicines incidents.
- A full range of medicines policies and standard operating procedures were accessible to staff on the trust's intranet.
- Medicines were mostly stored securely in locked cupboards and fridges on the wards. However, some medicines were seen to be stored outside of lockable cupboards and could be accessed by unauthorised people. A trust wide audit of medicines security had recently identified the need to improve security of storage of stock drugs, and a ward based medicines management audit had been introduced. However, this had not been fully rolled out and embedded in the surgical wards we visited.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.
- Ward based pharmacists visited the ward daily to review medication charts, and we saw reconciliation of people's medicines were regularly completed.
- Controlled drugs were stored, managed and recorded appropriately. Stock checks were completed twice weekly by nurses, and audits were carried as part of a rolling programme by pharmacy staff. However, we saw that on one ward the controlled drugs cupboard was not dedicated specifically for controlled drugs, but instead also stored multiple other medicines in addition to controlled drugs. This was not in line with the trust policy. We checked the balance of controlled medicines in the cabinets and found the stock balances matched with the registers. Two members of staff had signed each entry upon dispensation
- Medication charts for nine patients were reviewed and found to be complete, up to date, and reviewed on a regular basis by the pharmacist. Patient's weight and any allergies were also recorded in the inpatient care and risk document.
- We looked at the records for ten patients. Nursing and medical assessment information was available via paper-based records. Records were structured, legible and up to date. Medical records were stored securely in locked cabinets located adjacent to the patient areas.
- Medical records in the surgical admissions lounge and the pre-operative assessment clinic were in unlocked rooms, and computer screens were unlocked with patient information visible.
- Records showed nursing and clinical assessments were completed before, during, and after surgery.
- Patient records included care plans and risk assessments, for example; moving and handling, pressure care, nutrition assessments; they were all completed correctly.
- Standardised nursing documentation was kept at the end of patients' beds.
- Observations were recorded; the frequency was dependent on the acuity and level of care needed by the patient.
- Overall, the content of the records was accurate, complete, and in line with professional General Medical Council and Nursing and Midwifery Council documentation standards.
- Information governance training was part of the mandatory training programme. Information submitted by the trust showed 86% of surgical staff had completed this training. This was lower than the trust target of 92%.

Safeguarding

- The trust had a policy outlining the processes for safeguarding vulnerable adults and children. Staff confirmed they knew how to access the policy and contact the designated safeguarding lead, safeguarding link nurses or a social worker.
- Safeguarding training data showed; 82% of surgical staff had attended level two safeguarding children training and 90% of surgical staff had attended adult safeguarding training. This was appropriate for staff working in an adult care environment. The trust target was 90%.
- All staff we spoke to could identify a safeguarding issue and knew how to escalate safeguarding concerns. This information was flagged on an electronic system.

Records

Mandatory training

Surgery

- Medical and nursing staff confirmed they had received a role specific induction when they started work in their departments. Agency and locum staff also followed the same process.
- We viewed local induction checklists, which included departmental safety instructions, orientation and an introduction to the policies and procedures. We saw five completed induction programmes for permanent, bank and agency nursing staff.
- Staff received mandatory training in fire safety, health and safety, equality and diversity, information governance, infection control, resuscitation and safeguarding of adults and children.
- Staff told us they were given protected time to attend mandatory training or complete updates on line using the trust web based learning package.
- Information submitted by the trust showed that overall compliance with mandatory training was 87%. This was below the trust target of 90%.
- Twice daily handovers took place between surgical team with day and night staff in attendance.
- Most of the surgical wards had medical patients (outliers). Staff told us they had buddy wards to ensure consistency of care. Doctors from the buddy ward would telephone each morning and then review the patients in order to plan care effectively.
- Staff completed risk assessments on patients. Risks such as falls, VTE, malnutrition and pressure damage were assessed. For example, we saw the Malnutrition Universal Screening Tool (MUST) used to assess malnutrition risk, and the Waterlow tool used to assess patients' risk of pressure ulcers. We saw evidence that nurses reviewed and repeated these risk assessments. Staff took action on the result of these risk assessments; for example; patients who were at risk of pressure damage were nursed on pressure relieving mattresses. In the ten records we reviewed all of the risk assessments were complete.

Assessing and responding to patient risk

- Nursing staff throughout the trust used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- The trust had a pathway for the deteriorating patient. Clinical areas we visited displayed the pathway at the nurses' station which included contact details for on call doctors and consultants.
- We checked a sample of ten records and saw evidence of the NEWS being used appropriately to assess patients in all ten records.
- We saw a copy of the 'surviving sepsis' Pro-forma which was based on the UK sepsis trust guidance termed the 'Sepsis Six'. Use of the sepsis six guidance has been shown to be associated with significant mortality reductions when applied within the first hour. The six steps identified the need for rapid escalation and treatment when sepsis is suspected.
- Nurses told us there were no delays with doctors reviewing their surgical patients, we observed doctors on the ward responding promptly to their bleeps.
- The World Health Organisation (WHO) five steps to safer surgery checklist (SSC) is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway.
- The trust provided a report from the theatre computer system, indicating compliance of over 95% with the SSC from April 2011 to September 2015. During September 2015 a new computer system was introduced. The trust were unable to provide us with information from the new system during our inspection.
- At our announced inspection we checked 28 WHO five steps to safer surgery checklists, within patients paper notes. Of these, 21 (75%) had not been fully completed. All 21 had one or more signatures missing and boxes were not ticked to show what had been asked or checked, there were no identifiable trends in the incomplete checklists. There was a risk therefore that further serious incidents or never events may occur. When we discussed this with senior surgical staff they explained that two systems were currently in place for recording the checklist, one was on paper in the patients records and the other electronic. They felt this may have led to confusion and resulted in records not being completed fully.
- We reported this to the Chief Executive at the time of the inspection who told us that the inconsistent approach with variable use of the electronic system would be

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discontinued. Theatres and critical care management had taken the decision to standardise the process and ensure all stages were done on paper until the electronic system could deliver the complete form.

- At our unannounced inspection we checked a further ten WHO five steps to safer surgery checklists and found that five were fully completed, four were incomplete and one was missing. This indicated that despite measures taken by the trust practice was still inconsistent.
- We saw completed preoperative checklists and consent documentation in the patient record. This included a post-operative nausea and vomiting risk assessment (PONV) which indicated whether a patient would benefit from an anti-nausea medicine post anaesthetic.
- Staff were aware how to escalate risks that could affect patient safety, such as staffing and bed capacity issues. Daily involvement by the associate directors of nursing and ward managers ensured these issues were addressed by reallocating staff and reviewing skill mix.

Nursing staffing

- Staffing levels were reviewed every six months using The Safer Nursing Care Tool (Shelford Group, 2013) endorsed by the National Institute for Health and Care Excellence (NICE). This is an evidence based tool which allows nurses to assess patient acuity (acuity is the measurement of the level of nursing care required by a patient), to determine the recommended number of staff. The trust target was for an average ratio one registered nurse to eight patients across all general ward areas.
- Information provided by the trust showed a low vacancy rate of 0.7% within the surgical directorate. However the sickness rate was 3.2% which without bank and agency staff could have led to wards with reduced staff numbers.
- The ward and theatre managers reviewed staffing levels and patient dependency daily any staffing shortfalls due to unplanned sickness or leave were escalated to the associate directors of nursing. Staffing levels on the wards were increased when necessary so patients needing one to one care could be appropriately supported.
- Staffing levels were maintained with the use of bank and agency staff. Ward managers tried to use regular bank or agency staff and ensured temporary staff were accompanied by permanent trained staff where possible, so patients received an appropriate level of

care. We saw a report detailing the use of bank and agency staff across the surgery wards and departments between December 2015 and February 2016. It showed low levels of agency staff use to bank staff use. For example, one surgical ward used 2678 hours of bank and agency staff to cover staffing shortfalls over the period of which 56 hours were filled by agency staff. Agency staff completed an induction and checked that they had completed mandatory training prior to commencing employment. We saw completed induction checklists for both permanent staff, bank and agency staff.

- Wards displayed the planned and actual staffing figures. During our inspection the actual number of staff on duty was equal to the planned number of staff on all of the wards we visited. Senior staff told us they assessed the staffing situation across the trust and made a clinical decision about re-deployment of staffing resources.
- We reviewed the monthly safer staffing report for July, August and September 2015 all areas had more than 95% expected staffing.
- The trust used an electronic roster system which included assessment of staff numbers for minimum and safe staffing which alerted management if there were shortages.
- Nursing staff handovers occurred twice a day and included discussions about patient needs and any staffing or capacity issues.

Surgical staffing

- Surgical staff were managed within the surgical directorate; there were approximately 170 whole time equivalent (WTE) medical staff, including approximately 70 WTE consultants. The trust reported a 7% vacancy rate in surgery for medical and dental staff however the sickness rate was very low at 0.3%.
- Consultant medical staff were accessible 24 hours a day, seven days a week through an on call system. Senior medical staff reviewed patients daily during ward rounds. Senior medical staff were resident at the hospital during on call periods All staff told us the on call team responded to bleeps and reviewed patients promptly.
- Within surgery, higher rates of senior medical staffing to the England average levels were noted: Consultant staffing at 45% trust level which was higher than the 41% England average, middle grade staff at 14% so

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higher than the 11% England average, registrar grade medical staff at 29% so lower than the 37% England average and junior medical staff 12% so equal to the England average up to September 2014.

- Within surgery, there were higher rates of senior medical staffing to the England national average: Consultant staffing levels were at 45% compared to the England average of 41%. For middle grade staff the trust had 14% against an England average of 11%. For registrar grade medical staff there was 29% against a 37% England average, and junior medical staff 12% which was equal to the England average up to September 2014.
- Surgical medical cover encompassed a significant range of specialties. During daytime hours Monday to Friday each speciality managed its own team of doctors.
- There was sufficient on-call consultant cover over a 24-hour period with appropriate medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available if needed.
- Trainee doctors and middle career doctors (foundation year one and two) told us on the whole they received good support and could easily access the on-call consultant if needed.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff were provided with a local induction to ensure they understood the hospital's policies and procedures.
- Daily medical handovers took place during shift changes twice a day which included discussions about specific patient needs.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the trust including surgical services.
- Staff had knowledge regarding what constituted a major incident. They knew where to access the policy on the intranet and stated that staff would redeploy to the areas of most need. All staff reported to us that a practice drill took place last year.

Are surgery services effective?

Good



We rated surgery services as good.

We found:

- The trust adopted nationally recognised and approved guidelines.
- Overall, the trust performed well in national audits.
- Patient's physiological needs were catered for.
- Patient outcomes were generally as good as or better than the England average.
- Staff were competent to carry out their roles, felt supported and were able to develop their skills and experiences.
- We observed good multidisciplinary team working.
- Adequate services were available seven days a week to deal with emergency admissions and deteriorating patients in the out of hours period.
- Patient information was readily available and medical and care records were relevant and up to date.
- Discharges were planned well.
- Mental Capacity Act and Deprivation of Liberty Standards were applied when necessary.

Evidence-based care and treatment

- Policies and procedures were easily accessible on the trust intranet. Staff told us they knew how to access policies on the intranet and we observed a member of staff searching for a policy. Agency staff would refer to permanent staff if they needed to access any policies on the intranet.
- Patient needs were assessed throughout their care pathway and care and treatment was delivered in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and the Royal Colleges guidelines.
- We saw examples of policies and procedures based on nationally recognised guidance. The inpatient care and risk document which was completed for every patient contained the Malnutrition Universal Screening Tool (MUST), this identified adults who were underweight or at risk of malnutrition, the Waterlow Score used to identify patients at risk of developing pressure sores and the Diabetes Foot Screening Assessment used to detect the development of foot problems in diabetics.
- Comprehensive care pathways were in place for patients undergoing any form of anaesthesia for surgery including local and general. This meant there was a standard system in place for each patient admitted.
- The Admission for Adult Surgery document and Record of Anaesthesia contained the Lee Revised Cardiac Risk

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Index, this estimates a patient's risk of perioperative cardiac complications. Patients were categorised as needing immediate, urgent, expedited or elective surgery according to the Confidential Enquiry into Patient Outcomes recommendations. We saw this information documented in the patient records we reviewed.

- Following surgery, all patients were nursed in accordance with CG 50 acute illness in adults in hospital: recognising and responding to deterioration.
- In theatres we observed the use of a wall mounted flip chart of emergency and anaesthetic guidelines based mainly on the Association of Anaesthetists guidelines.
- The surgical directorate held a monthly clinical audit meeting. The meeting reviewed all mortality and received audit presentations from junior doctors. The junior doctors also took part in a quality improvement initiative run by the lead in quality improvement. Drug and fluid balance charts were redesigned as a result of audit carried out by the junior doctors.
- An enhanced recovery procedure was in place for patients having hip, knee, spinal, colorectal, urology and major gynaecological surgery. Enhanced recovery is an evidence based approach that helps people recover more quickly following major surgery. We saw a copy of the enhanced recovery checklist for colorectal patients which included information for the patient on what they could expect before and after surgery and discharge information. This was also supported by an evidence based Colorectal Enhanced Recovery Guideline dated July 2013.

Pain relief

- Patients' pain levels were assessed in the pre-operative assessment clinic. Pain control was discussed with patients and documented in the Admission for Adult Surgery document.
- All patients were asked about pain upon admission and we saw this documented in the ten care plans we reviewed.
- Patients told us that pain relief medication could be requested, that nurses answered call bells and responded to the request quickly.
- In the five medication records we reviewed pain relief medication had been prescribed and given appropriately.

- A dedicated pain team covering the hospital could be contacted by bleep. The team comprised of nursing and medical staff.

Nutrition and hydration

- All patients had their nutritional status assessed within 24hrs of admission using the Malnutrition Universal Screening Tool (MUST). The MUST tool calculates the overall risk of malnutrition. Patients were assessed as low, medium or high risk. Nutrition care plans were in place for each patient where risks were identified.
- A team of dieticians were available to assess patients with nutritional needs including those with a high risk MUST score. Staff told us that dieticians were easily accessible and responded promptly to referrals from nursing staff.
- In addition all patients were asked about their dietary preferences on admission including any special equipment required, swallowing difficulties, and the type of food they liked to eat.
- Drinks and snacks were available for patients in the day surgery unit. Any special dietary requirements could be met by special requests made to the hospital kitchen, for example; gluten free bread.
- Patients reported that the food choice was good and the food was of a satisfactory quality. The trust wide Friends and Family Test scored satisfaction with catering at 81% (trust target 80%).
- We observed staff serving lunch on one ward. Food temperatures were checked before serving. Patients were asked if they required any help with their meals. A blue heart symbol with a knife and fork on it indicated whether patients required assistance. We saw staff assisting patients with their meals; staff were seated next to the patient and performed the task in an unhurried manner.
- Staff handling food told us they had received Food Hygiene awareness training via the trust intranet.
- The section on nutrition and hydration in the inpatient care and risk document was completed in all of the ten care plans we reviewed.
- Patients were given information about when they must stop eating and drinking before their operation. Depending on the surgical procedure patients could drink up to two hours before surgery and eat up to four hours before surgery.

Patient Outcomes

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- The trust Hip Fracture Audit 2015 (320 cases submitted for audit) was better than the England average in all aspects. Surgery on the day of, or after the day of admission was 80.8% compared to England average of 72.1%. Pre op assessment by a geriatrician was 93% compared to England average of 85.3%. Patients developing pressure ulcers was 0.8% of patient's compared to an England average 2.8%.
- The trust Bowel Cancer Audit 2014 (222 cases submitted for audit) results were as good as, or better, than the England average in ten of the 11 areas audited.
- The trust National Emergency Laparotomy Audit (NELA) 2015 showed that seven out of eleven indicators were rated green. One example was that patients arrived in theatre in a timescale that was appropriate to their urgency. Two out of the 11 indicators were rated red; one of these was that less than 50% of patients had a risk assessment documented preoperatively. As a result of the NELA audit the trust was piloting an 'Emergency Theatre Booking Form' which included the P-possum risk calculation; this gave an indication of mortality and morbidity outcome. Medical doctors we spoke to told us the new form had improved the number of patients having a formal risk assessment documented before procedure from 20% to 80%.
- The trust had a lower than England average overall for standardised relative risk of readmission in the top three specialities, this means that fewer patients are readmitted following surgery.
- Patient Reported Outcome Measures (PROMS) results for groin hernias, hip replacement, knee replacement and varicose vein surgery were similar to the England average for all four procedures. PROMS data for April 2014 – March 2015 showed that patient's quality of life had improved following treatment.
- The Infection Prevention and Control (IPC) team monitored surgical site infection in the following areas, total knee replacement, spinal surgery, total hip replacement and breast surgery. The trust reported slightly higher levels of infection than the England average apart from breast surgery which was slightly lower.
- Between July 2014 and June 2015 there were around 23,600 spells of care for surgery. Day surgery accounted for 60% of those spells of care, elective surgery 16% and emergency surgery 24%.
- The average length of stay in hospital for patients in the top three specialities of trauma and orthopaedic,

urology, and ear, nose and throat (ENT), for elective and non-elective procedures, was shorter than the England average in all cases except elective trauma and orthopaedic (Trust 3.6, England average 3.4). This information, taken with the low readmission rates means that patients have a shorter, but just as effective stay in hospital following their surgery.

- We saw the minutes of the trauma and orthopaedic audit group which included reports from individual consultants on the personal National Joint Registry data. They benchmarked themselves against national data which showed that their performance was in line with England average.

Competent staff

- All new staff attended the corporate induction session and the corporate essential learning (CEL) programme. The CEL programme was made up of 13 modules which included infection control, dementia awareness, risk management and major incident plans. The CEL was repeated every three years and most of the content was available via on line training.
- In addition staff had a local induction plan which was individual according to their needs and the location of work. All agency and bank staff received local induction training. We saw a variety of local induction checklists for clinical, non-clinical, bank and agency staff.
- Staff told us they were given time to attend training sessions or complete on line training and we saw this in practice. Agency and bank staff were paired with experienced staff for support.
- We observed good interactive learning taking place during an interventional radiology procedure between the consultant and radiologist.
- The trust reported that in December 2015 medical staff appraisal levels were at 74% and nursing staff appraisal levels were at 84% compared to the target of 92%. The staff we spoke to had all attended an appraisal in the last 12 months or had an appraisal date booked. The appraisal covered personal development and staff told us there were opportunities for attending additional training appropriate to their role.
- All staff had a line manager. New staff also had a nominated preceptor. Staff told us their line managers were very supportive. We observed this in the interactions between the ward sister and their staff.

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- A staff policy was available to support line managers with poor performance. Ward sisters were able to describe the policy and gave examples of when it was used.
- The trust had systems in place to ensure that the registration status of qualified doctors and nurses' had been renewed on an annual basis. There was a nominated Responsible Officer for medical revalidation.
- The trust had engaged their library service to assist nursing staff with information about revalidation and provided practical support such as the use of IT equipment.

Multidisciplinary working

- We observed three multidisciplinary team (MDT) meetings taking place involving nursing staff, medical staff, occupational therapists, physiotherapists and discharge facilitators. Each patient was discussed and given an estimated discharge date. The team also discussed the carers or relatives and made sure they were informed of proposed discharge plans. Each speciality contributed, and changes to care or treatment agreed.
- The discharge facilitator liaised with community services such as district nursing and attended community MDT meetings if required. The discharge facilitator knew when and where beds became available in nursing homes, residential homes or community hospitals.
- Hospital social workers, who were not employed by the trust, were not able to attend every MDT meeting due to workload demand. Staff told us this occasionally led to delays in discharge.
- We observed good working relations between wards and theatres. Staff in operating theatres regularly updated ward staff on patient progress via telephone. A ward buddy system was in place so if a surgical ward had medical outlier patients and needed some advice about their care they had a nominated medical ward to approach.

Seven-day services

- Operating theatres were available seven days a week. An on call rota was in place and staff could attend quickly if needed in the out of hours periods.
- Physiotherapy services were provided seven days a week and an on-call system was in operation if they were required out-of-hours.

- Consultants were responsible for the care of their patients from pre-admission consultation until the conclusion of their episode of care.
- Ward based pharmacists visited the ward Monday to Friday to review medication charts and a pharmacy on-call system was in operation.
- Patients had access to the hospital and its staff 24 hours a day as an inpatient and following their discharge when it was required.
- Radiology services were available seven days a week with an on call system in place for the out of hours periods.
- The medical doctors we spoke with told us that pathology services were efficient and available in the out of hours periods.

Access to information

- Doctors we spoke with told us that referral notes from GPs were comprehensive and available with the patient; this meant that informed decisions could be made about on-going care.
- Elective surgery patients completed a questionnaire in the admission for adult surgery document which gave a general picture of their self-reported health. They also attended the Pre Op Assessment Clinic where a number of investigations could take place, for example, an electrocardiogram or ECG. This would provide health professionals information of the patient's current state of health.
- Comprehensive risk assessments were completed in the inpatient care and risk document. This meant that all the information to deliver effective care and treatment was readily available to staff.
- Discharge summaries were sent out to the patients' GP on the day of discharge by various means, such as e mail, post or given to the patient for them to hand to their GP.
- GPs could contact on call doctors directly to discuss patients.

Discharge Planning

- Discharge planning began within 24 - 48hrs of the patient being admitted and was discussed at MDT meetings. The trust reported the number of patients with evidence of discharge plans in place to be 87% against a trust target of 85%.
- The surgical discharge facilitator liaised with community services as part of the discharge plan.

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- The inpatient care and risk document, completed for every patient, contained a comprehensive discharge assessment, discharge care plan and discharge checklist and we saw these completed in the ten care records we reviewed. This was in line with the Discharge of Adult Patients Policy dated March 2014.
- Delayed discharges were common for patients who were medically fit but could not live alone. Staff told us packages of care were difficult to put together due to the lack of providers in the community. There was also a lack of nursing home beds, residential care beds and community hospital beds.
- Follow up appointments were made and given to the patient on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A 'Consent to Examination or Treatment Policy' was available to staff which included the action staff should take if a patient lacked the mental capacity to make decisions for themselves.
- Patients told us they had been informed of the risks involved in having surgery before they signed the consent form. Other patients confirmed that staff discussed with them what they were going to do before treatment or care ensuring they obtained their consent. We saw consent forms completed and signed in the records we reviewed.
- Our observation of practice, review of records and discussions with staff confirmed that the trust's consent policy was followed.
- We saw the 'Mental Capacity Act Policy' dated January 2016 which supported staff in assessing and making decisions about a patient's mental capacity. The Mental Capacity Act 2005 aims to empower and protect people who may not be able to make their own decisions. It also enables people to make advance decisions and statements to plan ahead in case they are unable to make important decisions in the future. Deprivation of liberty standards are part of the Mental Capacity Act 2005.
- The bed rail and low bed risk assessment in the inpatient care and risk document reminded staff to take into account patients' capacity and best interest issues. We saw this completed appropriately for one patient to whom this was relevant.

- We saw a copy of the trust Resuscitation Policy. The policy required that all in-patients must have their resuscitation status recorded on a Treatment Escalation Plan (TEP) form. TEP forms were completed in all ten of the patient records we reviewed.
- A 'Deprivation of Liberty Standards' (DOLS) policy was available with a clear flowchart for staff to follow to support them in making decisions about DOLS.
- Staff we spoke to told us they knew how to access the relevant policies and felt confident on managing consent, mental capacity and DOLS concerns but would seek advice from senior colleagues if necessary.
- Medical doctors told us they spent time describing treatment plans to patients in order for them to give informed consent. Patients told us they felt informed about their care and could ask questions of nursing staff or medical doctors if they needed more information.

Are surgery services caring?

Good



We rated the care provided by surgery services as good.

We found:

- On all the wards and departments we visited we saw staff acting in a kind and caring way towards patients and the public.
- Relatives and carers felt involved and informed.
- The trust achieved positive results and feedback from the friends and family test and in patient surveys.
- Spiritual and emotional support was available

Compassionate care

- We spoke with 22 patients. All the patients spoke positively about the care they received in hospital. They told us that staff were kind and considerate and 'put you at ease'. They felt well treated and told us staff were very attentive. Patients considered staff were friendly and helpful, and no matter how rushed they were always had a smile.
- In all wards and departments we visited we observed good interactions between all members of staff and patients. We saw written compliments and thank you letters displayed on ward notice boards which had been received during the past two months.

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- Patients told us they were treated with dignity and respect and we observed this on the wards and departments we visited. Patients were also asked on admission if they had any objection to personal care being carried out by a member of the opposite sex.
- The trust scored consistently better than the England average in the Friends and Family Test survey although the response rate was lower (Trust 23.6%, England average 35.5%).
- The trust had a team of volunteers who supported patients in completing the Friends and Family Test survey in order to increase their response rate. The discharge checklist also had a reminder about completion of the Friends and Family Test survey.
- We saw Friends and Family Test results clearly displayed in ward areas and staff told us they talked about the survey results at their staff meetings.
- Surgical wards scored above 97% for patients who would recommend the service to friends and family. In the most recent survey seven out of nine surgical wards scored 100%.
- As a result from some of the feedback from the Friends and Family test, actions were implemented to improve patient experiences. An example of this being patients were offered ear plugs at night to improve their sleep.
- The trust conducted a patient experience survey. We saw the survey results for January 2015 to October 2015. For the month of October 2015, 154 out of 159 patients felt they were always treated with dignity and respect, 148 out of 160 patients said staff were always kind and sensitive and 149 out of 160 patients said they were involved in decisions about their care and treatment.
- The trust had good results in the national Cancer patient experience survey 2013/2014, they scored in the top 20 % of all trusts for 12 out of 34 selected questions and bottom 29% for one out of 34 questions which was the statement 'patient definitely given enough care from health or social service'.
- The trust had good results for Care Quality Commission (CQC) inpatient survey 2014. Four out of 12 questions scored as a 'better performing trust' (help with meals, someone to talk to about worries and fears, no problems with delayed discharge and length of delayed discharge) the remaining eight questions were about the same as other trusts.

- In the patient led assessment of the care environment audits 2013, 2014 and 2015 the trust scored higher than the England average for privacy, dignity and wellbeing with the trust scoring 95% against an England average of 89% for 2015.
- We were given examples of where staff had gone beyond their duties to care for patients, such as making birthday cakes for patients, bringing take away food in for a young patient and making smoked salmon and scrambled egg for a patient. Also one ward provided drinks for visitors at a small charge and used the money to buy toiletries for use by patients who didn't have any. We observed one member of staff supporting a patient with learning difficulties in using their mobile phone to contact relatives.

Understanding and involvement of patients and those close to them

- Staff told us it was possible for relatives to stay overnight; the patient would be nursed in a single room where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities when relatives or carers stayed overnight in order to reduce anxiety and disorientation in the patient.
- We spoke to 17 relatives. They all told us they had been kept informed of the patients' progress and staff were approachable if they needed to ask any questions. Staff were aware of patient confidentiality and told us they always checked with the patient if they were unsure of who was making the request. Care and treatment was explained by all members of the multidisciplinary team in a way that could be understood. We observed a member of staff speaking with a gentleman to explain about his wife's care. We observed ward receptionists helping relatives with information requests and taking phone messages to patients from relatives.
- We observed good interactions between staff and patients in the recovery suite of the day surgery unit. Staff spoke in a quiet calm manner to patients explaining what was happening to them and what was going to happen next.

Emotional support

- Nursing staff told us that if they felt patients were anxious or distressed they would first spend some time trying to understand what the patients were worried about. We observed nursing staff sitting and talking to

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patients. Nursing staff were able to refer patients to the mental health services provided by a neighbouring trust and we saw this had taken place for one patient at the multi-disciplinary meeting we attended.

- We observed an orthopaedic surgeon visiting the surgical admissions lounge prior to theatre to explain to patients the plan of care and what to expect. There was a section in the patient's notes for recording such discussions. We saw this section completed in the notes we reviewed. Patients were kept informed of any changes or delays.
- Staff in the surgical admissions lounge spent time talking to, and reassuring patients who appeared anxious. Patients told us they had been informed of what to expect step by step which they said relieved their anxiety.
- Chaplains were visible on the wards providing spiritual support to patients.

Are surgery services responsive?

Good



We rated the responsiveness of surgery services as good.

We found:

- Services were planned in collaboration with Somerset Clinical Commissioning Group and the public.
- Improvements were being made towards meeting national referral to treatment targets. These had been challenging to the trust but work with commissioners was being effective.
- Access to hospital services for surgical patients was good, bed moves were kept to a minimum. If surgical patients could not be placed on a surgical ward procedures were in place to ensure care was not compromised. Information was provided for patients and their GPs on discharge in a timely manner.
- Translation and interpretation services were available.
- Extra measures had been put in place for patients with complex health and social needs.
- Complaints were managed well and response times to complaints were improving.

However, we also found:

- Delayed discharges affected scheduled operations due to beds not being available post operatively.

- The day surgery unit did not have a 24hr telephone hotline for patients.

Service planning and delivery to meet the needs of local people

- The trust provided services to a population of approximately 538,000 people in the following boroughs, Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset
- Services were designed with the collaboration of Somerset Clinical Commissioning Group, NHS England and in consultation with patient representatives.
- The local health profile indicated four areas that were above the England average which were: obesity, diabetes and over 65 hip fractures in Sedgemoor and diabetes in South and West Somerset.
- The Trust was introducing a one stop, joint, dermatology and maxillofacial clinic where patients received multi-disciplinary assessment and treatment (cryotherapy, biopsy or primary closure surgery) on the day.

Access and flow

- Patients were admitted as emergency patients through the surgical admissions unit or elective patients through the surgical admissions lounge.
- Patients who had day surgery received care in line with the best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011.
- The Association of Anaesthetists guidance state that it was best practice to have a dedicated telephone helpline for patients during the first 24hrs post day surgery discharge. The day surgery unit did not have this in place. Patients were advised to contact NHS 111 or their own GP if they had any concerns following discharge from surgery.
- Bed occupancy rates were consistently lower than the England average. The previous two winter periods had seen the highest bed occupancy (82% and 85%); these figures were still lower than the England average and within acceptable levels. The national audit office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crisis and increased numbers of health care acquired infections.

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- The demand for treatment had exceeded the trust's capacity in 2014/15, leading to an increase in waiting times in some specialties, which has affected overall hospital performance. In response to the poor performance the trust, in collaboration with stakeholders, had developed a RTT action plan with delivery plans for 2016/17 based on increased demands. We saw that RTTs were monitored at all levels of the trust and had been discussed at board meetings. Improvements were being made and data from October and November 2015 also showed significant improvements from the period September 2014 – August 2015.
- Data from January 2016 showed continuing improvement in RTT: dermatology 96%, ENT 87%, general surgery 87%, ophthalmology 89%, oral surgery 80%, orthopaedics 80% and urology 92%. So significant progress was being made towards meeting the national target of 92%.
- The urgency of referrals was assessed when they were received and graded as urgent or routine. The waiting list was reviewed on a weekly basis in each speciality and plans put in place for the longest waiting patient. Currently one patient was waiting in excess of 52 weeks to receive treatment however two operations had been rescheduled due to the patient being unwell.
- The RTT for non-admitted patients was consistently above 90% against the trust target of 95%. We saw RTT performance documented in the Operational Plan 2015-2016 dated May 2015.
- We saw the remedial action plan to improve the 62-day cancer standard which included redesigning the cancer pathway.
- Between April 2013 and May 2015 there were 14,579 delayed transfers of care. The main reason given was patients were waiting for NHS non-acute care. The trust figures for this was 59.2% delayed transfers compared to the England average of 20.2% delayed transfers.
- Cancelled operations as a percentage of elective admissions performance was worse than England average, at 1.1 compared with 0.9. This was showing an improvement in the first quarter 2015/2016. Senior doctors told us this was mainly due to unavailability of post-operative beds.
- The trust had a better than England average for cancelled operations that were rebooked within 28 days. This meant that patients who had their operation cancelled at the last minute had a new date for their surgery within the following 28 days.
- Senior staff told us that they tried to make decisions about whether to cancel operations the day before the operation. Surgical operations were graded one to three; those graded three would be the likeliest to be cancelled. Cancer patients were grade one, complex operations or those requiring surgeons from two specialities were grade two and routine elective operations were grade three.
- The trust had good procedures in place for surgical outliers. Staff told us a senior doctor and the associate directors of nursing reviewed surgical outliers daily. Each surgical ward we visited had medical outliers. On one trauma and orthopaedic ward there were ten medical outliers out of 25 patients. Nursing staff told us that they could always get advice from medical doctors if they were worried about a patient. Doctors were evident on all the wards we visited.
- We saw patient information leaflets for some surgical operations with instructions for patients on what, and what not to do once they were discharged. A range of patient information leaflets could also be obtained from the trust website.

Meeting people's individual needs

- The Trust provided a comprehensive interpretation and translation service available 24 hours a day, seven days a week via a contracted supplier. This service included face-to-face interpreting, British Sign Language (BSL), telephone interpreting and written translation. Core patient information was available in Portuguese and Polish. Information could be translated into different languages or braille on request. Large print and easy read material was available on request. The top three language requests between September 2014 and October 2015 were: Polish 40%, British Sign Language 15% and Portuguese 11%.
- The Trust had a team of chaplains who offered 24/7 support to patients. The chaplains were available for prayer, chapel attendance or a bedside visit. The chaplaincy team was also available to offer support to patients' friends and family.

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- The chapel held morning worship with Holy Communion on Sunday mornings and Muslim prayers on Friday afternoons. Wheelchairs or escorts could be arranged for those attending if needed.
- We saw that male and female patients were able to have separate areas in the surgical admissions lounge and we did not find any mixed sex breaches on the surgical wards we visited during our inspection. The trust had not reported any mixed sex breaches for the six months prior to our inspection.
- Food was available on the wards throughout the 24-hour period, microwave meals were kept in freezers. A range of diet choices was available including vegetarian, gluten free, kosher and Halal. We saw nutrition pictorial menus to assist patients to choose meals they liked.
- All patients were asked about their religious and spiritual preferences on admission and we saw completed nursing care documents. Nursing care documents also contained an 'About me' section. This section captured general information about the patient such as sleep and rest patterns, communication and personal hygiene and allowed the patient to express any personal preferences.
- Diabetic patients could be identified by their electronic patient record. The trust had a team of diabetic nurse specialists who received daily reports of diabetic patients admitted to the hospital. All wards had a diabetes champion. The inpatient care and risk document included diabetes foot screening assessment and we saw the diabetes specialist podiatrist carry out a ward visit to a patient with diabetes.
- We saw a range of policies and procedures on the hospital intranet relating to patients with diabetes, these included pre and post-operative procedures.
- Wheelchair access was good throughout the hospital. Disabled toilets were located at frequent intervals off hospital corridors. Lifting equipment was available and wards in the new Jubilee building had integrated overhead electronic lifting devices.
- There was no system on the electronic patient record for identifying if a patient was blind or deaf and the trust did not monitor the numbers of blind or deaf people treated at the hospital.
- The trust was able to identify patients with learning disabilities on the electronic patient record system. This enabled the trust to monitor the numbers of patients with learning disability patients using services to ensure services were tailored to meet their needs and plan for when patients with learning disability patients were due to visit the hospital. The trust reported that between April 2014 and March 2015, 132 patients with a learning disability had used hospital services and the average number of patients with learning disability patients referred to the Learning Disability Liaison nurse per month was 11.
- There were systems in place to alert the Learning Disability Liaison Nurse that a learning disability patient was being or had been admitted.
- The Learning Disability Nurse worked closely with the dental team who treated a high proportion of patients with learning disability. This involved contacting carers and planning to make the hospital experience as stress free as possible for the patient.
- Additional admission planning arrangements were in place for patients with learning disabilities including individual hospital passports, which provided information about their individual needs and admission planning meetings.
- Ward and theatre staff described to us the adjustments that could be made for patients with learning disabilities. These included single rooms with the facility for relatives or carers to stay overnight, being first on the theatre list, relatives staying with patients until anaesthetised and generally being given greater time and aiming for consistent nursing staff. One housekeeper told us how they had spent extra time explaining the menu choices to a patient with a learning disability, as they would not eat until they knew the minute detail of the food served.
- We saw the easy read, one quick question survey for patients with learning disabilities displayed in patient waiting areas and ward areas.
- The trust had carried out a small preliminary audit of the patient records of patients with learning disabilities. The audit was capturing information on reasonable adjustments, Mental Capacity Act 2005, restrictive measures and deprivation of liberty standards. The learning disability liaison nurse was reviewing the documentation and data recorded for patients with learning disabilities as a result of the audit.
- The wards and departments we visited all had dementia champions. The ward dementia champions took the lead to ensure that care was personalised and where

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possible that the patients usual habits and routines were catered for. Staff told us that they did not move patients living with dementia from ward to ward to avoid them becoming confused and disorientated.

- The symbol used to alert staff that a patient was living with dementia was a forget-me-not flower. The inpatient care and risk documents included questions about dementia and 'About Me' questions which had to be completed on admission. The 'About Me' questions were based on the Alzheimer's Society 'This is me' tool that allows health and social care professionals to know about patient's needs, interests, preferences, likes and dislikes. In the ten care notes reviewed we saw all of the sections completed appropriately.
- One ward had been refurbished as a dementia friendly trauma ward. This included colour coded bays, clear signs on doors, new flooring, large face date and time clocks, lounge area (still under development), memory box and twiddlemuffs. Twiddlemuffs are knitted hand muffs with interesting bits attached inside and out designed to provide stimulation for active hands. Patients living with dementia can find twiddlemuffs reassuring and comforting.
- The forget-me-not flower on their electronic patient record identified patients living with dementia. In the last year 884 patients with dementia were treated at the hospital. On average there were 30 patients with dementia being treated in the hospital at any one time.
- The trust took part in the national audit of dementia. The dementia champions completed monthly dementia care metrics. There were ten dementia metrics, which were measurements of care, and these include whether the patient environment was uncluttered, whether the patient could access food and drink and whether discussions had taken place with the patient's carers. We saw the dementia care assessments for the period August 2014 to December 2015. The assessments had improved over time with more of the criteria being assessed as green (positive); however, information was missing in several areas.
- We saw that all patients had a board positioned on the wall above each bed which displayed key information about their care needs and included the symbols which indicated whether a patient had significant communication difficulties. We saw that for one patient the forget me not symbol was highlighted which informed medical and nursing staff the patient was living with dementia.

- Occasionally due to the cramped environment in the older buildings, we noted that it was possible to hear conversations from the next bed through the curtains. However, there were some quiet rooms available where sensitive conversations could take place.

Learning from complaints and concerns

- Staff described to us the action they would take if a patient wished to make a complaint. Depending on the severity of the complaint, this would involve staff trying to resolve the complaint at a local level, escalating it to the ward sister or giving the complainant's information to the patient advice and liaison service (PALS). All the staff we spoke to about complaints showed a willingness and preference to discuss the complaint with the patients or their representatives face to face.
- Patients and visitors told us they would feel comfortable making a complaint as nursing staff were approachable and understanding.
- Posters explaining how patients could complain were clearly visible around the hospital. The Patient Advice and Liaison Service (PALS) were located in the hospital and leaflets were available for patients explaining how PALS could assist in managing complaints.
- We saw a copy of the complaints policy that clearly described the complaints process including a review by the complaints team who allocated a priority to each complaint. Complaints allocated a red priority, the highest priority, were also investigated in line with the serious incident policy.
- All complaints were reviewed on completion for learning points. Learning was disseminated at ward and departmental level by ward sisters or department managers via team meetings or staff bulletins.
- Satisfaction of the complaints process was assessed through the NHS Benchmark Club and the Patients Association Questionnaire by surveying complainants once the complaint was closed.
- Between January 2015 and December 2015 there were 15 complaints across the wards and departments we visited. The trust reported that half of these were responded to within the trust target of 90%. The trust had acted on this by securing additional support to strengthen the process for managing and responding to complaints. The trust reported that trust wide performance had improved in January 2016 (82%) and February 2016 (92%). Complainants were kept informed of delays in the response time.

Surgery

Are surgery services well-led?

Good



We rated the leadership of surgery services as good.

We found:

- Values of the trust were clear and embedded in staff appraisal documents.
- Clear governance structures were in place which included: quality improvement programmes, risk management and responding to feedback.
- Risk registers were in place for each speciality, we saw that these were up to date and reviewed regularly.
- There was strong local leadership with staff respecting line managers and feeling supported in their roles.
- The trust valued its staff; there was a culture of openness.
- Processes were in place for public and staff engagement.
- Innovation and improvement was evident.

Vision and strategy for this service

- The surgical directorate's annual service plan 2015 – 2016 identified priorities for the year. These were realistic, and based on areas for improvement, such as the return to treatment cancer waiting times. We also saw the update on progress to the board report dated November 2015.
- The trust values were, 'To put patients first by working as one team; leading and listening; and striving for the best. Together, we make the difference'. Staff appraisals reflected the values so objectives could be set to continuously improve.
- We found staff were not able to articulate the values of the trust. However, staff displayed them in their daily work and we observed them putting patients first by working as a team, leading and listening, striving for the best and trying to make a difference.

Governance, risk management and quality measurement

- Areas we inspected came under the management of directorates, the surgical directorate and the theatres and critical care directorate.

- The organisational structure chart showed clear lines of accountability from the board to the ward and vice versa.
- A governance committee was in place, which gave assurances to the board that the trust was meeting its regulatory requirements, and that robust arrangements for governance were in place.
- Information was disseminated through a network of meetings. Ward sisters attended monthly clinical governance meetings. Main points from the meetings were cascaded to staff through ward meetings or ward bulletins. We saw copies of ward bulletins and staff described to us the type of information they received.
- Each area we visited displayed key performance data such as results of hand hygiene audits, friends and family test and trends in patient feedback.
- Risk registers were in place for each speciality, we saw that these were up to date and reviewed regularly.
- A rolling programme of audit was in place including local and national audits.
- The trust held a Nutrition Steering Group. This group reviewed audits of ward catering facilities. We saw a copy of the latest audit report dated February 2015, which showed an improvement on the last audit and identified some further areas for action.
- The trust produced a monthly team brief and weekly staff bulletins both available on the trust intranet.
- The trust were working with staff unions to deliver a 'be safe' campaign looking at working for better standards of care and having confidence in raising concerns at work for patient safety.
- The trust had reacted positively to address referral to treatment times and while England targets were not quite being met, a significant improvement had been made to improve the timeliness in which patients were treated.

Leadership of service

- The head of the directorate supported by the directorate teams led surgical services.
- Local leadership was good; ward sisters and departmental managers were visible and liaising with staff throughout the day. Staff were extremely complimentary about their immediate managers.

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- Ward sisters had attended LEAD training; this was aimed at promoting consistent leadership behaviours within the trust, in line with the vision and values. We observed ward and department managers behaving in line with the trust values.
- Ward sisters and department managers attended directorate meetings.
- We saw the trusts Raising Concerns (Whistleblowing) Policy. This described how staff could raise concerns including consulting with Whistleblowing champions. Staff we spoke with told us they were aware of the policy and did not have any reservations about raising concerns with their line managers.
- Trust wide staff sickness rates were lower than the England average.
- The trust had a number of ways of gathering feedback from the public. These included participating in national surveys and audits, reviewing and responding to NHS friends and family test comments, holding events for Musgrove Partners and stakeholders to share their experiences and provide advice to improve patient care and the Patient Advice and Liaison Service.
- Feedback from the NHS friends and family test was circulated to all ward managers and department leads and disseminated to staff so they could see the monthly results and comments. Staff were aware of the feedback and we saw it displayed on ward notice boards.
- The trust commissioned a listening event for people with a learning disability which took place October 2015. We saw the presentation of feedback from individuals. Feedback was not summarised or trends identified but contained many useful comments in particular about easy to use signage around the hospital.
- In July 2015 a patient experience event was held for colorectal cancer patients. Feedback was collected by questionnaire and at a face-to-face group meeting. We saw a report from this event dated October 2015. Actions had been identified to improve the service. Examples of actions were; inclusion of behaviours and attitudes in nurse training, ensuring patients were aware of the relevant websites on the internet and the production of a colorectal digital video disc for patients.

Culture within the service

- The trust had developed a People Strategy in May 2014. The main aim of the strategy was to create collective leadership. The strategy was monitored through the quarterly Pulse Check – the trust staff survey. The strategy was reviewed in September 2015 and there was a general positive improvement for example, an increase in the number of positive responses to the question in the Pulse check, ‘would you recommend the trust as a place to work?’ (80%).
- The culture in the trust encouraged candour, openness and honesty. Staff told us they felt free to speak openly with managers and patients and report any matter of concern.
- There was a lead for Duty of Candour (DoC) and a Duty of Candour Policy. Staff received DoC training as part of their induction programme and then every three years after this. Duty of candour compliance data was shared both monthly and quarterly with the directorates. A report detailing serious incidents was presented at the Governance Committee and included details of the compliance with DoC for each individual incident.

Public engagement

- Feedback on the NHS Choices website November 2015 reflected mainly positive comments. Thirteen different services were commented on, orthopaedics and colorectal cancer services were two of the three services that received negative feedback. The trust was currently rated as four stars based on 181 ratings. We saw that the trust had responded to the feedback on NHS choices.

Staff engagement

- In the 2015 NHS staff survey the response rate was 45%, which is above average for acute NHS trusts, and compared with a response rate of 28% the previous year.
- The trust conducted a quarterly staff survey. The survey was made up of fifteen questions; responses were rated as red or green, green being positive. The question with the most positive response was ‘How likely are you to recommend this organisation to friends and family if they need care and treatment?’ 94% green. The question with the least positive response was ‘I think that it is safe to speak up and challenge the way things are done’ 56% red response. ‘We saw the results for surgery staff for the quarter July 2015 – September 2015.
- A rolling programme of Equality and Diversity and Health and Safety training were included in the

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corporate essential training programme; 87% of all surgical staff had attended the training against the trust target of 95%. However, this was within the trusts amber target of 85 – 95%.

- The General Medical Council survey 2015 rated the trust as within expectations in all areas. This survey looks at areas such as induction, training, supervision access to education and satisfaction.

Innovation, improvement and sustainability

- The trust had a Going the Extra Mile (GEM) Award for staff. Colleagues, patients and the public were encouraged to nominate staff who they felt had improved the patient experience, made an invaluable contribution, an example of best practice, innovative, inspiring or leading the way.
- The Musgrove Award Scheme also recognised staff achievement. Patients were encouraged to nominate staff and following shortlisting successful staff attended a celebratory gala dinner where winners were announced.
- The trust was part of the South West Academic Health Science Network appointed by NHS England. The network worked collaboratively bringing together all the expertise in Devon, Cornwall, the Isles of Scilly and Somerset on patient safety and quality of care.
- Colorectal Specialist Nurses had been trained to use clinically developed criteria and pathways to direct patients to the relevant test or clinic thus avoiding unnecessary steps or diagnostic procedures in the patient's pathway. This improved the speed of diagnosis for patients with suspected colorectal cancer.

Critical care

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

Information about the service

Critical care services are based at Musgrove Park Hospital. The 12-bedded critical care unit has six intensive therapy beds (ITU) and six high dependency beds (HDU), is based near to the main theatres and is managed within the Theatres and Critical Care Directorate.

The critical care team consists of eight consultants, more than 65 nursing staff, and representatives from all the allied specialties including microbiology, physiotherapy, radiology, nutrition, pharmacy and speech and language therapy. A critical care outreach team assists in the management of ill patients on the wards.

The critical care unit provides critical care at levels two and three as defined by the Intensive Care Society. Level two patients are those requiring observation that is more detailed or intervention including support for a single failing organ system, or post-operative care and those 'stepping down' from higher levels of care. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all patients requiring support for multi-organ failure.

For the reporting period January 2015 to December 2015 there were 816 admissions to critical care.

During our inspection we spoke with two patients, four relatives and 23 staff, including junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, pharmacist staff, administrative and clerical staff and, staff from the chaplaincy department.

As part of our inspection we observed interactions between patients, their relatives and staff, considered the environment and looked at seven medical and nursing care records and, seven medication prescription charts. Before our inspection, we reviewed performance information from and about the hospital.

Critical care

Summary of findings

Overall critical care at this hospital was rated as good.

Safety of critical care was rated as requires improvement. There was limited assurance about safety. Overnight, we could not be assured medical assistance would be immediately available to provide advanced airway management before the consultant arrived. This did not meet Core Standards for Intensive Care 2013.

The environment did not meet national standards and this had not been highlighted on the critical care risk register. Guidelines for the Provision of Intensive Care Services (GPICS) state existing facilities that do not comply with HBN 04-02 should identify a program of work/time-line to establish when national standards will be met and, should note this as part of their risk register.

Infection prevention and control was not always given sufficient priority. During our inspection, we noted peeling paint, rust on radiators and broken and stained ceiling tiles in various areas across ITU and HDU.

Where daily checks were required for cleaning, storage of medicines and checking of resuscitation equipment, staff had not always signed to indicate this had been done.

However, patients were protected from abuse. Staff had an understanding of how to protect patients from abuse.

We judged that the effectiveness of this service was good. Patients received effective care and treatment that mostly reflected current evidence-based guidance, standards and best practice. Patients had a comprehensive assessment of their needs, which included pain management, nutrition and hydration and physical and emotional aspects of their care. Outcomes for patients were routinely collected and monitored, and were mostly positive.

The care provided to patients in critical care was outstanding. Patients were truly respected and valued as individuals and were empowered partners in their care.

We found the responsiveness of critical care to be good. Services were tailored to meet the needs of the individual patient with a proactive approach to understanding the needs of different groups of people.

The leadership of critical care was good. This was an innovative service with a clear vision and a strong focus on patient centred care. Staff were engaged and demonstrated commitment to delivering high quality patient-centred care.

Critical care

Are critical care services safe?

Requires improvement



The safety of critical care services at Musgrove Park Hospital required improvement.

We found:

- Medical staffing overnight did not meet Core Standards for Intensive Care 2013 (1.1.3): There must be immediate access to a practitioner who is skilled with advanced airway techniques.
- Infection prevention and control was not always given sufficient priority.
- Where the environment did not comply with national standards we did not see a long term plan to address this.
- Where daily checks were required for cleaning, storage of medicines and checking of emergency and resuscitation equipment, staff had not always signed to indicate this had been done.

However we also found:

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and we saw good opportunities for learning from adverse events.
- Performance showed a good track record and steady improvements in safety with low levels of patient harm identified.
- Staffing levels and skill mix were mostly planned, implemented and reviewed to keep patient's safe at all times. Staffing shortages were acted upon appropriately.
- Systems, processes and standard operating procedures in patient records and, the monitoring and maintenance of equipment were implemented, reliable and appropriate to keep patients safe.
- Staff had an understanding of how to protect patients from abuse.
- Staff had mostly received up-to-date mandatory training in subjects relevant to their role.

- Incidents were reported through the trust's electronic reporting system. All the staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- Between June and November 2015 there were 126 incidents reported in critical care.
- Low or no harm incidents accounted for 80% of the incidents. There were seven moderate incidents, and 17 incidents were reported as a near-miss incident. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so. One incident was graded as 'major' and recorded as one of two serious incidents occurring in critical care. There were no incidents that resulted in severe harm or death.
- The most frequently reported incident categories were 'delay in transfer', 'unsafe/inappropriate staffing levels' and, 'pressure damage acquired in critical care'.
- Between August 2014 and October 2015 two serious incidents requiring investigation had occurred. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response (NHS England, March 2015).
- Following these serious incidents we saw root cause analysis investigations had taken place. Root cause analysis is an approach for identifying the underlying causes of why an incident occurred. We requested the serious investigation reports for both incidents and saw there had been full investigations. Learning from the incidents had been recorded along with agreed actions.
- Staff reported getting feedback from incidents via email, staff meetings, during handovers and through the critical care 'take note' project. The 'take note' project, led by a band six nurse, was a learning tool which informed staff of incidents that had occurred both locally and trust wide. Senior staff told us this project was soon to be shared trust wide.
- Mortality and Morbidity meetings were held monthly to discuss patient deaths. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Minutes we reviewed from

Incidents

Critical care

meetings held between November 2014 and November 2015 demonstrated where individual reviews had taken place with evidence of shared learning and identified actions required, where appropriate.

- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- Staff we spoke with had a varying degree of understanding about duty of candour. Junior staff talked of being open and transparent with the public but could not always give examples of when it would be applied. Senior medical and nursing staff had a full understanding and gave examples of where duty of candour had been applied. For example, both during and following the investigation process of a serious incident.
- New employees of the trust were given awareness of duty of candour as part of the trust induction program. On an on-going basis, all employees completed a three-yearly update as part of the corporate essential learning.

Safety thermometer

- Critical Care (ITU and HDU) participated in the NHS safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).
- The safety thermometer results for September 2014 to September 2015 were low for falls with harm and, catheter acquired urinary tract infection (CUTI), there was a higher prevalence of pressure ulcers grade two to four, with five detected through the safety thermometer during this reporting period. Data for VTE dated October 2015 to January 2016 showed an average harm free care rate of 93%.
- Critical care had a safety dashboard on display, this meant patients and the public could see how the ward was performing in relation to patient safety.

Cleanliness, infection control and hygiene

- ITU had one side room available with negative pressure airflow control. Negative room pressure is used to prevent cross-contaminations from room to room. It included a ventilation system that generated negative pressure to allow air to flow into the room but not escape from the room, thereby preventing contaminated air from escaping the room. The isolation facility within the high dependency unit (HDU) was a two-bedded bay but this did not have airflow control. During our inspection this area was being used for an infectious patient, so the second bed had been closed.
- Intensive Care National Audit and Research Centre (ICNARC) data for the reporting period 1 July 2015 to 30 September 2015 showed critical care performed better than similar units for unit acquired Meticillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.difficile) infections. MRSA and C.difficile are infections capable of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. C.difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics.
- ICNARC data for the same reporting period for the number of unit-acquired infections in blood and unit-acquired MRSA in blood was also better than similar units.
- From December 2014 to January 2016 there had been one case of unit-acquired Meticillin-resistant Staphylococcus aureus (MRSA) colonization (not a reportable blood stream infection) and two cases of Meticillin-susceptible Staphylococcus aureus (MSSA) bloodstream infections. MSSA differs from MRSA due to the degree of antibiotic resistance.
- Throughout ITU and HDU, with the exception of one member of staff, we observed staff to be complying with best practice with regard to infection prevention and control policies. All staff were observed to wash their hands or use hand sanitising gel between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. Staff were observed to be adhering to the dress code, which was to be 'bare below elbows'.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste including the disposal of sharps such as needles and environmental waste.
- During the reporting period January to October 2015, hand hygiene audit compliance averaged at 94%.

Critical care

- Cleaning records were available in all the rooms on the intensive therapy unit (ITU) and HDU where staff could sign to indicate rooms had been cleaned on a given day. We saw where these had been mostly completed. However, staff had not always signed to indicate the toilet and washing facilities in ITU had been cleaned daily.
- During our inspection we noted peeling paint, rust on radiators and the outer casing within which emergency equipment was stored and broken and stained ceiling tiles in various areas across ITU and HDU. We were not assured these areas were cleaned and decontaminated effectively.
- Cleanliness audits for critical care averaged 95% for the reporting period January to October 2015.

Environment and equipment

- ITU and HDU were located in one department, on the ground floor close to theatres, in an old part of the hospital. The environment for both areas was small and appeared cluttered with minimal space around the bedside. Nursing staff told us they felt the environment was not always suitable for the type of patients accommodated in this area.
- A CQC inspection during September and October 2013 had identified facilities that were 'cramped, with a lack of storage facilities'. Storage facilities remained a challenge for the units. During this inspection, equipment including; clean laundry, a food reheating trolley, armchairs, a trolley and cleaning equipment were stored along the corridor between the two units. This could provide an obstruction in the event of an emergency.
- Staff used storage areas to change. Changing facilities for male staff were in a cupboard used to store stationary. Female changing facilities were used to store physiotherapy equipment.
- In 2015 a significant water leak had occurred causing disruption to the service. We saw where this had been addressed at the time of the incident. However, during our inspection we noted water stained ceiling tiles throughout the unit where leaks had occurred. The risk of substantial leaks due to the age and condition of the building and the roof had been identified on the trust risk register.
- National standards (HBN 04-02) outlines standards all new-build critical care units should comply with. Guidelines for the Provision of Intensive Care Services

(GPICS) state existing facilities that do not comply with HBN 04-02 should identify a program of work/time-line to establish when national standards will be met and, should note this as part of their risk register. With the exception of issues with the roof, the environment had not been identified on the trust risk register. We discussed the environment with the medical and nursing leads for the service. Staff considered both ITU and HDU were not 'fit for purpose' but had not been given a time-line of completion for a more suitable environment. Service leads told us this had left them feeling "frustrated".

- We observed patient-care equipment to be ready for use. We checked and noted 16 out of 17 items of patient equipment had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service.
- We observed resuscitation equipment on ITU and HDU. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw where staff had signed to confirm they had checked equipment and it was safe and ready for use in an emergency. However, checks on the defibrillators were not always carried out on a daily basis as per trust policy. Between November 2015 and January 2016 there were 20 occasions on ITU and 26 occasions on HDU where there was no signature to indicate this equipment had been checked.
- Emergency intubation equipment for critical care was available. Staff were aware of its location in the event of an emergency. Standards published by the Intensive Care Society in 2014 state that all critical care areas should have their own 'Difficult Airway' trolley. Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway. Checks on this equipment were completed by a member of the medical team. We saw where checks were not always carried out on a daily basis as per trust policy. In January 2016 there were six occasions and, to date, in February four occasions where there was no signature to indicate this equipment had been checked.
- Equipment was available for bariatric (overweight) patients, for example larger commodes, hoists and chairs.

Medicines

Critical care

- Medicines were not always stored appropriately. We looked at the clinic rooms where medicines were stored and found that the medicines fridge temperatures were not always monitored and recorded regularly. Checks on the fridge temperatures were not always carried out on a daily basis as per trust policy. Between November 2015 and January 2016 there were 13 occasions on ITU and 8 occasions on HDU where there was no signature to indicate temperatures had been checked.
- We reviewed the storage and administration of controlled drugs (CD's) on ITU and HDU. (Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation). We found them to be stored appropriately and drug records were accurately completed.
- We looked at the prescription and medicine administration records for four patients on ITU and three patients on HDU. The prescription charts were fully completed to record administration, this meant patients were receiving all their medicines as prescribed. Where medicines had not been given we saw documented evidence of the reason for the omission. Records of patients' allergies were recorded on the prescription charts.
- There was a dedicated senior clinical pharmacist allocated to critical care. However, pharmacy cover was limited to 0.2 whole time equivalent (wte) per week. Guidelines for the provision of intensive care services (GPICS) recommends the minimum staffing level of 0.1 wte each week per level 3 bed (or two level 2 beds).

Records

- Across ITU and HDU we reviewed seven nursing and medical records. Records were paper-based and held at the patient's bedside.
- Individual nursing and medical records were written and managed in a way that kept patients safe. Records were accurate, complete, legible, up-to-date and stored securely.
- In all seven records the time and decision to admit to ITU or HDU was recorded in line with the National Institute for Health and Care Excellence (NICE CG50: Acutely Ill Adults in Hospital: Recognition and response to acute illness in adults in hospital).

- Patient records were multidisciplinary and we saw where entries had been made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists and dietetic staff.
- Risks to patients, for example falls, malnutrition and skin pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.

Safeguarding

- Staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. During our inspection a safeguarding concern had been raised by staff. We observed how appropriate measures had been put in place to protect the patient.
- Staff received safeguarding of vulnerable adults training (level one) as part of their mandatory training. Completion rates for medical staff, health care assistants and nursing staff were above the trust target of 90%. Completion rates for safeguarding children (level two) were just below the trust target of 90% for both medical (87%) and nursing staff (86%). Safeguarding of vulnerable adults training (Level two) completion rates was requested from the trust but not provided.
- Executive leadership for safeguarding was provided by the Director of Patient Care in addition to, safeguarding leads for adults and children's.

Mandatory training

- Staff received training in mandatory topics such as; hospital, immediate and advanced life support, infection control and manual handling. There was no trust target for compliance with life support. Information received before our inspection showed, to date, training compliance in advanced life support was medical 100% and nursing 67%, for immediate life support medical 59% and nursing 62% and, hospital life support nursing 81%.
- The trust target for compliance with infection control and manual handling was 90%. Information received before our inspection showed, to date, training compliance in infection prevention and control was; administrative and clerical (A&C) 91%, medical 80% and, nursing 90%. Training compliance in manual handling was; A&C 72%, medical 92% and, nursing 78%.

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- A number of mandatory topics were accessed as part of the trust essential learning programme through an online learning resource. Topics included; awareness of waste; inoculation incidents; counter fraud; back awareness; dementia; equality and diversity; information governance; conflict resolution; health, safety and risk; slips, trips and falls; fire safety and; major incident. Completion rates in essential learning for medical staff, health care assistants and nursing staff were above the trust target of 90%.
- Treatment escalation plans (TEP) were included in the patient records we reviewed. TEPs outlined the level of intervention individual patients required. A 'do not attempt cardiopulmonary resuscitation record' (DNACPR) was also included in the TEP as required.
- A critical care outreach team (CCOT), based in critical care was present in the hospital at all times. CCOT provided a supportive role for medical and nursing staff when dealing with a deteriorating patient. They also provided support and training to staff in developing the skill and confidence in managing complex patients, were involved in the morning consultant-led ward round and, followed up all patients discharged to the wards.
- We saw a daily 'ward round' document in use, this included clear documentation of the ward-round, date/time, consultant leading the ward-round, and management plan. Clear documentation in the notes served as an important communication tool to the multidisciplinary team.

Assessing and responding to patient risk

- Nursing staff throughout the trust used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- Patient observations were taken and recorded at the required frequency including ventilator observations. Appropriate action was taken in response to changes in observations.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. Outcomes of assessments were reflected in the seven nursing records we reviewed.
- Staff had immediate access to an emergency tracheostomy management algorithm to support them in an emergency as recommended in the 2014 Intensive Care Society tracheostomy standards. Laminated posters were displayed at the bedside of those patients with a tracheostomy in situ. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help patients breathe.
- A tracheostomy ward round, led by a consultant intensivist in collaboration with a nurse specialist for 'head and neck', took place daily to assess tracheostomy care and improve standards both in critical care and throughout the hospital.

Nursing staffing

- Nursing staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.
- The unit used a locally developed acuity tool which was completed twice a day. Acuity is the measurement of the level of nursing care required by a patient. An acuity-based staffing tool regulates the number of nurses on a shift according to the patients' needs.
- The staffing allowed for one to one nursing for level three patients and one nurse for every two level two patients. This met the Guidelines for the Provision of Intensive Care Services (GPICS).
- The planned nursing establishment for critical care was 59.2 whole time equivalent staff (wte). As of October 2015 the actual establishment was 55.7 wte. The critical care nursing lead had identified staffing as a concern and we saw where it had been raised on the trust risk register. Staff turnover (this refers to the number or percentage of workers who leave and are replaced by new employees) for April 2014 to March 2015 was at 11%. Sickness for the same period was reported to be 7.7%. This was higher than the national average sickness rate in July 2015 of 4.4%. Current staffing rotas available at the time of our inspection showed there were seven band five registered nurses at various stages of their six-week supernumerary induction period.

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- We saw where the unit leader was awaiting start dates for three new members of staff and had also been allowed to recruit two further wte staff to support the unit whilst new staff were undertaking their supernumerary period.
- Planned nurse to patient ratios were based on the unit being 90% occupied with five level-three patients and six level-two patients. However, this was flexible and when required according to patient dependency the staffing was adjusted. On the day of our inspection we saw where staffing levels were displayed in the clinical area. Staffing levels were in line with planned levels.
- The critical care nursing leads had implemented innovative systems to address shortfalls in staffing levels or when patient dependency was such that additional nurses were required. These included; a 'text out' service to all staff who may be available to cover a shift at short notice; new starters with a minimum of six-months experience on the unit, were rostered on one 'on-call' shift per month and staff were asked to 'stand down' from shifts when patient dependency/unit activity was low. In this instance staff would agree to go home and 'pay back' the time owed at a later date.
- Staffing was planned using an electronic rota system. In order to acknowledge the skill mix availability in critical care the unit leader had applied 'rules' to the system to ensure equal numbers of skilled and new staff were available on each shift. This system ensured there were no more than two new starters (those staff who had completed their six-week supernumerary period) on each shift and, there was an equal distribution of more experienced staff available.
- Agency use for the reporting period April 2014 to March 2015 averaged at 7%, with the lowest use at 4% and highest at 11%. The lead nurse for critical care told us agency use had been higher at times and as such had been identified on the trust risk register.
- There was an effective system in place for providing an induction to critical care where agency and bank staff worked. This meant the area could be assured that agency or bank staff were suitably competent, skilled and experienced to work on either ITU or HDU. During our inspection we saw completed records demonstrating where an induction to the area had taken place.
- The critical care lead told us agency and bank staff usage was limited to employing only individuals who had worked on the unit previously or had critical care

experience. A number of bank and overtime shifts were, in the first instance, filled by staff already in substantive posts on the unit. We saw from staff rotas for November 2015 to January 2016 where critical care staff had 'picked up' extra shifts.

- There was a supernumerary clinical co-ordinator per shift across ITU and HDU. Clinical co-ordinators provided clinical nursing leadership, supervision and support.
- There were structured patient handover sessions held twice daily for nursing staff using a detailed handover checklist. This was communicated as a large team followed by a specific handover at the patient's bedside. This ensured all aspects of the patient's care and treatment were communicated effectively and included; patient risks, resuscitation status, any vulnerable patients and any changes to a patient's clinical condition or treatment.

Medical staffing

- Critical care was led by a consultant in intensive care medicine who was Faculty of Intensive Care Medicine accredited (FICM); this met with the Guidelines for the Provision of Intensive Care Services (GPICS).
- Specialist Critical Care Consultant cover was provided 8.30am to 6.30pm Monday to Friday and, 9am to 12pm Saturday and Sunday. At all other times a consultant on call was available to contact and attend within 30 minutes.
- There were eight consultants who provided a seven day, 24 hour service in critical care. During their rostered period on critical care they did not have any other clinical commitments. Consultants worked five consecutive day shifts and a maximum of three night shifts to improve continuity of patient care within the unit.
- The consultant to patient ratio on ITU and HDU did not exceed the range of 1:8 to 1:15 and met with GPICS.
- Locum use for the reporting period April 2014 to March 2015 was 0%.
- Medical trainees were available on the unit and ranged from foundation programme doctors to specialist registrars with advanced airway skills. A specialist anaesthetic registrar was present on the unit out of hours; however, they also had commitments to cover maternity. GPICS standards state there must be rapid 24/7 availability of a doctor with advanced airway and

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resuscitation skills, and Core Standards for Intensive Care 2013 state there must be immediate access to a practitioner who is skilled with advanced airway techniques.

- We discussed this with the leads of the service who confirmed an audit of specialist anaesthetic registrar activity had been completed. Results from November 2015 showed one third of the registrars activity was in maternity and, approximately once every sixth night the registrar would be needed outside critical care, this included the emergency department. For example, during our inspection the registrar was in attendance in the emergency department attending to a patient requiring advanced airway care. Were this situation to occur out of hours, we were told the on call consultant would attend within 30 minutes. We could not be assured immediate medical assistance would be available before the consultant arrived. The service leads recognised this as a risk but felt reassured that no critical incident had occurred as a direct result of this work pattern. However, this had not been noted on the risk register for critical care.
- During our out-of-hours inspection the specialist anaesthetic registrar was not available on the unit. However, nursing staff told us a junior doctor, who was, at the time, in medical handover, did have advanced airway management skills.
- Critical care operated a closed unit model with the day to day management of the patients being the responsibility of the critical care medical team. The duty critical care consultant held overall accountability. A closed unit model refers to all admission, discharge and significant management decisions of the patients within the units being made by an intensive care consultant. In a closed model, the intensive care consultants takes over the primary responsibility for the care of the patient and is ultimately responsible for all decisions made within critical care. In open models, the team who was originally caring for the patient for example surgeons keeps formal responsibility for the patient and their treatment. Closed models have been associated with reduction in mortality.
- Multi-disciplinary handover rounds occurred twice daily. We observed a well-structured approach where decisions and changes to treatment were made. A

formal structured handover was used, supported by a written plan in the medical notes to ensure continuity of care. Daily goals were written on whiteboards at every bed space.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. A trust-wide major incident plan was in place to guide staff in responding quickly and effectively to any major incident.
- An action card detailing the action to be taken during a major incident was available in ITU and HDU. Copies were displayed in staff areas and had been appropriately updated. Staff we spoke with were familiar with these plans.
- In 2015 critical care had experienced a disruption to services due to a leak in the roof. Staff discussed this incident with us and were able to describe the processes they had followed in order to deal with the incident appropriately and minimise the disruption to patient care delivery.

Are critical care services effective?

Good



The effectiveness of critical care services was good.

We found:

- Care and treatment was mostly planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patient's had a comprehensive assessment of their needs, which included pain management, nutrition and hydration and, physical and emotional aspects of their care.
- Patients care and treatment, and their outcomes, was routinely collected and monitored. Outcomes for patients were mostly positive.
- Critical care were proactive in participating in research to improve the health and outcomes of patients.
- Most staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice and were supported to deliver effective care and treatment through clinical supervision, the appraisal process and mentorship.

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- Staff worked collaboratively to understand and meet the range and complexity of patient's needs.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

However we also found:

- Local guidelines had not been monitored or reviewed to ensure consistency of practice.
- Core Standards for Intensive Care Units (GPICS) were not always met. For example, there were insufficient numbers of nursing staff with a post registration award in critical care nursing.

Evidence-based care and treatment

- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine (ICSFICM), Intensive Care National Audit and Research Centre (ICNARC) and the South West Critical Care Network performance and outcome data to determine the effectiveness and outcomes of the treatment they provided.
- We saw critical care services were adhering to local and national guidelines, for example International Standards for Neurological Classification of Spinal Cord Injury (ISNCSCI); Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar); NICE Quality Standard QS66 Intravenous Fluid Therapy in Adults in Hospital; NICE quality standard QS3 Venous thromboembolism in adults: reducing the risk in hospital and; NICE Guideline (CG103) Prevention diagnosis and management of delirium.
- Lung protective ventilation strategies were followed to reduce or prevent acute respiratory distress syndrome (ARDS); a life-threatening medical condition where the lungs cannot provide enough oxygen for the rest of the body.
- Between January and September 2015 there was 99% compliance with the Peripheral Venous Catheter (PVC) care bundle. A care bundle is a structured way of improving processes of care and patient outcomes.
- Use of other care bundles included; the ventilator-associated pneumonia (VAP) reduction care

bundle; Richmond Agitation-Sedation Scale (RASS), a medical scale used to measure the agitation or sedation level of a patient and; CAM-ICU pain, agitation, and delirium care bundle.

- We reviewed two weaning plans on the intensive therapy unit (ITU) for patients with a tracheostomy; this was following an assessment for rehabilitation by the multidisciplinary team. A tracheostomy is an artificial opening into the windpipe (trachea) and is held open by a tracheostomy tube. This helps people to breathe more easily. Weaning is reducing the amount of ventilator support a patient receives in order to facilitate them breathing independently. A ventilator is a breathing support machine.
- All patients were screened for delirium twice daily. Delirium is an acute medical condition and a common occurrence in critical care units. Patients with delirium are likely to spend longer in hospital and have an increased risk of long-term cognitive impairment or death. A review of seven sets of patient records demonstrated delirium screening had been undertaken.
- Local guidelines, policies and procedures were available to staff at the bedside and via the trust intranet. However, we found a number of guidelines used at the bedside had not been approved through the directorate governance group or, were out of date and had not been reviewed. We escalated our concerns to the unit leader and service leads. When we returned the following day, the unit leader had an action plan in place to review all clinical guidelines, including obtaining approval at governance level, over an eight-week period.

Pain relief

- Pain management in critical care followed the Faculty of Pain Medicine's Core Standards for Pain Management (2015) in relation to adult acute pain management.
- We reviewed seven medical and nursing care records during our inspection; patients were assessed in respect of their pain management. This included observing patients for the signs and symptoms of pain. Staff used a pain-scoring tool for patients who were awake and those patients who were ventilated (receiving breathing support through a tube).
- A review of seven medication prescription charts demonstrated patients were given pain relief where appropriate at regular intervals.

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- During both the nurse handover and, the multidisciplinary ward round we observed staff assessing and reviewing patients pain requirements as required.
- Where further advice or support was required staff told us they were able to access the trust Acute Pain Team.
- A band 8a pharmacist independent prescriber was available for three hours a day across ITU and HDU and, present on the multidisciplinary ward round once a week as a minimum. The pharmacist independent prescriber could independently prescribe pain medication for any condition within their clinical competence. An on call pharmacy service was available out of hours.
- Patients and relatives told us staff responded quickly if a patient appeared to be in pain or distress. One patient told us, "If I [the patient] needed painkillers they would be given within minutes".

Nutrition and hydration

- All patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- A standardised feeding plan for patients who were being fed by nasogastric tube (NG) was available. This meant there was no delay in patients being fed if a dietician was not available. A NG tube is a narrow bore tube which is passed into the stomach through the nose. It is used for short, or medium-term nutritional support.
- A Dietician was available to attend critical care three days per week in addition to referrals made at other times. This was in line with the Core Standards for Intensive Care Units (GPICS) recommendation: 0.05-0.1 wte dietician per critical care bed.

Patient outcomes

- Critical care contributed data to the Intensive Care National Audit and Research Centre (ICNARC). This meant the care delivered, and mortality outcomes for patients were benchmarked against similar units nationally.
- ICNARC data for the reporting period 1 July to 30 September 2015 showed critical care mortality performance was better than other similar units nationally. This demonstrated an improvement in mortality performance since data for the reporting

period 1 April 2015 to 30 June 2015 showed critical care mortality performance for those patients with a predicted mortality risk of less than 20% was worse than similar units nationally.

- Service leads told us, following April to June's results, a review of patient medical records had taken place. Whilst the review had concluded there were no avoidable deaths it had enabled the service to improve the coding process for this group of patients.
- ICNARC data for the reporting period 1 July to 30 September 2015 showed the unit was performing worse than similar trusts for unplanned readmissions to critical care with, six out of 235 patients readmitted within 48 hours of discharge to a ward. Data provided to us at the time of our inspection showed, for the reporting period 1 October to 31 December 2015 there had been no unplanned readmissions to critical care. However, this data had not yet been validated by ICNARC.
- The critical care service engaged, participated and contributed in the South West critical care network. This included audit activity and regular benchmarking against other Critical care services in the region. Results from October 2015 South West critical care network peer review visit were largely positive. Comments included, "the unit is well run and has clear ambitions for the future; the clinical leadership is high with good communications evident between the teams and; with good data metrics and a positive attitude to critical care there is a good culture here".
- Critical care participated in the Potential Donor Audit (PDA). PDA audit results for the reporting period April to September 2015 showed the trust as the best trust in the South West region for; approaching patients and, securing a good number of donors. Trust performance was measured using the gold, silver, bronze, amber, and red (GoSBAR) scheme with gold indicating 100% compliance. For this reporting period the trust had been rated gold/silver.
- Critical care were proactive in participating in research to improve the health and outcomes of patients. For example, the National Emergency Laparotomy Audit (2016) established to describe and compare inpatient care and outcomes of patients undergoing emergency bowel surgery in England and Wales. The Intensive Care

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Foundation 'Breathe' research study. LeoPARDS: a study evaluating the use of levosimendan in sepsis and; the ICNARC 'POPPI' study (provision of psychological support to people in intensive care).

- Local audit activity included; audit of accuracy of adult fluid balance charts; verification of death and; audit into the discharge time of critical care patients and their care following transfer to general wards. We saw audit results and evidence of action plans being created to address where improvements in performance were required. For example, medical handover prior to a patients discharge to the ward included a consultant to consultant telephone call in addition to access to an electronic patient reported-outcome (EPRO) system.
- There was a designated data coordinator to support the mandatory requirements of data collection and input for ICNARC and, a small team of part time research nurses who had responsibility for coordinating and facilitating the research studies that the unit was participating in.

Competent staff

- There were 26 out of 75 nursing staff who held a post registration award in Critical Care nursing with a further six staff due to complete the award during 2016. This did not meet Guidelines for the Provision of Intensive Care Services (GPICS) standard: a minimum of 50% of registered nursing staff will be in possession of a post registration award in critical care nursing. We discussed this with the unit leader who told us there had been problems accessing the course through the local universities and, due to the numbers of new starters the service had to limit the number of staff attending the course. We saw where this had been identified on the trust risk register.
- Arrangements for supporting and managing staff were through one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- Appraisals for the reporting period April 2015 to January 2016 were; 100% for medical staff and 90% for the remaining staff in critical care including, the critical care outreach team (CCOT). Nursing staff reported appraisals as a "useful exercise", and were given the opportunity to identify areas of learning.
- The trust had plans in place to support nurses to revalidate. Staff within the trust library supported nursing staff to develop skills in reflection for inclusion in revalidation portfolios
- CCOT provided 'at the bedside' teaching and were involved in local initiatives to improve practice. For example, structured teaching on; patient transfer, bilevel positive airway pressure (BPAP; a non-invasive form of therapy for patients suffering from sleep apnoea) and; advanced life support. Simulation training had been provided for sepsis management: Sepsis is a potentially life-threatening condition triggered by an infection. Training was also provided on the doctor and nurse inductions.
- Through funding provided by the trusts charitable funds staff were able to attend educational events provided by the European Society of Intensive Care Medicine (ESICM).
- Nursing staff developed skills and knowledge in order to become competent critical care nurses through the National Competency Framework for Adult Critical Care Nurses.
- Each week an area of clinical practice was identified as the 'weekly focus'. This involved posters in the clinical area and discussions at nurse handover. For example, the week of our inspection the focus was the changing of intravenous giving sets: a clear plastic tube used to give fluid directly into a vein.
- Critical care 'team days' were in place. This allowed for a group of staff to complete mandatory or essential training. Most staff we spoke with told us they had good access to training.
- A six-week supernumerary period was in place for all newly employed nursing staff. This allowed staff new to the unit, a period of orientation and additional training. The unit lead told us a nurse's competency would be assessed at the end of the six-week period and extended if it was felt necessary. One nurse told us "It was very well planned".
- A dedicated clinical nurse educator (CE) was available in critical care. The CE was responsible for coordinating the education of staff, training and, assessing competencies against the National Competency Framework for Adult Critical Care Nurses.
- Band five and six development programmes were in place to develop staff. The band five programme ran over a six-month period and was used to prepare senior band five staff for the band six role. The programme involved a number of activities. For example, spending time with CCOT and the research nurses, taking charge of a shift and, completing a project of their choice.

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- Clinical supervision was available in critical care. Clinical supervision is a formal process of professional support and learning that addresses individual needs of staff.
- We observed the multidisciplinary ward round used as a teaching opportunity for medical and nursing staff.
- All of the consultants working in the units had the correct competencies as defined by the Intensive Care Society.
- A revalidation process was in place with good opportunities for training for medical staff.
- A member of the medical staff had an advanced level of training in Intensive Care Echo and was in the process of teaching other members of the medical team. Echo is the scanning of the heart.

Multidisciplinary working

- There was strong collaborative working amongst the multidisciplinary team. We observed staff that were engaged and committed to delivering safe effective care. The MDT included nursing and medical staff, physiotherapists, dietician and speech and language therapists, microbiologist, and pharmacist.
- MDT ward rounds were held twice daily. We observed a ward round during our inspection. We saw a holistic approach where each individual patient's progress was discussed and included both physical and emotional aspects of their care as well as, a review of the patients discharge plan. Physiotherapists, dieticians and speech and language therapists and pharmacists did not routinely attend ward rounds, but had input into patient care when required. This was not in line with the Core Standards for Intensive Care Units (GPICS).
- In the seven medical notes we reviewed we saw evidence of daily treatment plans from the MDT and microbiology. These were clear, well-structured and allowed for effective communication throughout the MDT.
- All staff we spoke with told us that there were good lines of communication and working relationships between the different staff groups. The unit leader and service leads told us they were "proud" of the working relationships within the MDT.
- Multidisciplinary meetings were held monthly. In September 2015 funding for a clinical librarian to support staff during MDT's and other meetings was secured to perform literary searches and give staff

instant feedback and information to facilitate these meetings. Minutes we reviewed from meetings held demonstrated a MDT approach with discussion involving all members of the team.

- The critical care outreach team (CCOT) followed up patients discharged from critical care within 24 hours of the patient's discharge to the ward. This was an opportunity for CCOT to support the ward staff and, to ensure that the patients' transition to the ward had been straightforward enabling continuity of care.
- Each patient was required to receive a rehabilitation assessment within 24 hours of admission to critical care. In the seven sets of medical notes we reviewed we saw where this had taken place. However, physiotherapy staff told us they were under resourced and not always able to complete the assessments within 24 hours or at weekends.

Seven-day services

- Critical care Outreach provided a 24 hour, seven day a week service and consisted of 6.32 wte band 7 specialist nurses who had either achieved or were working towards the National Outreach Forum competencies. The service responded via a bleep to deteriorating and critically ill patients allowing earlier involvement and support from the intensive care team for the acutely ill patient.
- There was 1.2 wte physiotherapy cover for critical care. There was a daily physiotherapy service available that worked closely with critical care staff, and an on-call service operating out of hours.
- Monday to Friday a microbiology ward round took place independently of the multidisciplinary ward round. At weekends a Consultant Microbiologist was available by phone. On Saturdays microbiology staff were present in the hospital during the morning and would visit the critical care unit for a 'micro clinical round'. On Sunday, they would not visit critical care but would phone through important results and, were available to provide medical staff with advice or support if required.
- Diagnostic imaging was available on call outside normal working hours. The unit leader told us there were never any problems obtaining diagnostics or laboratory support out of hours.
- In the seven sets of medical notes we reviewed we saw where new admissions to critical care were assessed by a suitable consultant within 12 hours from the time of arrival on the unit.

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Access to information

- Information needed to deliver effective care and treatment was available to staff in a timely and accessible way. This included care and risk assessments, care plans, case notes and test results.
- We observed the use of information technology to share relevant information including diagnostic test results prior to the start of the daily morning ward round.
- The Critical Care Consultant ensured that the medical staff on the receiving ward were informed of a patient's impending discharge. A member of the medical staff would speak to a named member of the receiving team and document the key parts of the discussion in the notes. A discharge summary was completed that included key events, drugs usage, and on-going management plan.
- Nurse handover to receiving wards was delivered via telephone by the nurse currently responsible for the care of the patient. The responsible nurse would also accompany the patient to the ward. The unit leader told us a formal handover document was currently under review.

Consent and Mental Capacity Act

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
- Where patients had the mental capacity to make a decision we saw consent to care and treatment was obtained and documented in the medical notes.
- Where patients lacked the mental capacity to make a decision, we observed, in the medical notes, where staff had made 'best interests' decisions in accordance with legislation.
- During a ward round we observed the consultant respect a patient's right to make an 'unwise' decision regarding their treatment. Prior to agreeing with the patient's decision a mental capacity assessment had been completed and documented in the patient's notes.
- We observed the use of restraint for a patient who had become physically aggressive during a sedation hold. A sedation hold is when a patient's sedative infusion is stopped to allow them to wake and has been shown to reduce mortality and the risk of developing ventilator related complications. Staff had followed the trust restraint policy and a risk assessment had been

undertaken. We discussed this with the staff involved who demonstrated they had considered a Deprivation of Liberty Safeguard (DoLS) application but that it was not required at this time. Staff explained a DoLS would have been required if the restraint had continued for a significant period of time.

Are critical care services caring?

Outstanding



The care provided to patients in critical care was outstanding.

We found:

- There was a strong, visible person-centred culture demonstrated by all staff. We observed staff positively interacting with patients and, patients were treated with kindness, dignity, respect and compassion while they receive care and treatment. An example of staff going the extra mile included the marking on a white board behind the patient's bed information to enable meaningful conversation.
- All staff recognised and respected the totality of patient's needs. Patient assessment and reviews included patient's and relative's personal, cultural, social and religious needs and, ensured patients were active partners in their care.
- Staff understood the impact that a patient's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. For example, we saw the effective use of patient diaries to record the patient's journey during their time on the critical care unit.
- Feedback from patients and their family's was continually positive about the way staff treated them.
- The critical care outreach team (CCOT) were available to offer emotional support and reassurance to patients and their relatives.

Compassionate care

- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment. All the staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.

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- We spoke with two patients and four relatives and all were positive about the care they had received. One patient said “the staff have been brilliant”. A relative of another patient explained that they were very happy with the care that their relative had received since they had been admitted to intensive care. Another relative told us “staff have been very kind”.
- Patients appeared comfortable and relaxed, the atmosphere was calm and alarms were silenced promptly.
- We observed patients being treated with dignity and respect. Bed curtains were used to provide privacy during patient care and we heard a nurse ask if they were able to enter a curtained off bed space before entering.
- We heard a nurse who was caring for patients ask if they would like a blanket to ensure they were warm enough before going out onto the hospital corridor.
- A peer review in October 2015 was undertaken by South West Critical Care Network, Relatives’ feedback was gathered as part of this review. Feedback from relatives who the review team had spoken with had been exceptionally positive of the unit.
- Patient and relative feedback was collected twice yearly through the critical care patient experience survey. Responses to statements were rated on a scale of one (strongly disagree) to five (strongly agree). Between June and November 2015 responses had been received from 12 patients and 115 relatives. Responses to 10 statements were all positive with responses rated as 4.4 or above. Statements rated as five included; overall you were treated with respect and dignity, the staff on HDU worked well as a team, you were given enough privacy when treated or examined and, you were treated as an individual rather than just another patient.
- Staff told us of occasions where they had encouraged relatives to bring patient’s pets on to the unit and were now exploring the use of ‘Pet therapy’ as part of the rehabilitation process for patients.
- White boards were on the wall in each bed area. Whilst these were predominantly used to communicate treatment plans, we observed where patient’s individual preferences had been recorded for example, ‘I like to watch rugby’.
- We observed a nurse greet a relative who had arrived with their family member as they were admitted to the critical care unit. The nurse introduced themselves, took time to explain about visiting the unit, the use of the doorbell and where the relative could wait. The nurse was professional and reassuring and spoke in a calm manner.
- After discharge from hospital patients and relatives were invited to attend a meeting at the hospital as an opportunity to discuss their experience. Feedback obtained from these meetings from patients who had been admitted to critical care recorded that families were ‘kept informed’ during their relatives time on critical care and that the ‘staff always had time for the family’.
- Visitors were made welcome, visiting times were flexible and we saw how thoughtful the staff had been by providing an armchair at the patient’s bedside for relative’s who was staying for long periods to ensure they were as comfortable as possible.
- We saw how a patient was involved in their own ventilator weaning plan. The staff listened to how the patient felt about how much ventilator support they needed and when they felt they were ready for it to be reduced. We observed decisions regarding changes to the ventilator support being made in conjunction with the patient. (Ventilator weaning is gradually reducing the amount of support the ventilator gives a patient to help them breathe until they are able to breathe on their own).
- There was recognition of the impact that an admission had not only on the patient but also on the family and advice on financial and legal matters was made available on the unit once a week through a local law firm. How and when this service was available (the way it was delivered) took into account that relatives would not want to leave the hospital to get the advice, but that a patient’s admission could have a significant impact on their finances.

Understanding and involvement of patients and those close to them

- All staff recognised and respected the totality of patient’s needs. During the multidisciplinary ward rounds patient’ and relative’s personal, cultural, social and religious needs were taken into account.

Emotional support

- We saw evidence that patient diaries were an integral part of patient care on the unit. During morning

Critical care

handover the nurse in charge informed the doctors, nurses and physiotherapists which patient's had patient diaries. Feedback from meetings held with relatives and patients after discharge reported that the diaries were "very useful" and "very helpful". Patient diaries are a record of the patient's journey during their time on the critical care unit. They can be used by both patients and their relatives. The diaries can help patients 'fill in the missing gaps' from the time they were critically ill and diaries are known to improve the quality of life after discharge including preventing depression.

- We looked at a 'patient diary' that was being completed by staff, family and friends of a patient being cared for on the unit. This included drawings, messages and information about the patient's time on the intensive care unit.
- Patients and relatives were given emotional support whilst on the units. We observed friendly and open conversations between staff and visitors.
- Chaplaincy support was available on request. We spoke to two of the hospital chaplains, who explained that they and their volunteers visited the critical care unit, and spent time supporting both patients and relatives.
- The critical care outreach team (CCOT) were available to offer emotional support and reassurance to patients and relatives.

Are critical care services responsive?

Good



We found the responsiveness of critical care to be good.

We found:

- The service took into account the needs of different people, including those in vulnerable circumstances. For example, we saw the use of assistive devices and a tablet computer to aid effective communication for vulnerable patients.
- Access to care and treatment was in a timely way. Intensive Care National Audit and Research Centre (ICNARC) data results demonstrated patients could mostly access the right care at the right time.
- There were a low number of complaints about the service. Complaints and concerns were managed appropriately at local and divisional level with evidence of shared learning as a result.

However we also found:

- There was no critical care follow-up clinic available to patient's discharged from critical care.
- There were a high number of delayed discharges from critical care, 10% of discharges were delayed for a period of 24 hours or more.

Service planning and delivery to meet the needs of local people

- The Critical Care Unit provided a 24 hour emergency service for patients. Patients could be admitted from other hospitals, the emergency department, theatres or from any ward.
- The Critical care unit provided six intensive therapy beds and six high dependency beds to approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset.
- There was no critical care follow-up clinic available to patients, although this had been acknowledged as being of benefit to patients and a business case had been made for one clinic a month to be made available in the near future.
- Emotional support, for example; access to a counsellor after discharge, would currently be accessed via the patient's or relative's general practitioner. Critical care staff explained that at a follow up clinic, support could be provided or facilitated by staff that had a more detailed knowledge of the patient's intensive care journey.
- A relative area that included a quiet area, a lounge and outside space was available to relatives. Secure lockers were also provided to relatives to lock away belongings.
- Accommodation was available through the trust charity; additional details of local hotels were also provided. Relatives could stay overnight using recliner chairs in the patient's rooms if required.

Meeting people's individual needs

- The unit had a daily quiet period in an afternoon during which, where possible, patients would rest and we observed this on the unit. During this time lighting appeared dimmed and we noticed voices were lowered around patient bedside areas. This is in line with NICE Guideline (CG103) 'Prevention diagnosis and management of delirium', which recognises patients with severe illness as being at risk of delirium, and documents that interventions to prevent delirium

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include; promoting good sleep patterns by avoiding nursing or medical procedures during sleeping hours, and reducing noise to a minimum during sleep periods. Delirium is a state of mental confusion that can happen if you become medically unwell.

- Assistive devices were in use to promote an individual patient's independence. These included a chin operated nurse call system which enabled the patient who could not use a hand operated call bell, to always be able to obtain assistance, and specialised glasses that enabled the patient to view their surroundings whilst they were laying down. We observed nurses making sure that a member of staff was always near to the patient; this ensured the patient's needs were responded to in a timely manner.
- A nurse told us where they had challenged a decision made on the morning ward round regarding the prescription of a patient's usual medication to ensure their comfort. The patient had complex needs and the nurse felt the medication should be administered as part of the treatment plan to address the patient's symptoms of pain.
- The trust provided a comprehensive interpretation and translation service available 24 hours a day, seven days a week via a contracted supplier. This service included face-to-face interpreting, basic sign language, telephone interpreting and written translation. Core patient information was available in Portuguese and Polish. Information was available in different languages via a translation service. Large print and easy read was available as requested. Nursing staff told us there were no issues with accessing interpreting services. One member of staff described a very responsive service where they had been able to access this service within 30 minutes of the referral.
- A visitor information folder was available and included details of admission, visiting times, transfer to the wards, the multidisciplinary team, telephone enquiries, organ donation, glossary of critical care terminology and information leaflets for local support organisations.
- The specialist nurse for organ donation (SNOD) was employed under a service level agreement (SLA). A service level agreement (SLA) is a contract between two providers.
- Support for patients with learning difficulties was available if needed. Staff were aware of how to refer patients electronically and were aware of the trust lead nurse.

- For those patients with difficulties communicating a communication app was available via a tablet computer in addition to pictorial cards. We observed the tablet computer in use during our inspection.
- A chapel was provided at the hospital and was available to visitors, staff, patients and their relatives. A wheelchair and escort service was provided for those who needed it to attend the chapel. In addition chaplains and their volunteers were available to listen and support in the chapel quiet corner or on the unit as required
- Patients who were unable to visit the chapel would be seen on the unit. Chaplains were always available to be called into the hospital if they were needed outside of their usual working hours.
- A member of the critical care outreach team (CCOT) team was currently training to be a counsellor. The team were also awaiting directorate approval to commence a 'call for concern' initiative. This would be for relatives of patients discharged to the wards and would allow relatives to contact CCOT via telephone if they had any concerns about the patient's care.

Access and flow

- For the reporting period January to December 2015 there were 816 admissions to critical care. Of these, 86% were planned admissions following surgery.
- Between April 2014 and March 2015 bed occupancy rates were lower than the England average for nine out of the 12 months. The last time the unit was full was in July 2014. It is generally accepted that when occupancy rates rise above 85% it can start to affect the quality of care provided to patients. Bed occupancy for the reporting period April to November 2015 was below the England average for the entire reporting period.
- Escalation processes were in place to address those times when both the intensive therapy unit (ITU) and high dependency unit (HDU) were full. Processes included; assessing the acuity of patients on the unit, ensuring nursing staffing was appropriate and reviewing discharge arrangements to the wards. During our inspection we saw where this process was followed in order to accommodate an admission from the emergency department.
- Discharges from critical care to a general ward must occur within four hours of the decision. Between January 2015 and December 2015 there were 459

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delayed discharges of four hours or more from critical care, 10% of these discharges were delayed for a period of 24 hours or more. Critical care leads told us this was largely due to patient flow throughout the hospital.

- Intensive Care National Audit and Research Centre (ICNARC) data from 1 July 2015 to 30 September 2015 showed the number of out of hour's discharges from critical care was five out of 235 admissions and better than other units nationally. Current data for the reporting period 1 October 2015 to 21 January 2016 showed an upward trend in out of hour's discharges with 24 out of 311 discharges occurring between the hours of 10pm and 7am. Discharges out of hours, for example at night, have been associated with an excess mortality and patients find it unpleasant to be moved from critical care to a ward outside of normal working hours.
- ICNARC data from 1 July 2015 to 30 September 2015 showed the rate of non-clinical transfers out of critical care was similar to those of similar units. (A non-clinical transfer is when patients are moved to a critical care unit in another hospital due to lack of beds. Clinical reasons would be for different specialist care, such as treatment for patients with severe burns). Current evidence and guidance indicates patients transferred to other critical care units for the same type and level of care spend longer in hospital overall and have poorer outcomes. Current data for the reporting period 1 October 2015 to 21 January 2016 showed a downward trend with no non-clinical transfers out reported.
- Between 1 July 2015 and 30 September 2015 there was a low rate of patients readmitted to critical care (6 out of 235). A low rate of readmissions indicates patients were discharged at an appropriate point in their treatment and with suitable support.
- Between January and December 2015 the number of elective operations cancelled due to lack of ITU or HDU beds was 16.
- The decision to admit to ITU or HDU was made by an Intensive Care consultant together with the consultant or doctors already caring for the patient.
- Patients should be admitted to Critical care within four hours of the decision to admit. We reviewed seven sets of medical notes and saw where the patient had been admitted to ITU or HDU within four hours of making the decision to admit. We asked the trust for the number of admissions to critical care during the last year that had met this target, this information was not supplied.

Learning from complaints and concerns

- Between November 2014 and November 2015 three formal complaints were received in critical care. We discussed complaints with the unit lead who was able to describe the issues identified in each of the three complaints. They told us complaints were usually responded to via letter but that in the past meetings with the complainant had been arranged.
- Staff would speak to anyone raising a complaint at the time they raised it. Senior managers were also available to talk to anyone with a concern or complaint. The aim was to try and resolve the problem or complaint at the time it was raised.
- Complaints were discussed at ward meetings, multidisciplinary meetings and local and divisional governance forums where learning points would be identified. Minutes we reviewed from these meetings showed where individual complaints had been discussed.
- We saw details of how to make a complaint or raise concerns in poster and leaflet form displayed in the clinical area and the relative's area.
- As part of the ABCDE assessment of new admissions to critical care, the team had added F (for family) to remind staff to communicate with the family about any concerns or worries they may have. The Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach is a systematic approach to the immediate assessment and treatment of critically ill or injured patients.

Are critical care services well-led?

Good



The leadership of critical care was good.

We found:

- The leadership for critical care was strong and empowered all staff to strive to deliver a good service. Staff were engaged and demonstrated commitment to delivering high quality patient-centred care.
- There was a vision and strategy for this service of which patient safety was at the centre, this aligned to the vision and strategy for the trust.

Critical care

- There were processes in place to manage and evaluate current performance.
- The governance framework in place supported the delivery of patient care and included involvement of all staff within critical care. For example, local initiatives ensured learning was shared across the multidisciplinary team.

However, we also found:

- There was not always an effective process in place to manage current risks. Issues identified during our inspection had not been highlighted on the service risk register.

Vision and strategy for this service

- The leads for critical care had a clear vision for the service that included providing a caring and safe environment for patients and their families. Leads described a vision of moving forward with a new build that was fit for purpose and able to cope with an increase in capacity that included a level one facility. Level one care was provided for those patients at risk of their condition deteriorating, or those recently relocated from higher levels of care. We were told capacity was increasing at a rate of 10% year on year. Leads felt the trust supported this vision but due to the financial position of the trust they could not see when this was going to happen.
- Critical care services aligned to the trust vision which was 'to put our patients first by working as one team; leading and listening; and striving for the best. Together, we make the difference'.
- Throughout critical care all the staff we spoke with described what was important to them when delivering their day to day work. Examples included; delivering good patient care, working as a team and respecting each other.
- Service leads were proactive in collecting quality data to support operational and clinical decisions in order to evaluate clinical care and benchmark against other critical care units.

Governance, risk management and quality measurement

- There was a governance framework in place to support the delivery of patient care. Opportunities to assess,

review and evaluate care were provided through regular multidisciplinary team meetings, mortality and morbidity meetings, directorate governance meetings, and a systematic approach to clinical and internal audit.

- Minutes of the meetings we reviewed demonstrated a multidisciplinary attendance and a shared responsibility for governance. All the staff we spoke with were able to give examples of where changes to care delivery had been made as a result of an incident, complaint or following a review of the service through clinical audit.
- Local initiatives, for example, the 'take note project' and 'raising standards project' ensured learning was shared across the multidisciplinary team. During the week of our inspection particular focuses included; changing of intravenous fluid lines and close observation of mouth tapes used to secure a tracheal tube. A tracheal tube is a tube that is inserted into the windpipe to assist a patient to breathe.
- Critical Care had eight identified risks recorded on their risk register. These included compromised patient care due to lack of knowledge and skills of the nurses on each shift, risk of substantial leaks due to the age and condition of the building and the roof, high percentage of temporary nursing staff usage, age of specific ventilator equipment, use of electronic paper records in ward areas, financial overspend, high incidents of pressure damage and continued use of non-specialist critical care beds. Senior service leads were aware of these risks and were able to demonstrate to us actions they had taken to mitigate their impact. These included; a number of changes to the provision of nurse staffing, the implementation of the clinical nurse educator and, the use of safety projects to highlight areas of concern.
- However, whilst the service leads were aware of further issues we identified during our inspection, these had not been raised on the risk register for critical care. These included; the number of clinical guidelines we found that had not been approved or reviewed at directorate governance level, medical staffing overnight, infection control issues identified as a result of the environment, and areas of non-compliance with the Core Standards for Intensive Care Units (2013).
- Service leads were aware of these issues; a business case had been submitted for the provision of a 'follow-up' clinic for patients discharged from critical care and an immediate plan had been put in place to review all policies, procedures and clinical guidelines used throughout critical care. The environment

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remained service leads biggest challenge. They were very aware of the unsuitability of the environment but were not aware of a long term plan for when this would be addressed by the trust.

Leadership of service

- The senior leadership team consisted of a clinical director, clinical lead, nursing leads, as part of a job share, and a divisional manager. Nursing and medical staff within critical care who we spoke with were all aware of the leads for the service and consistently described leaders who were helpful, listened and were approachable.
- The senior leadership team were passionate about delivering high quality safe patient care and spoke with pride about a multidisciplinary team that shared that focus.
- Members of the local leadership team were visible. There was clear nursing and medical leadership by staff who had the relevant skills, knowledge and experience to run the service. All the consultants who worked on the unit were Faculty of Intensive Care Medicine accredited (FICM). There was an identified lead nurse at band 8a matron level who had overall responsibility for the nursing elements of the service, and a supernumerary clinical coordinator on duty 24/7.

Culture within the service

- All the staff we spoke with demonstrated passion and commitment to the care of their patients and we saw a culture centred on the needs and experience of patients and their families.
- We observed effective team working in critical care and an obvious mutual respect amongst staff. All the staff, including medical, nursing and allied health professionals we spoke with told us they felt proud of working for the trust and enjoyed working within critical care. We observed staff working well together and could see staff were supportive of each other.

Public engagement

- Critical care proactively sought patients and their family's views and experiences to shape and improve the services and culture through, local feedback survey's and patient support groups.

Staff engagement

- We spoke with 23 staff from a variety of roles. All staff were engaged, felt able to raise concerns and felt empowered to suggest new ways of working within their areas.
- The trust recognised the hard work and contribution of their staff and publicly said thank you through their 'going the extra mile' (GEM) awards and the 'Musgrove awards for tremendous achievement' (MAFTA). At the time of our inspection staff within critical care had received, or been nominated for, both awards.
- We saw many examples of how staff were kept informed of developments within the service. For example; multidisciplinary meetings, posters, email and through medical and nursing handover.

Innovation, improvement and sustainability

- All staff within critical care were focused on continually improving the quality of care they delivered.
- We saw the use of a number of initiatives to mitigate the risks identified as a direct result of previous low staffing levels and skill mix. These included; banked Hours; clinical supervision; an on call system; the appointment of a Practice Educator and; the band five and six development programmes.
- Local safety projects were in place to highlight current incidents and areas of concern and included the 'take note project' and, 'raising standards project'.
- Critical care services were actively involved in a number of research projects, demonstrating their commitment to continuously striving to improve care delivery.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology services provided by Taunton and Somerset NHS Foundation Trust are provided at Musgrove Park Hospital. There are a total of 42 maternity beds and the trust reported 3314 babies born from January 2015 to December 2015.

Services available to women included home birth, a consultant led nine-bedded Labour Ward, the Bracken Birth Centre which was a four bedded midwifery-led birthing unit with four postnatal beds, antenatal clinics, a fetal medicine clinic and Willow Ward which was a postnatal inpatient ward with 12 beds. Antenatal inpatients services were provided on Fern Ward which had 12 beds and included an antenatal day unit and Triage for antenatal patients.

Community Midwives (CMW) were employed by Taunton and Somerset NHS Foundation Trust. They worked in two teams across a wide geographical area providing midwifery care and a home birth service. The teams provided care in partnership with general practitioners (GPs), Health Visitors and children's centres. They also provided an on-call service for the midwife-led birth unit at the Mary Stanley Midwifery Led Unit at Bridgwater Hospital which was not covered by this inspection.

There were gynaecology inpatient beds provided on Hestercombe Ward which was a mixed surgical ward, a gynaecology outpatient area, and an early pregnancy assessment centre (EPAC). Emergency gynaecology patients were seen on the Surgical Assessment Unit (SAU). Some terminations of pregnancy for fetal abnormalities

were carried out within the gynaecology service; however, the majority of terminations of pregnancies were outsourced to another provider which was not covered by this inspection.

During the inspection we visited all the wards and departments relevant to both services. We spoke individually with 42 staff including managers, medical staff, midwives, nurses, maternity support workers, domestic assistants and clerical staff. We held focus groups for both nurses and midwives where they were able to express their views as a professional group. We spoke to 18 patients and families and reviewed 18 sets of records and 14 prescription charts across both services, along with information requested by us and provided by the trust.

Maternity and gynaecology

Summary of findings

Overall, maternity and gynaecology services at Musgrove Park Hospital were rated as good.

The safety of maternity and gynaecology services were rated as requires improvement, with effectiveness, caring, responsiveness and leadership rated as good.

The maternity service provided an average ratio of one whole time equivalent (WTE) midwife to 31 births, which was below the national standard of one midwife to 28 births.

Anaesthetic staffing out of hours did not meet the guidance of the Association of Anaesthetists of Great Britain and Ireland (AAGBI); this states that a duty anaesthetist must be immediately available on Labour Wards 24/7 and that there should be a minimum of 12 consultant anaesthetist sessions per week.

Where daily checks were required for cleaning and checking of emergency and resuscitation equipment, staff had not always signed to indicate this had been done.

Rates of compliance with appraisals, safeguarding and mandatory training including skills and drills training for midwives were below the trust targets.

Frequently occurring incidents were not always reported.

Midwifery staff had not received training in the care of the critically ill woman and anaesthetic recovery in line with current guidance, however systems were in place to ensure women having general anaesthetic received suitable care during recovery.

Some maternity guidelines were not compliant with current evidence based guidance, however plans were in place to address this.

The normal birth, home birth, overall caesarean section and instrumental delivery rates were all better than the national average. The average waiting time for women waiting for epidurals was less than 30 minutes. The maternity service had achieved UNICEF Baby Friendly stage three accreditation, and breastfeeding statistics

for initiation within 48 hours of birth were higher (better than) the trust target. The service had introduced a range of care initiatives that had been successful in reducing the still birth rate.

The care provided to patients in maternity and gynaecology services was good. Without exception, patients and their families said they had been treated with kindness and respect and described staff as caring.

Women were given a choice of place of birth in line with national guidance. Services were arranged to meet women's needs with a range of specialist clinics and midwives to support them.

There was no dedicated elective caesarean section list which could lead to patients facing delays.

The emergency gynaecology service was fragmented.

There was a clear vision and strategy in place for the development of the service and areas of improvement within the governance process had been identified and were being implemented.. A staff leadership programme was available and staff described a culture of good teamwork and supportive colleagues..

Service leads had an awareness of issues highlighted within the "Safe" domain in relation to staffing, mandatory and safeguarding training, anaesthetic cover for Labour Ward and incident reporting and were making slow progress towards resolving these issues.

Senior midwives in maternity were aware of a difference in status to other staff of the same grade in the other parts of the hospital. Band seven staff were not always supernumerary in comparison to other hospital staff of the same grade which affected their ability to support more junior staff.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement



The safety of maternity and gynaecology services at Musgrove Park Hospital required improvement.

We found:

- The maternity service provided an average ratio of one WTE midwife to 31 births, which was below the national standard of one WTE midwife to 28 births; however the service was still able to provide one to one care in labour to the majority of women.
- Anaesthetic staffing out of hours did not meet the guidance of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) which states that a duty anaesthetist must be immediately available on Labour Ward 24/7 and that there should be a minimum of 12 consultant anaesthetist sessions per week.
- Where daily checks were required for cleaning, and checking of emergency and resuscitation equipment, staff had not always signed to indicate this had been done.
- Safeguarding and mandatory training rates, including skills and drills training for midwives were below the trust targets.
- Service leads stated that frequently occurring incidents were not always reported.
- There was no audit of water temperature in the birthing pools.
- Midwifery staff caring for the high dependency women had not received additional training in the care of the critically ill women in line with guidance from the Royal College of Anaesthetists 2011.
- Midwifery staff had not had anaesthetic recovery training and competency assessment. This did not comply with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia. The trust had systems in place to mitigate this, which ensured women were not placed at risk.

However, we also found:

- There was an effective use of Maternity Early Warning Scores (MEWS) and appropriate escalation for women who were identified as being at risk.
- There was adequate consultant obstetric cover in the delivery suite at 60 hours a week which was in line with Royal College of Obstetricians and Gynaecologists RCOG guidelines (2007).

Incidents

- The organisation had a clear incident reporting policy in place that identified staff responsibilities. Staff understood their responsibilities to raise concerns, record, and report safety incidents, concerns and near misses. However, in a report to the Governance Committee of 14 May 2015, service leads stated that “it is however widely felt that some types of issue are not reported because they occur frequently, for example, anaesthetist availability, delay to theatre because theatre one in use, delay to elective section list.” Staff we spoke to felt that they did not always have enough time to report incidents and did not always receive feedback on incidents that had been reported, for example; when reports had been made about staffing concerns due to high work load.
- From June 2015 to November 2015, there were 418 incidents reported. The majority (71%) of the incidents were no harm or low harm incidents and 28% were classified as minor. At the time of our visit the trust had 67 open incidents, which the trust were still investigating. All apart from one incident had been open for less than 2 months.
- The trust reported six serious incidents to the NHS strategic executive information system (STEIS) between October 2014 and September 2015. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response (NHS England, March 2015) We reviewed the root cause analysis (RCA) in relation to one of the reported serious incidents and found actions to be appropriate. We saw that the Induction of Labour Fetal Monitoring guidelines had been changed as a result of recommendations from this RCA, demonstrating a culture of learning from incidents.
- Members of the governance team reviewed all incidents daily. Outside of normal working hours, reported serious

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incidents were reviewed by the on-call Supervisor of Midwives to check that no immediate action was required. We were able to see evidence of action plans being implemented, reviewed, and updated.

- There were multiple routes for staff to obtain feedback of lessons learned including learning boards on the wards, a weekly summary of incidents circulated to all staff via email and a safety briefing at every handover, which included immediate learning and actions from serious events. Governance staff also provided a monthly incident report with themes and actions. These briefings were stored in a safety folder on every ward and were available for staff to read.
- Multi-disciplinary maternity and perinatal mortality and morbidity meetings were held quarterly and we reviewed minutes from these meetings, which showed that actions were appropriate.
- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- The majority of staff we spoke with demonstrated that they understood the duty of candour and were able to give an example of when the process had been used within their service, however, two of the medical staff were unable to give examples of when it would be applied.

Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system of reporting on harm free care. Data was collected on a single day each month to indicate performance in key safety areas. The areas of harm for which they recommended reporting were: perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from the baby and psychological safety. Also included were admissions to neonatal units, and babies having an Apgar score of less than seven at five minutes (The Apgar score is an assessment of overall new born well-being). This is a system of reporting on harm free care specific to maternity services.
- The average maternal infection rates from March to December 2015, were higher (worse than) the average

values for all organisations that participate in the scheme at 10.5 per 1000 against 5.9 per 1000. However, the organisation performed a retrospective audit of septic women in October 2015 and introduced a new sepsis guideline and proforma together with the introduction of a sepsis six trolley which we saw on Labour Ward. Staff will perform a repeat audit in the coming months to monitor the effectiveness of the new process.

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. The safety thermometer captures information on the number of pressure ulcers, venous-thromboembolisms (blood clots), falls and catheter urinary tract infections. The maternity and gynaecology service participated in the NHS safety thermometer and collected the data. We noted that there had not been any reported incidents in relation to the safety thermometer since March 2015, so 100% harm free care had been achieved for this period.

Cleanliness, infection control and hygiene

- Clinical areas were visibly clean and there were ample hand gel dispensers available at the entrance to wards and all around the unit, with instructions on how to cleanse hands. We observed staff following good hand hygiene practices and most staff followed bare below the elbow practices. Staff had access to, and were seen to use personal protective equipment such as gloves and aprons.
- Hand hygiene audit results for October 2015 were 100% for Willow Ward, Bracken Ward, Labour Ward and Antenatal Clinic. For gynaecology Hestercombe Ward was 90% and surgical assessment unit (SAU) 73% both below the trust requirements. The trust had introduced measures to improve compliance with hand hygiene audits including support from specialist staff and continued auditing and reporting.
- The second (old) theatre on the Labour Ward was old with cracked and stained ceiling and staff told us it was difficult to keep clean, this was on the maternity risk register. However, the theatre was rarely used and was to be decommissioned as part of the quality improvement plan.
- Cleaning audits results for October 2015 for maternity for Willow Ward and Labour Ward were 99%, Fern Ward

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97% and Bracken Ward 96%, all of which met the trust's requirements. For Gynaecology, Hestercombe Ward was 93% and SAU 96% which were both slightly below the trusts requirements.

- HOUDINI (a method of risk assessment to check the clinical need for a catheter) stickers were in use on Hestercombe Ward as part of on-going indwelling catheter care plans.
- All rooms on Hestercombe Ward were en-suite and had blood pressure machines for individual patient use.
- There was no sluice or macerator on Fern Ward. Staff told us they disposed of urine samples down the toilet, and placed used disposable bed pans in yellow clinical waste bags, these were stored appropriately.
- Community midwives used bio bins for clinical waste and disposal of placentas; this had been found to be an effective method of disposal of waste at home births.
- We did not see evidence of labelling equipment when cleaned to show it was ready for use. This meant that staff would not know that equipment they were using was clean.
- We obtained the weekly day and night-shift cleaning rotas for Labour Ward for the week commencing 18 January 2016. Two out of the seven nights there was no ward assistant and the tasks for those nights were unsigned for. During the day around half of the tasks were unsigned, for example; on Wednesday 20th and Saturday 23rd January 2016 the cleaning tasks for the patients bathroom was not signed as completed.

Environment and equipment

- The maternity environment was documented as a risk on the directorate register as it was too small for the current level of activity and which was described in the trust's Quality Improvement Plan as "not fit for purpose". Fern Ward was being used as a day care and triage area, induction of labour and inpatient unit, patients we spoke to mentioned that the facilities were cramped and privacy was sometimes difficult. This had been highlighted as an issue since 2012 and work was in progress to improve the environment.
- The second (old) theatre on Labour Ward was rarely used because of infection control concerns and was due to be decommissioned as part of the quality improvement plan. One of the Labour Ward rooms was being converted into an abnormal delivery room which meant the number of delivery rooms on Labour Ward will be reduced when the work is complete. There was a

general lack of storage facilities throughout the unit. We saw that the corridors between Bracken Birthing Centre and the rest of the unit were used as a storage area for equipment and filing cabinets. We found equipment stored in the corridor on Labour Ward presenting a potential hazard for emergency access for women. On Willow Ward there was a lack of storage space with furniture from the discharge lounge moved into the clean utility area when not in use.

- There was no dedicated recovery area for the Labour Ward theatres. Following procedures, patients would be taken to a labour room to be recovered, which the Governance Committee had acknowledged to be inefficient. The Labour Ward was equipped with suitable resuscitation equipment.
- Doors to gain entry to the ward areas were locked and staff gained entry via a swipe card system. CCTV cameras were in use in on all entry and exit doors. The cameras and door access were controlled by Labour Ward staff out of hours.
- Staff told us that Emergency buzzers were located in Bracken Birth unit which were linked to Labour Ward.
- An adult resuscitation trolley for maternity was located on Labour Ward. A process was in place for daily checks that equipment was sealed and in date. Out of the 27 days of checks so far in January there were signatures missing for four days. We found three items out of date, we highlighted this to staff and they were changed immediately. All other wards across the unit had emergency equipment including; a bag and mask, oxygen and suction equipment. Staff we spoke to knew where the nearest trolley was located. On early pregnancy assessment unit (EPAC) there were clear signs directing staff to the nearest available trolley on Ward 9.
- There were five neonatal resuscitaires located throughout the maternity unit. The checking and documentation for these was inconsistent with six days out of 27 so far in January; missing a daily check signature for Willow Ward and five out of 27 days missing for one of the Labour Ward resuscitaires. Staff would not be assured that a resuscitaires was fit for purpose prior to use. Senior staff told us that midwives would risk assesses the women on Labour Ward and would decide whether a resuscitaires was needed in the room for delivery. There were no plans to increase the number of resuscitaires and there had been no reported incidents from a lack of resuscitation equipment.

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- Within the ward areas, emergency equipment bags had items appropriately packaged, stored and ready for use. Epidural trolleys were found to be clean and well stocked.
- The anaesthetic machines in both theatres were checked daily and documented accordingly, the theatre trolleys were visibly clean and the equipment and supplies were in date.
- Equipment was available for bariatric (overweight) patients, for example larger commodes, hoists and chairs.
- Cardiotocograph (CTG) machines were available for women whose babies needed monitoring in labour and these were clean and portable appliance tested (PAT). Real time electronic display of the output of these CTG machines was also displayed in the Labour Ward staff office. All other equipment observed had in date PAT stickers demonstrating when the equipment was next due for service. A register was in use to confirm all equipment was serviced.
- Women who chose to have a home birth were encouraged to have a tamper evident sealed pack including compressed Entonox gas and emergency drugs. Staff delivered these directly to their home address in order to ensure availability of drugs and prevent staff having to carry heavy equipment. This process had been risk assessed as safe. Community midwives had been issued with personal safety devices and mobile phones, however, staff told us that the phones were not always serviceable due to loss of signal which caused communication problems.
- Birthing pools were available on Labour Ward and Bracken Birth Centre. We reviewed the trust's Water Birth policy which included cleaning of the equipment and maintenance of water temperatures prior to, and during birth. However, there was no audit of water temperatures which meant that babies may be born into water that is too hot or cold. We raised this with service leads who told us that this will be added to the audit programme. There were emergency evacuation procedures to evacuate a mother from the birth pool in case of an emergency. Training had been given to staff supporting women having a pool birth and emergency drills had taken place to embed practice.
- Emergency drugs were stored in sealed drawers on the resuscitation trolley and in sealed emergency bags on the delivery suite.
- Controlled drugs had been checked according to trust policy in all areas; however, the Labour Ward had no dedicated pharmacist and no regular pharmacy audit.
- Intravenous fluids (IV) were stored in a patient area on Fern Ward and in an unlocked cupboard on Willow Ward. This was escalated to ward managers and quickly resolved. On the SAU, IV fluids were stored appropriately, however IV antibiotics were stored in an unlocked room.
- We reviewed 14 prescription charts in total, two charts on the Labour Ward and five on the gynaecology wards and seven on the antenatal ward. All charts had signed and dated prescriptions; allergies were documented and were legible.
- An external clinical review of the service was undertaken at the end of 2015, triggered by an ongoing medicines management incident that was referred to the Nursing and Midwifery Council (NMC). The report's findings had not yet been published. We saw evidence of regular audits of medicines prescriptions and administration.

Records

- Records were kept securely in closed cupboards in all areas. The women using the service were provided with their own set of care records to bring to the hospital.
- We reviewed 18 sets of notes which included five on Willow Ward, two on Labour Ward, five on Hestercombe Ward and six on the antenatal ward, Records were accurate, complete, legible, up-to-date and stored securely.
- Child health records, known as 'Red Books', were distributed to mothers for each new-born baby after the new-born and infant physical examination was completed.

Safeguarding

- Safeguarding policies and procedures were up to date and included relevant guidance and legislation. A stand-alone female genital mutilation (FGM) policy for both women and girls was developed by the obstetric lead for FGM, with input from the Juniper team, a team dedicated to the support of women and girls in

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vulnerable circumstances that provide a resource for the wider service with regards to child sexual exploitation and safeguarding. Child sexual exploitation was included within the safeguarding policies.

- Safeguarding within Maternity was part of essential learning. Safeguarding had three levels of training; level one for non-clinical staff, level two for clinical staff and level three for staff working directly with children and young people. Training was online and staff were responsible for accessing this. Completion rates for safeguarding training up to level two were above the trust target of 90% for all staff within Maternity and Gynaecology.
- The trust was unable to access level three safeguarding training because the Local Safeguarding Children Board was unable to provide places. This was on the trust's risk register and they tried to mitigate this by enhancing the Level two e-learning with an additional four modules covering domestic abuse, fabricated or induced illness, sexual exploitation and female genital mutilation. At the time of the inspection, 54% of maternity staff had completed all four of the modules which was below the trust target of 90%. The trust planned to achieve 90% compliance with Level three training by the end of July 2016.
- Staff we spoke to were clear about their responsibilities and were able to describe an alert system on the inpatient records if a safeguarding concern had been raised.
- Gynaecology staff were able to give an example of a recent safeguarding referral and understood their responsibilities with regards to FGM.
- There was a midwife appointed trust wide for maternity safeguarding.
- There was evidence of multidisciplinary working with the paediatric team and health visitors around safeguarding.

Mandatory training

- A practice development midwife was employed who had responsibility for organising specialist training. Midwifery staff were responsible for booking their own mandatory training days using an online system. However, this system meant that it was difficult to track staff compliance with training, supervisors of midwives checked staff's compliance during their annual review. The lack of accurate data was confirmed when the

mandatory training data initially supplied by the trust was found to be out of date and required amendments. Service leads told us that they had asked for access to the system to ensure they had more accurate data.

- Midwives completed three mandatory study days per year which included two update days and one skills and drills day, which covered obstetric and neonatal emergencies. Data provided by the trust for December 2015 showed that 67% of midwives had attended the midwives study day including CTG interpretation and 52% had attended the midwives skills drills day. Overall, 73% of midwives have had CTG training via either the study day or the K2 package.
- There was a plan in place to deliver 90% compliance with mandatory training by September 2016. This was managed via the Maternity Governance Committee and overseen by the Trust Performance Assurance Framework (PAF) process.
- Data showed 19% of medical staff had completed the skills drills day. The trust identified that some medical staff had completed training at other trusts and had captured this data. This data showed that 57% of medical staff had been trained.
- Other mandatory training included a study day for manual handling and a new-born feeding day, attendance was 29% for maternity support workers and 60% for midwives.
- All midwives and obstetricians were given access to an external e-learning training package called 'K2' which would support the skills of CTG interpretation and obstetric emergencies. Data provided by the trust informed us that 43% of midwives and 66% of doctors of staff had completed the package.
- A number of mandatory topics were accessed as part of the trust's essential learning programme through an online learning system. Topics included; awareness of waste; inoculation incidents; counter fraud; back awareness; dementia awareness training; equality and diversity; information governance; conflict resolution; health, safety and risk; slips, trips and falls; fire safety and major incident. Completion rates in essential learning for midwives staff was 88.8% as of December 2015 which was slightly lower (worse than) the trust target of 92%.
- The trust target for compliance with infection control and manual handling was 90%. Information received

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before our inspection showed to date training compliance in infection prevention and control was 88% across all staff groups in maternity. Staff within EPAC were 100% compliant.

- Newly qualified midwives had a comprehensive training programme to complete in their preceptorship period. Progression to the next grade was dependant on the completion of this.
- We were told that the multi-disciplinary skills and drills training would continue in April 2016 with four additional midwives currently in training to deliver the PROMPT (Practical Obstetric Multi-Professional Training) training, which they would deliver with two of the obstetricians.
- Service leads confirmed that mandatory training had been cancelled in December 2015 and during some periods of peak demand or short staffing.

Assessing and responding to patient risk

- The World Health Organisation (WHO) surgical checklist; five steps to safer surgery (designed to reduce the number of surgical errors) was in place. We observed completion of the checklists and did not find any concerns. The trusts own audits of completion of surgical checklists from October 2014 to September 2015 demonstrated average compliance with the trusts target of over 95%. Theatre teams performed “safety huddles” where all members of the theatre team met together for elective caesarean sections to ensure all important details of a patient’s care were known to them.
- Nursing staff throughout the trust used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature, respirations and heart rate. Early warning scores have been developed to enable early recognition of a patient’s worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. In gynaecology NEWS was used together with the surviving sepsis pro-forma. Sepsis is a potentially life-threatening condition triggered by infection. We checked five sets of notes and found these had been completed and scores calculated, with evidence of appropriate escalation where required.
- In maternity services, the Maternal Early Warning Score (MEWS) was used to assess the health and wellbeing of

women who were identified as being at risk. We checked 13 sets of notes and found these had been completed and scores were calculated in all but two cases.

- Staff caring for the high dependency women had not received additional training in the care of the critically ill women. This did not follow the best practice guidance, ‘Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman.’ (The Royal College of Anaesthetists 2011). However, senior staff told us that the critical care outreach team were available to support staff looking after women who needed high dependency care.
- Staff received updates in caring for women whose condition was deteriorating, but had not had anaesthetic recovery training and competency assessment. This did not comply with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia. However, we were told that an appropriately trained recovery nurse would be called from main theatres to recover women undergoing general anaesthesia and if no staff were available the anaesthetist would stay with the patient until they were fully recovered.
- Intentional rounding is a structured process where staff on wards carry out regular checks on patients at set intervals which help to ensure all patients receive attention on a regular basis. We observed a midwife performing ‘intentional rounding’ including checking that the patient had a name band, that the cannula site was healthy (a cannula is a small tube placed into a vein and is used to put fluids or medicines straight into the bloodstream), that the patient had received all prescribed medications that were on her drug chart and ensuring that MEWS scores had been escalated appropriately.
- Venous thromboembolism (VTE) risk assessments, which are blood clots in the deep veins of the leg, were consistently completed. All of the five gynaecology notes, and 12 of the 13 maternity notes were correctly documented.
- Maternity was included in the Sign up to Safety scheme which led to a retrospective audit of cases of sepsis and the introduction of a sepsis trolley. We reviewed the notes of a patient being treated on Labour Ward for suspected sepsis and we found that prompt action had been taken when MEWS triggered the sepsis protocol.

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Midwifery staffing

- Data from the maternity dashboard informed us of an average midwife to birth ratio of 1:31 from April 2015 to December 2015, this was below the RCOG (Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour) recommendation of 1:28. The trust had identified a shortfall of 6.6 WTE midwives following a BirthRatePlus staffing review in July 2015 and was actively recruiting band 5 and 6 midwives plus a band 7 antenatal ward manager. During our visit the BirthRatePlus staffing acuity tool was being repeated and had begun to be used for the next three months. A review of the findings from BirthRatePlus was planned for June 2016. This was a tool used to calculate midwifery staffing levels based on the ward activity and needs of the women.
- Inadequate midwifery staffing levels was documented on the directorate risk register. This risk had been regularly reviewed, was included on the quality improvement plan and had led to the Birth Rate Plus acuity tool being used.
- NICE NG4 Safe midwifery staffing recommends that organisations use a “red flagging” system to highlight critical staffing incidents. The service is currently unable to operate this system due to the recent implementation of a new IT system and plans to commence in April. This meant that the service may not be aware of the warning signs that something may be wrong with midwifery staffing and then take action.
- Staffing was planned using an electronic rota system. In order to acknowledge the skill mix availability, the workforce planner had applied ‘rules’ to the system to ensure correct numbers of skilled and new staff were available on each shift. The service did not use agency staff. Unfilled shifts and sickness were covered by a small pool of bank staff or permanent staff working additional hours.
- The service designated a senior member of staff to be “bleep holder” for the maternity unit. This individual could respond to short notice sickness or skill mix concerns by using staff flexibly within the unit to cover times of peak workload. This allowed the service to mitigate the risk of a shortage of staff, and one to one care in labour was provided to the majority of women. This meant that other areas could be left short staffed and occasionally Bracken Birth Centre would be closed to allow staff to cover Labour Ward, Data supplied by the trust informed us that Bracken Birth Centre was closed for deliveries once between April 2015 and December 2015.
- Labour Ward had senior midwife co-ordinators to manage the ward on a daily basis. The co-ordinator in charge should not be directly responsible for woman in labour due to managerial duties. During our visit we saw that the coordinator was also caring for women on Labour Ward due to increased activity. One member of staff told us that this was a regular occurrence. We also observed specialist midwives, community midwives and matrons working on Labour Ward to assist with patient care as part of the escalation policy.
- We spoke with a range of staff of various grades in the maternity and gynaecology service. They felt there was insufficient staff but during busy periods they all worked together to ensure patient’s needs were met appropriately.
- All women were provided with a named midwife and when women were in established labour the majority received one to one care until delivery of their baby, from observations on Labour Ward we confirmed this did happen. Data provided by the trust indicated that 97% of women were provided with one to one care however this data included all stages of care and it was not possible to establish the proportion for labouring women. The trust told us that they were looking to refine this data in future to provide a more accurate picture of one to one care in labour.
- Expected levels and actual levels of staffing were displayed on notice boards in all ward areas which were consistent with the rotas that we looked at.
- Midwifery staff handovers took place in staff offices with the doors closed to maintain confidentiality.
- Staff on Labour ward told us that they did not have reception or clerical cover overnight, which placed an extra burden on the clinical staff and had led to clerical errors that can be costly and take time to correct. For example; errors inputting baby details onto the computer system that allocated NHS numbers.

Nursing Staff

- The nursing staff ratio on the mixed orthopaedic/ gynaecology ward was one nurse and one care assistant to eight patients

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- The early pregnancy assessment centre (EPAC) team was small and did not use bank staff to cover holidays and absence. Appointments had to be cancelled during these periods.

Medical staffing

- Consultant obstetric cover in the delivery suite was 60 hours a week. This meant a consultant was present on the delivery suite from 8.30am to 6.30pm, Monday to Friday and 8.30am to 1.30pm on a Saturday and Sunday. This was in line with RCOG guidance (2007). There were eight consultant obstetricians of which one was a locum post.
- Out of hours maternity cover was provided by a tier two or three registrar with a senior house officer, supported by an on-call consultant. However, data provided by the trust told us that, on occasions, the registrar also had to cover gynaecology as that service did not always have a dedicated registrar.
- Anaesthetic cover for Labour Ward consisted of ten consultant anaesthetist sessions per week and 90% were covered by a consultant, the remaining 10% were covered by a senior trainee which does not meet the recommendations of the 2013 guidance of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) which states there should be a minimum of 12 consultant sessions per week. A specialist anaesthetic registrar was present on the unit out of hours; however, they also had commitments to cover the Intensive Care Unit (ITU). This is contrary to the 2013 guidance of the AAGBI which states that a duty anaesthetist must be immediately available 24/7.
- We were told that the on call anaesthetic consultant would attend within 30 minutes in the event of an emergency. We could not be assured immediate anaesthetic assistance would be available before the consultant anaesthetist arrived. The service leads had recognised this as a risk and felt reassured that no critical incident had occurred as a direct result of this work pattern; however it was documented on the risk register.
- There were three multidisciplinary handovers a day. We observed each handover, but there was no formal paperwork for handovers which followed a 'situation, background, assessment, recommendation (SBAR) format.

Major incident awareness and training

- Staff had access to the business continuity plans via the intranet, and service leads told us that the service participated in the trust major incident drills.
- Staff who attended focus groups stated that they were aware of it and of their responsibilities in line with the major incident policy, but were unclear where hard-copy information could be quickly accessed in the event of a major incident.

Are maternity and gynaecology services effective?

Good



The effectiveness of maternity and gynaecology services at Musgrove Park Hospital was good.

We found:

- The normal birth, home birth, overall caesarean section and instrumental delivery rates were all better than the national average.
- The maternity service had achieved UNICEF Baby Friendly stage three accreditation and breastfeeding statistics for initiation within 48 hours of birth were higher (better than) the trust target.
- The service had introduced a range of care initiatives that had been successful in reducing the still birth rate.
- Women said that they were able to access pain relief in labour and after they had had their babies, and this was provided to them in a timely way.
- Staff worked well together with women and their families to plan the women's care throughout the pregnancy and after birth.

However, we also found:

- Care and treatment was mostly planned and delivered in line with current evidence-based guidance, standards, best practice and legislation, however, the service was non-compliant with some guidance but had plans to address this.
- Some items on the maternity dashboard were not benchmarked which staff may not be able to check if performance was within acceptable limits.

Evidence-based care and treatment

- Local guidelines, policies and procedures were available to staff via the trust intranet.

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- We reviewed ten guidelines. The majority of policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, Termination of pregnancy for fetal abnormality guidance were also followed.
- However, it was stated in the directorate exception report of December 2015 that three maternity related NICE guidelines, CG107 Hypertension in Pregnancy, CG129 Antenatal care for twin and triplet pregnancies and CG 192 Antenatal and Postnatal Mental Health were non-compliant. This meant we could not be sure that women were receiving care that was evidence based care, and could lead to some inconsistencies in practice. The trust expected to be compliant by mid-February 2016.
- There were two guidelines documented on the directorate risk register for non-compliance. The gynaecology guideline relating to ectopic pregnancies and one maternity guideline which should reflect RCOG Guidance – the investigation and management of the small for gestational age fetus. This was due to the fact that the unit had no capacity to increase the number of ultrasound scans required to meet compliance. Risks were partially mitigated by ensuring that community midwives were trained in the use of customised growth charts and by offering some additional ultrasound scans.
- Termination of pregnancy which was undertaken for fetal abnormality was delivered in line with the Abortion Act 1967 and supporting guidance.
- The service obtained consent from all women for disposal of pregnancy remains which followed Human Tissue Authority guidance (2015).
- Entonox (a pain relieving gas) was piped in all labour rooms. Pethidine and diamorphine injections were available on Labour Ward if women required stronger pain relief.
- Entonox was also delivered to women's home prior to planned home births in tamper proof packs following completion of a risk assessment.
- Epidurals were available to women in labour on the Labour Ward at all times, although this was dependant on the availability of an anaesthetist. The waiting times for epidurals had not been formally audited for four years; however, a "snap shot" audit performed by one anaesthetist in February 2015 using a sample of 47 patients, showed the range of waiting times was between 0 and 240 minutes. The average wait was 28 minutes and 84% of women were waiting less than 30 minutes, which is in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) Obstetric Anaesthetists guidance.
- Women said that they were able to access pain relief in labour and after they had had their babies, and this was provided to them in a timely way.
- Staff on the surgical assessment unit (SAU) monitored the pain score of gynaecology patients and documentation was observed in the patient records.
- The rate of epidural or spinal anaesthesia for elective and emergency caesarean section compared to general anaesthetic was 91.1% which was within line of the requirements of the RCOG Safer Childbirth 2007.

Nutrition and hydration

- The maternity service had been assessed in February 2014 and achieved UNICEF Baby Friendly stage three accreditation. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding. The service is due to be reassessed in June 2016.
- Breastfeeding statistics for initiation within 48 hours of birth from April 2015 to December 2015 of 81.7% were higher (better than) the trust target of 80% and 70.5% of women were still breastfeeding on discharge from hospital. The service did not supply infant formula, women who did not wish to breast feed brought their own supplies into hospital and facilities for preparation of formula were provided. This was in line with UNICEF

Pain relief

- Aromatherapy was used on Labour Ward and the Bracken Birthing Centre by trained staff, women were also offered the use of TENS (transcutaneous electrical nerve stimulation) machines for pain relief. Staff told us that there were plans in place to offer hypnobirthing on Bracken and a midwife had been seconded for six months to introduce a hypnobirthing programme.

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baby friendly guidelines. A leaflet called the Essential Guide to Breastfeeding was given to all antenatal women at booking and included details of breastfeeding support groups.

- The service employed an infant feeding coordinator for two days a week who told us that hand expression by antenatal women was encouraged and packs for colostrum collection were given to women on ANC and Fern Ward, especially those mothers with diabetes. The service also held a weekly infant feeding clinic and had 15 trained peer support volunteers.
- The service was able to offer a procedure to divide tongue-tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve any identified feeding problems.
- Staff used the Malnutrition Universal Scoring Tool (MUST) to assess and record patients' nutrition and hydration status correctly in three out of the five gynaecology patient records that were reviewed. In the two records without risk assessment the patients had recently been admitted to the ward from theatres.

Patient outcomes

- The service maintained a maternity dashboard which reported on the clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. The dashboard performance was reviewed monthly at maternity governance and management meetings. Any serious concerns identified were escalated by the Clinical Director and the Head of Midwifery to the Executive Team via the Patient Assurance Framework (PAF). However, some items on the dashboard were not benchmarked, or allocated a RAG (red, amber or green) rating which highlights areas of concern and would trigger an investigation. This meant that staff could not monitor whether performance was within acceptable limits in areas such as serious perineal trauma (third and fourth degree tears), or an obstetric haemorrhage (bleeding following birth) of more than 1000mls blood. However, the trust was part of the South West Maternity and Children's Strategic Clinical Network (SWSCN) in order to measure their performance against other trusts in the region.
- The proportion of obstetric haemorrhage greater than 1500mls for December 2015 was 2.9% which was higher (worse than) the average of other trusts in the SWSCN of 2.2%.
- The proportion of serious perineal trauma for December 2015 was higher (worse than) the average of other trusts in the SWSCN for normal births (3.7% against the average of 2.5%) and assisted births (8.6% against the average of 6.6%).
- There were 3314 babies born under the care of the service from January 2015 to December 2015. The normal birth rate from April 2015 to December 2015 was 65.3% which was higher (better) than the normal birth rate in England of 60.1%, and the trust target of 60%.
- The trust had introduced a range of care bundles to reduce still birth rates. A care bundle is a structured way of improving processes of care and patient outcomes. These included individualised fetal growth charts, standardised methods of measuring fundal height (which is a measure of the size of the uterus and is used to assess the baby's growth during pregnancy), increased ultrasound scanning and a focus on smoking cessation and CO (carbon monoxide) monitoring. They had also trialled the use of an innovative placental teaching aid for smoking women. Leaflets were given to all pregnant women at 16 weeks to give information on monitoring their babies' movements. The stillbirth rate from April 2015 to December 2015 was 0.1 per 100 births which was a significant reduction on the average for the period April 2012 to January 2015 of 0.4 stillbirths per 100 births and which was lower (better than) the national average of 0.49 stillbirths per 100 births..
- Detection rates for small gestational age babies (SGA) was 45% which was higher (better than) the national average of 38%.
- Both the elective caesarean section rate (9.6%) and the emergency caesarean section rate (12.5%) from April to December 2015 were lower (better) than the national average. Overall, the caesarean section rate during this period was 22.1% lower (better) than the national average of 25.5%.
- Between April 2015 to December 2015, the induction rate was 27.7%, which was higher (worse) than the trust target of 20% and the national average of 25%. Staff felt this was due to the increased vigilance on reducing still births although this view was not verified.
- Between April 2015 and December 2015, 12.6% of babies were delivered by medically assisted instrumental delivery (forceps and ventouse extraction) which was below (better than) the trust target of 15%.

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- The home birth rate for babies born between April 2015 to December 2015 was 3.1% so above (better than) the national average of 2.3% but below the trust target of 4.5%.
- From July 2014 to June 2015 there were a total of 1404 gynaecology cases performed in both main theatre and as day case procedures. There was a 4.2% readmission rate for main theatre cases which was higher (worse than) the trust target of 2.4%. The average gynaecology re-admission rate for both elective and emergency admissions from December 2014 to November 2015 was 7.6%.
- Of the cases performed in main theatre, 96.4% stayed less than three days and 97.4% of the day case procedures were discharged on the same day. The national average for length of post-operative stay is 3.4 days.
- Local gynaecology audit activity in 2015/16 included: management of gynaecology emergencies, management of ectopic pregnancies, heavy menstrual bleeding, venous thromboembolism (VTE), enhanced recovery and hysteroscopy. Results were presented to the audit committee and recommendations made which we reviewed and were appropriate to the results. For example an audit of benign gynaecology readmissions undertaken in September 2015 found that there was minimal significant post-operative complications and recommended that individual cases should be discussed at the quarterly mortality and morbidity meeting and that the audit be repeated in 2016.
- Maternity outliers (maternity patients that were being cared for in other parts of the hospital for conditions unrelated to their pregnancy), had individualised plans for review and were monitored by the Labour Ward co-ordinator. Details of the patient were kept on the whiteboard and we observed daily communication between Labour Ward and the main hospital.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening programmes. We saw evidence that the service is meeting all of the KPIs for July to September 2015.
- The service has seen an increase in the number of women who have carbon monoxide levels monitored at booking from 3% in 2013/14 to 82.9% in 2015/16 to date.
- From April 2015 to December 2015, the average number of term babies unexpectedly admitted to the special

care baby unit per month was eight. In December 2015 this figure increased to 16. The risk midwife told us that this was being reviewed and retrospectively audited to identify any themes and trends in the admissions.

Competent staff

- A preceptorship programme was provided for all newly qualified midwives, which had to be completed before progressing to a higher grade, staff within this group told us that they had been allocated a named mentor and felt well supported.
- Supervisors of midwives (SOMs) help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for a SOM is to have a caseload of 15 midwives. The ratio of supervisors to midwives was 1:17, with two midwives undergoing training which would bring the ratio to 1:13. The SOMs were holding revalidation “surgeries” for staff to ensure they were prepared for revalidation. The Local Supervising Authority (LSA) had audited the service in December 2015 but the report had not yet been released.
- Weekly CTG meetings took place to discuss high risk cases and establish lessons learnt. We were told that these were predominantly attended by medical staff due to maternity department workload.
- Staff in the Juniper team were involved in staff training and were included on one of the mandatory midwives study days covering domestic abuse, FGM, mental health and teenage pregnancy.
- The service offered seven apprentice maternity care assistant (MCA) places as a career pathway, which included day release to the local college and would be equivalent to an NVQ three qualification after a year. However, one of the apprentices we spoke to felt unsupported and that they were “just left to get on with things”.
- Although nurses on Hestercombe Ward and the surgical assessment unit received in house specific training and support on gynaecological care, senior medical staff told us that they were concerned that patients were not always receiving appropriate care’.
- Appraisals for staff at band seven and above were undertaken against the core leadership values, and band six and below were against the trust’s values. Average appraisal rates up to February 2016 for Maternity were 81% so below the trust target of 90%. However nine out of the ten Obstetrics and

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Gynaecology consultants had received an appraisal within the 12 months prior to our inspection. Rates of six monthly performance reviews completed for band seven staff and above in maternity were 32.2%.

Multidisciplinary working

- The maternity service promoted multidisciplinary team working, including antenatal services, community midwives, health visitors, neonatal unit, GPs and social services. Staff worked well together with women and their families to plan the women's care throughout the pregnancy and after birth.
- Hospital and community staff reported a good working relationship between the teams.
- Specialist midwives and community staff regularly liaised with external agencies such as mental health services, children's social care, health visitors, drug and alcohol agencies, probation service and many others to co-ordinate high-risk cases to provide a multidisciplinary approach to care.
- The physiotherapists and occupational therapists supported patients after surgery on the gynaecology ward and for assessments prior to discharge home.
- The majority of midwives we spoke to felt there was a good working relationship with the medical staff.
- Staff we spoke to said there was a good working relationship with the critical care outreach team who were available to support staff looking after women who needed high dependency care.

Seven-day services

- Maternity and emergency gynaecology services were available 24 hours a day, seven days a week. The early pregnancy assessment centre (EPAC) was open between 9 am and 5 pm Monday to Friday. Out of hours calls were answered by staff on the SAU.
- A consultant obstetrician was present on the delivery suite from 8.30am to 6.30pm, Monday to Friday, and 8.30am to 1.30pm on a Saturday and Sunday. On-call staff were required to attend within 30 minutes.
- There was an anaesthetic consultant on-call for the maternity service 24 hours a day, seven days a week providing epidurals when requested, although there were times when they were responsible for more than one area.
- Sonographers were available Monday to Friday 9.00am until 5.00pm for ultrasound scans, Venous Thromboembolism Doppler scans (scans for the clots in

the deep veins of the legs) and computed tomography pulmonary angiography (CTPA) scans, which is a test to see how blood flows through the lungs. There was a flexible working arrangement in place for Saturday working dependant on demand.

- A Supervisor of Midwives (SOM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided midwives with access and support at all times.
- One patient we spoke to had an early pregnancy bleed and was referred via accident and emergency but as it was a weekend she was unable to be seen on EPAC and had to wait until Monday, which she said added to her distress. The inability to provide a seven day EPAC service was on the directorate risk register.

Access to information

- The service had a paper based notes system, with all care documented in individual hospital notes, and the hand held notes which the women carried with them.
- Staff told us that they had access to maternity notes at all times as long as their care was booked within the Taunton and Somerset region. The notes were kept within the maternity department; separate from the main hospital filing system until after the patient was discharged and postnatal care notes were returned.
- Staff were able to access test results and trust policies and procedures via the trust intranet system.
- The new hospital wide IT system did not link with the maternity system and this was documented on the directorate risk register. Additional training specifically for maternity staff had been requested and was being delivered in February 2016. This was documented as a risk on the directorate risk register and although an action plan had been agreed by the trust quality steering group there were no immediate plans to progress the plan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with national legislation and guidance, including the Mental Capacity Act.
- Patients gave verbal consent for their care and treatment and this was clearly documented in the women's records. The five gynaecology records we reviewed contained written consent for surgical procedures.

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- Training on consent, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and learning disability was part of mandatory training for all staff. Data supplied by the trust showed that compliance rates for mandatory training were 91% for nursing and midwifery staff and 71% for medical staff, which was slightly lower than the trust target of 92%.
- We were told that in the event of a termination of pregnancy due to fetal abnormality, the antenatal screening midwives co-ordinated the signing of HSA1 Certificates (which is a requirement of the Abortion Act 1967). Staff organised consultant appointments that were convenient to the woman in order to counsel patients prior to gaining consent. A documentation log of these cases was kept to ensure correct procedures were followed. Staff were aware of the implications around the maturity of women making the decision and we were told that policies were available on the trust intranet to assist staff when making assessments using the Gillick competencies and the Fraser guidelines. Gillick competency and Fraser guidelines are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are maternity and gynaecology services caring?

Good



The care provided to patients in maternity and gynaecology services at Musgrove Park Hospital was good.

We found:

- Feedback from patients and their families was consistently positive about the way staff treated them.
- The percentage of women who would recommend friends and family to give birth at this hospital and would recommend the postnatal ward was above the England average between October 2014 and October 2015
- Partners were allowed to stay overnight to provide emotional support in certain circumstances.

However, we also found:

- The environment in both maternity and gynaecology made it difficult to maintain confidentiality, dignity and privacy, although staff tried hard to do so..

Compassionate care

- Without exception, women and their partners we spoke to felt that they had been treated with respect and compassion, and said all staff “were brilliant”, or “were amazing”.
- We observed staff respecting the women’s dignity by knocking and waiting to be invited in to rooms, or behind the curtains around the woman’s bed space.
- We observed that staff were sensitive and caring in their handling of a distressed patient on Fern Ward.
- The NHS Friends and Family Test (FFT) is a satisfaction survey measures patients’ satisfaction with the healthcare they have received. The data from October 2014 to October 2015 showed the maternity department scored above the England average for birth and postnatal ward care and around the average for antenatal care. However the data for the same period showed that the maternity department scored below the England average for postnatal community care.
- The trust scored similarly to other trusts in the questions in the ‘Care Quality Commission Survey of Women’s Experiences of Maternity Services 2015’.
- Maintaining women’s confidentiality was difficult in antenatal clinic because of the proximity of the reception desk to the waiting area, however reception staff were aware to use a private office when making confidential calls. Similarly in EPAC (early pregnancy assessment unit) confidentiality was difficult due to the waiting area located directly outside the office door. Staff told us that the door could be closed if required but we did not observe this.
- One patient told us that she felt that privacy was lacking on Fern antenatal day care as all women undergoing induction of labour (IOL) were together in one bay but felt that staff tried hard to maintain her dignity. Another patient told us that her partner had been allowed to stay with her overnight on Fern Ward as she was in early labour and that staff had moved beds around to try to give them and the other women on the ward more privacy.
- We were told of a recent case where a woman with a disability was cared for on Willow Ward. Adjustments were made to accommodate her needs, including

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allowing her partner who was also her carer to stay with her. There was however, only one side room available within the postnatal ward so facilities to offer this level of care were limited.

- We observed that a new white board was in use on Fern Ward which displayed names and full details of the patients care and was visible to patients and visitors. We raised this during our visit and the ward manager planned to review its use and consider patient confidentiality.

Understanding and involvement of patients and those close to them

- We observed a receptionist on the surgical assessment unit (SAU) talking to relatives, offering reassurance and conveying messages for patients unable to get to the phone. We observed this member of staff making tea for patients and setting up a phone for use by a patient with restricted mobility.
- The women we spoke with shared their birth experiences with us and told us that they were listened to and supported at all times by the midwife caring for them.
- Women we spoke with told us that they had been involved in the planning of their care and were provided with information so that they could make informed choices. A supervisor of midwives (SOM) told us that they would be closely involved in the planning of care of care for women with more complex needs.
- We spoke to one birthing partner who told us that they had been allowed to stay overnight on Labour Ward and on Willow Ward in a side room and was made to feel welcome. Another relative told us that he was well supported and informed whilst his partner was having an elective Caesarean Section under a general anaesthetic.

Emotional support

- Partners we spoke to were very happy with the care and their involvement.
- Patients and relatives were given emotional support whilst on the units. We observed friendly and open conversations between staff and visitors.
- Staff dealt with bereavements compassionately. They provided support to parents, relatives and each other. Staff offered the chaplaincy service to women to provide extra support

- A specialist bereavement midwife worked one day a week within the maternity unit to provide support for women and staff. Staff felt well supported to care for women and families.

Are maternity and gynaecology services responsive?

Good



We found the responsiveness of maternity and gynaecology services at Musgrove Park Hospital to be good.

We found:

- Women were given a choice of place of birth in line with national guidance.
- Services were arranged to meet women's needs with a range of specialist clinics and midwives to support them.
- The service offered specialist antenatal clinics including haematology, diabetes, maternal medicine and fetal medicine.
- People using the maternity services could access clinical midwife specialists. For example; a screening coordinator, a bereavement midwife, an infant feeding coordinator, a diabetic specialist midwife, a safeguarding midwife, an alcohol and substance misuse midwife, a teenage pregnancy midwife, a hypno-birthing midwife and a mental health midwife.
- There were a low number of complaints about the service. Complaints and concerns were managed appropriately at local and divisional level with evidence of shared learning as a result.

However, we also found:

- There was no dedicated elective caesarean section list which could lead to procedures being delayed or postponed and although patients were warned in advance that this was a possibility.
- The emergency gynaecology service was fragmented.

Service planning and delivery to meet the needs of local people

- Women were given a choice of place of birth in line with national guidance, which recommended both a choice in place of birth and lead carer. This included choice to

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have a home birth, birth in a local facility under the care of a midwife in a midwife led unit (MLU), or birth in a hospital supported by midwives, anaesthetists and consultant obstetricians.

- The Bracken Birth Centre and Mary Stanley Unit offered midwifery led care for low risk women and care which followed the model of home from home birth. A recent review of the risk assessment for the unit in response to patient's feedback had led to the upper limit of Body Mass Index (BMI) being raised from 30 to 35, which meant that more women were eligible to safely use this service. The birth centre had a triage room, three birthing rooms and four postnatal beds, which were separate from the Labour Ward. One of the rooms had a birthing pool and all three rooms were quiet with subdued lighting and no obvious medical equipment. However, staff allocated to this unit could be moved to Labour Ward as part of the escalation process and therefore the unit would be unavailable.
- People using the maternity services could access clinical midwife specialists. For example; a screening coordinator, a bereavement midwife, an infant feeding coordinator, a diabetic specialist midwife, a safeguarding midwife, an alcohol and substance misuse midwife, a teenage pregnancy midwife, a hypno-birthing midwife and a mental health midwife. However, it was documented on the directorate risk register that there may be some delay in treatment and care planning for women with perinatal mental health concerns because there was no commissioned pathway for perinatal mental health in Somerset. The specialist midwife has been given additional hours but the Head of Midwifery told us this was still considered insufficient. A proposed county wide plan had been agreed by all stakeholders and was awaiting a commissioning decision.
- The service offered specialist antenatal clinics including haematology, diabetes, maternal medicine and feto-maternal medicine. There were also satellite antenatal clinics in Bridgwater and Minehead.
- Early pregnancy assessments and a fertility clinic were available on early pregnancy assessment unit (EPAC) and outpatients' clinic. Antenatal day care and triage was located on Fern Ward.
- Gynaecology clinics ran within the outpatients department and the Gynecological-oncology Rapid Access and Colposcopy Examination (GRACE) Centre. These included post-menopausal bleeding PMB,

endometriosis, colposcopy, hysteroscopy and Gynae-oncology outpatient services. The service had recently registered to become an endometriosis centre for the region, with specialist endometriosis nurses working closely with consultants and acting as a dedicated point of contact for patients.

- Staff in Antenatal Clinic (ANC) and Early Pregnancy Assessment Centre (EPAC) had received some training in counselling however, there was no private room in EPAC for staff to break bad news in private.

Access and flow

- There were two closures of the maternity unit between January 2014 and June 2015. This meant that the hospital was closed to new admissions as part of the escalation procedure, and women in labour needed to be diverted to other local hospitals. The unit was closed on both occasions for 24 hours because of bed capacity.
- Bed occupancy in maternity ranged between 32.9% and 47.3% between July 2013 and June 2015 with an average of 43%, which was below (better than) the England average of between 55% and 60%.
- From October 2015 to December 2015 there were 11 gynaecology patients cared for outside of the gynaecology ward due to unavailability of beds, which equated to 30 bed days. Procedures were in place for gynaecology review of all these patients.
- From July 2015 to December 2015 the number of last minute cancellations of gynaecology procedures for non-clinical reasons averaged less than two per month.
- Between April 2015 and December 2015, 89.5% of women attended an antenatal appointment within 12 weeks 6 days of pregnancy; this was higher (better) than a trust target of 85%.
- The average referral to treatment time (RTT) for gynaecology patients in 2015 was 6.7 weeks. This was within the recommended time of 18 weeks and was achieved for 93.1% of their patients which was slightly lower (worse than) the England standard of 95%.
- The service had introduced two initiatives to speed up the postnatal discharge process. Firstly, a DVD had been made which gave women important information and advice about going home with their new baby; this was shown to all women prior to discharge. This had the benefit of making midwives available for other tasks and ensured consistency of the information given, however, this DVD was only available in English. Secondly, an area

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had been created within Willow Ward to provide a discharge lounge. On the day of our inspection the area had been reverted to a standard bed area because of the demand for postnatal beds.

- GPs could make direct referrals to EPAC and SAU for pregnant women, or those with a gynaecological complaint. Women could self-refer to EPAC and the Antenatal Day care on Fern Ward or be referred by community midwives.
- Community midwives provided an on call service to facilitate births at home and at the Mary Stanley Birthing Unit, however, this was not a guaranteed service during times of low staffing or peak workload. From April to December 2015 four women had been refused admission to Mary Stanley Birth Centre due to maternity staffing or capacity, which is 3.5% of the total births at that location.
- There was no dedicated recovery area for the Labour Ward theatres. Following procedures patients would be taken to a Labour Ward room to be recovered which was inefficient and blocked Labour Ward beds.
- Within the unit, there was no dedicated elective caesarean section list. Women who were booked for surgery that day were informed that their operation may be delayed if emergency cases took priority. Incident data supplied by the trust informed us that ten incidents relating to elective caesarean section delays had been reported in 2015,, however, the service had acknowledged that some types of incidents were not reported due to staff becoming desensitised because they occur frequently, for example; delay to the elective section list.
- The service implemented the enhanced recovery after surgery programme (ERAS) within gynaecology. Initial reports suggested that this had been effective in promoting early mobilisation and early discharge for women following surgery and an audit report was awaited.
- Senior staff told us that it was hoped that the recent addition of maternity wards to the hospital wide bed state management system would improve the visibility of the service and flow problems.
- Staff working on the Fern Ward day care told us that a lack of medical staff within the unit, particularly at weekends and long delays in accessing scans for patients led to an inability to discharge women and caused flow problems.

Meeting people's individual needs

- The emergency gynaecology service was fragmented. Emergency patients attended SAU (surgical assessment unit) which was a mixed sex unit, the male and female patients were separated by means of small partitions. Although there was a private assessment room for the women and separate shower and toilet facilities they had to walk through the male bays to access these facilities. There were no private room facilities on the ward. We learned of women experiencing a miscarriage behind a curtain in the main ward area.
- Staff on SAU told us that wherever possible they would try to transfer women with pregnancy loss at more than 14 weeks gestation to the Labour Ward bereavement suite which they considered was a more appropriate place. Inpatient early pregnancy loss on SAU was within an open ward with little or no privacy.
- The organisation used an interpreting service to communicate with women with whom English was not their first language. Boards and leaflets in EPAC waiting area included details of translation and interpreting services, PALS (patient advice and liaison service), and support services. However, staff told us they also used family members to interpret for women, which was not best practice.
- The Juniper team (for women in vulnerable circumstances) had developed guidelines for the care of women acting as surrogate mothers and same sex couples to ensure their needs were met. Within the community, the Juniper team included three additional midwives involved with specialist groups including homeless, teenagers and women in vulnerable circumstances, as well as those suffering with drug or alcohol dependency and mental health issues. The teenage specialist midwife looked after women for both their antenatal and postnatal care to ensure continuity of care for these women.
- Women we spoke with told us that the meals were of an acceptable standard and that snacks including fruit, toast and sandwiches were available. Women could choose whether to eat in the dining area or by their bed.
- Specific dietary needs for example, vegan or Halal were catered for on request, and a multi-faith chapel was available for women and their families in the main hospital.
- Tea and coffee was provided for women and their relatives on antenatal day care unit on Fern Ward, with

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an honesty box for contributions. We saw that fresh drinking water was provided at every location within the service and vending machines with drinks and snacks were located in ANC.

- The Rowan (Bereavement) Suite included a recently refurbished clinical room, a sitting room and bathroom; this offered a private space available to women over 14 weeks gestation. The service also offered a range of keepsakes for bereaved families including facial casts. However staff in EPAC told us that they did not have a private space for women being given bad news although they were sensitive to individual needs and made every attempt to support women.
- Midwives and nurses working in gynaecology knew how to access support from the learning disability nurse for women with a learning disability. Staff told us about using 'this is me documents' for women living with dementia or with a learning disability.
- We were told of examples where individual patient needs were met. For example, a community midwife told us of a woman with complex needs requiring twice weekly appointments. Her care was provided at home or in the clinic at a time that suited her.
- A pathway was developed for women who requested surgical termination for fetal abnormalities, a service which the hospital did not provide. Antenatal clinic (ANC) staff liaised with the chosen provider, for example BPAS to provide a timely response that did not contribute to the distress of the woman's situation.
- Adjustments had been made to cater for bariatric (heavier) patients within maternity and gynaecology. Labour Ward theatre had equipment suitable for heavier patients; for example an electric trolley which was used to transport patients from Bracken to Labour Ward which was suitable for heavier patients. Hoists were available on Hestercombe Ward and larger chairs were available. Labour Ward had a disability accessible bathroom and patients were cared for on electric beds following epidurals or caesarean section. Pregnant women with a BMI over 30 were also offered free activity classes.
- There were antenatal education classes run by community midwives, these included information about labour, birth and the postnatal period.
- There were posters on the back of toilet doors informing patients of contact details for a support service if they were in an abusive relationship.

Learning from complaints and concerns

- Patient Advice and Liaison Service (PALS) information leaflets were displayed in some areas. The leaflets informed patients how to raise concerns or make a complaint. Women we spoke with felt confident to address concerns locally.
- A complaints workshop was being planned for the month of our visit with gynaecology consultants to consider learning from complaints and to get senior staff to understand the patients' experience.
- Complaints in maternity and gynaecology were addressed at the clinical governance meetings. Information was fed back to the staff via ward meetings and via the supervisor of midwives. Data provided by the trust informed us that between April and Dec 2015 there had been 12 formal complaints relating to maternity, and seven relating to gynaecology. At the time of our visit there was one maternity and two gynaecology complaints outstanding, all three of which were within the required timescales for reply.
- The service was able to demonstrate learning from complaints and gave an example of a pathway that was developed for women who needed surgical termination for fetal abnormalities which the hospital did not provide, which was the result of a complaint.

Are maternity and gynaecology services well-led?

Good



The leadership of maternity and gynaecology services at Musgrove Park Hospital was good.

We found:

- There was a clear strategy and there was a Quality Improvement Plan (QIP) in place for the service.
- The maternity and gynaecology services had a clear vision for the development of the service and had identified areas of improvement within the governance process, which they were working towards.
- Service leads had an awareness of issues highlighted within the "Safe" domain in relation to staffing, mandatory and safeguarding training, anaesthetic cover for Labour Ward and incident reporting and were making slow progress towards resolving these issues.

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- We saw that the maternity risk register was reviewed and updated regularly. Actions taken were visible and the process completed by removing risks from the register. The majority of issues identified during our inspection had already been highlighted on the service risk register.
- The service had completed a full gap analysis (which is where current practice is compared with what is required) responding to the Kirkup report in May 2015, benchmarking themselves and producing a report which we reviewed. An action plan was produced to ensure full compliance with all the recommendations and had been linked to the maternity QIP. Junior staff were aware of the QIP but not the Kirkup Report
- All band seven midwives had completed the LEAD leadership programme.
- Throughout maternity and gynaecology, the majority of staff described a culture of good teamwork and supportive colleagues.
- Staff were friendly, welcoming and enthusiastic.

We also found:

- The Head of Midwifery (HOM) was not visible to more junior staff although the postholder had also been the Directorate Manager until October 2015 and prior to then had been unable to dedicate enough time to the HOM role.
- Senior midwives in maternity were aware of a difference in status to other staff of the same grade in other parts of the hospital. Band seven staff were not always supernumerary and were not always able to be supportive to junior staff because of their own clinical responsibilities.

Vision and strategy for this service

- The maternity service leads had a clear vision of the development of the service which was demonstrated by 'The Three Year Quality Improvement Plan for Maternity Services 2015/18'. The objectives were clear and had been developed through a structured process including staff engagement. This was aligned to the trust vision which was 'To put our patients first by working as one team; leading and listening; and striving for the best. Together, we make the difference'.
- The strategy for the gynaecology service was to re-integrate the early pregnancy assessment centre

(EPAC) and emergency gynaecology into the maternity unit to provide less fragmented and more woman-centred service. This had been an on-going process since 2012.

- Band five and six midwives who attended one of the focus groups were unclear about the strategy of the service although were aware of the quality improvement plan.

Governance, risk management and quality measurement

- The service had an awareness of issues highlighted within the "Safe" domain in relation to staffing, mandatory and safeguarding training, anaesthetic cover for Labour Ward and incident reporting and was making steady progress towards resolving these issues.
- There were weekly obstetric risk meetings, monthly maternity risk meetings and monthly maternity governance meetings, where specific incidents and trends were reviewed. A review of the minutes demonstrated that the meetings were multi-disciplinary and covered topics such as stillbirths, incidents, supervision, antenatal screening, safeguarding, risk management and the patients' experience, including complaints. The service leads told us that these meetings were not always well attended, and the issues discussed overlapped with the monthly paediatric and gynaecology meetings, so plans were in place to integrate these meetings to improve attendance and efficiency
- Incidents reported for gynaecology had previously been reported to surgery for Hestercombe Ward and SAU. Within the last month gynaecology had set up its own governance structure and would be working towards a separate incident reporting system.
- All incident reports were sent to the Maternity Incident Review Group (MIRG) for approval of recommendations and actions to ensure that they were achievable and relevant. Following this they were sent to the trust governance team for approval however senior staff told us that responses from the central team were not always timely.
- Serious concerns or issues arising from unit-level governance meetings were escalated to the PAF (performance assurance framework) group which was chaired by the Director of Operations. The directorate risk register was also discussed at this forum.

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- There were processes in place to identify, monitor and address risks. We saw that the maternity risk register was reviewed and updated regularly. Actions taken were visible and the process completed by removing risks from the register. Most of the issues identified during our inspection had already been highlighted on the service risk register.
- The gynaecology service had established a separate governance and audit process within the past year and had its own clinical service lead.
- Midwives were encouraged to be involved in audit and governance meetings but we were told this was rare due to workload pressure.
- We reviewed a copy of the Directorate Exception Report from December 2015 which detailed areas for improvement, with clearly assigned responsibilities and timescales. The government had commissioned an independent investigation into maternity and neonatal services nationally (the Kirkup report), to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015, and included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere.
- The service had completed a full gap analysis (which is where current practice is compared with what is required) responding to the Kirkup report in May 2015, benchmarking themselves and producing a report which we reviewed. The service had identified areas of further improvement in relation to a greater need for multi-disciplinary working, staff awareness of the importance of incident reporting, the governance of incidents and complaints and mandatory training for staff, particularly cardio-tography (CTG) training. An action plan to ensure full compliance with all the recommendations had been linked to the maternity Quality Improvement Plan. Staff we spoke to at a focus group for band five and six midwives were unaware of the implications of the Kirkup Report but were aware of the Quality Improvement Plan however some identified areas of improvement had not yet been achieved, for example ensuring that all midwifery staff completed the K2 (on-line CTG training) package and facilitating the supernumerary status of the band seven senior midwives..

- An external clinical review of the service was undertaken at the end of 2015, triggered by medicines management concerns. The report's finding had not yet been published.

Leadership of service

- The service was led by a team consisting of a Clinical Director (CD) supported by a directorate business manager and head of midwifery (HOM). Further leadership was provided by two clinical service leads (maternity and gynaecology), a deputy business manager and three matrons who organised the day to day running of the maternity service.
- The CD was well regarded by senior staff and described as hard working and enthusiastic. Staff told us that they believed that maternity and gynaecology services had been an “invisible” service to the executive board in the past and that the CD had pushed the service forward.
- Staff told us the trust chief executive appeared to be interested in maternity and was the executive sponsor for the maternity Sign up to Safety programme, and had walked the gynaecology pathway.
- Prior to October 2015, HOM was also carrying out the role of the directorate business manager. Recent changes in the management structure and the creation of a new secondment post led to separation of the two roles. This had allowed the HOM to focus more on the leadership of the service however, the majority of staff we spoke to thought that the HOM was not visible and were unclear as to her role.
- The band seven midwives within maternity had been identified by the trust as lacking leadership skills and dedicated management time as they were used as part of the escalation plan to cope with increased workload. All matrons and band seven midwives had completed the trust LEAD programme and most attended an “away day” in January 2015. Service leads told us senior midwives would have more dedicated management time following the recruitment of additional staff.
- Senior midwives in maternity were aware of a difference in their status to other staff of the same grade hospital wide. Matrons told us that, apart from community staff, maternity was the only part of the trust where band seven staff were not supernumerary and where matrons could subsequently take on a more senior management role. As a result, trust band seven development days were difficult to access for maternity staff because of their clinical responsibilities. Service leads told us there

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were plans to give these staff more protected time when extra midwives had been recruited. Band seven midwifery staff confirmed that they were often asked to work clinically, and were sometimes unable to complete their management tasks.

- Junior staff we spoke to were mixed in their opinions of senior staff. Some thought that managers were visible and approachable; others thought that they were not supportive, but that there had been improvement over recent months. One junior member of staff that we spoke to was unable to identify who their line manager was.

Culture within the service

- Staff were friendly and welcoming. They were generally enthusiastic and strived to provide quality care and were proud to work at the hospital, however, two of the staff we spoke to said they wouldn't recommend the organisation as an employer. Two staff members also thought low staffing levels was beginning to affect morale.
- The trust has a staff survey called 'Pulse Check', which questioned staff on a range of issues, including how likely they would be to recommend the service to friends and family, leadership of their immediate manager and feeling respected and valued. The "Pulse Check" measured positive values and the results for maternity were lower (worse than) the trust target of 90%, with 60% in April 2015 to June 2015 and 70% in July to September 2015.
- Throughout maternity and gynaecology, the majority of staff described a culture of good teamwork and supportive colleagues.
- We were told that innovation was encouraged from all grades of staff, and were given the example of a newly qualified band five midwife who had reorganised the planning of community midwives visits, and made it more efficient and workable.

Public engagement

- Findings from the Friends and Family Test was used to monitor and influence the standards of the services provided.
- The Head of Midwifery, midwifery matrons and community midwives attended meetings of the Somerset Service Liaison Committee (MSLC) on a quarterly basis. The MSLC is a forum for maternity service users, providers and commissioners of maternity

services to come together to design services, that meet the needs of local women, parents and their families. For example, minutes of the meeting in September 2015 state that there were discussions around funding for breastfeeding clinics and mental health services.

- The service was invited by NHS England to be a pilot site for the introduction of 'Always Events' which focused on learning about the service from the user's perspective. We saw a tops and pants display (which included patient feedback about what was good (tops), or bad (pants), about the service) in the Bracken Birthing Centre which asked women for their feedback about what was good and bad about their experience.
- Service leads told us they were planning to continue the development of the internet site for local women and for example had plans to upload the discharge video on to it so women could view it at home.

Staff engagement

- The maternity team held a series of "Big Conversations" which involved 150 staff from all areas and grades within the hospital to identify themes to feed into the Quality Improvement Plan. Staff members we spoke to had been involved in these activities and thought they were a good opportunity to contribute to the future of the service.
- All band seven midwives had completed the LEAD leadership programme and some band six midwives were starting the programme.

Innovation, improvement and sustainability

- Staff could be nominated for a Musgrove Award for Tremendous Achievement (MAFTA) awards for their dedication and work. We saw evidence of a nurse within the Gynecological-oncology Rapid Access and Colposcopy Examination (GRACE) Centre unit having received an award for hard work and dedication.
- One of the midwives at the service had also recently won a MAFTA award for her innovative ideas. She had designed a fabric placenta as a teaching aid and designed the "smoke free buttons" located throughout the hospital, which when pressed plays a voice recording outside to remind patients and visitors of the smoke free message.
- Staff told us they were very proud of their newly refurbished bereavement suite on the Labour Ward, which provided a more comfortable and less clinical environment for women experiencing pregnancy loss

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- A re-organisation of antenatal care was planned which will include the relocation of the antenatal triage service to Bracken Birth Centre. A lead midwife for normality had already been appointed and the community midwives and Bracken unit teams were planning to merge, in order to try to focus on increasing the number of low risk births away from Labour Ward.

Services for children and young people

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

Information about the service

Children's services at Taunton and Somerset NHS Foundation Trust are at Musgrove Park Hospital where care is provided to children and young people between the ages of 0-19 years of age.

The children's' service has 27 beds, including two high dependency beds; however, very sick children may also be cared for in the adult critical care unit. The majority of beds are located on the inpatients ward - Oak ward which has 18 beds and seven cubicles.

Acorn ward has nine cubicles, operates as a short stay ward and provides specialist care for young infants. The paediatric day care unit / Woodlands ward is open three days a week and has six beds which are used for most elective day case admissions, including blood tests and minor treatments. A six bed children's day surgery unit is based in a separate day surgery unit. In addition, there is a dedicated children's outpatient service and child development centre.

The level two neonatal unit accommodates up to 18 babies from 27 weeks gestation, which includes four intensive care, four high dependency cots and 10 special care cots. Babies below 27 weeks gestation are transferred to a tertiary regional centre in Bristol, in line with Neonatal toolkit requirements. The trust identified that staffing for the unit fell short of nationally recommended levels and had risk assessed this. On 32% of shifts was not compliant against the neonatal staffing toolkit.

Wales and West Acute Transport (WATCH) and Newborn Emergency Stabilisation Team (NEST) provide retrieval services for children and neonates.

During our inspection of children's services, we visited the Somerset neonatal intensive care unit, the children's outpatients department, Oak and Acorn wards, the two-bed high dependency unit, child development centre, the children's day surgery unit and adult critical care unit.

We spoke with 14 medical staff, 31 nursing staff including managers, 17 members of the multi-disciplinary team and eight parents.

Services for children and young people

Summary of findings

Overall, the children's and young people's service was rated as good.

We found services for children, young people and their families were effective, caring, responsive and well led. However, improvements were needed for the service to be safe.

Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance.

A paediatric nursing community team of 10 children's nurses supported the children's and neonatal service throughout the Somerset region.

Shortfalls in trained nurse provision on the neonatal unit and within children's services were managed through escalation pathways and through the support of an identified bleep holder.

The trust said funding for the two-bedded high dependency unit (HDU) was proportional to bed occupancy and monitored through the South West Specialist Clinical Network. The funded HDU staffing establishment was 4.71 whole time equivalent trained nurses. Eight band six nursing staff (not all of which were full time) worked in the HDU and were managed and supported by a band seven nurse who was HDU and advanced paediatric life support (APLS) trained. We were told that the majority of time the HDU was staffed by band six nurses who had completed the HDU course; however, there were occasions when an experienced band five nurse who did not have the HDU course would work in the HDU area.

The service was not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding was secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.

Neonatal staffing did not fully meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011) (BAPM) because they could not always provide 1:1 and 1:2 care for babies who required intensive care or high dependency care. The staffing report (1 April 2015 – 26 January 2016) confirmed that 32% of shifts were not compliant against the neonatal staffing toolkit. Because of this the neonatal caseload has been reduced by 0.34%. The failure to comply with the neonatal toolkit in respect of staffing and the potential risk to the neonatal intensive care service had been recognised as a risk on the women's and children's risk register.

The South West Neonatal Network recorded neonatal daily staffing levels across the South West and the trust was comparable in terms of levels of neonatal staffing with other units in the South West.

There was generally good access and flow within the children's service. The 18-week referral to treatment (RTT) performance showed data for "referral to treatment – incomplete and stopped pathways" confirmed that RTT targets were not always achieved in all specialities. The trust identified that actions had been implemented to improve compliance and that some shortfalls had been caused through patients not arriving for their appointment and delays associated with patient choice of date.

Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS).

Monitoring records of resuscitation equipment and neonatal transport systems showed that monitoring of this equipment had not taken place daily.

There were shortfalls in the management and storage of some medication in the neonatal unit and child development centre.

Training shortfalls existed in some areas, for example in mandatory training, advanced paediatric life support (APLS) and European paediatric life support (EPLS) training. This meant that the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the RCN (2013) staffing guidance.

Services for children and young people

Staff were caring, compassionate and respectful. Staff were positive about working in the service and there was a culture of flexibility and commitment.

The service was well led and a clear leadership structure was in place. Individual management of the different areas providing acute children's services were well led. A governance system was in place and we saw clinical risks were identified. Feedback from staff, parents, children and young people had resulted in changes to aspects within the service.

Are services for children and young people safe?

Requires improvement



The safety of the service required improvement.

- Neonatal staffing did not fully meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011) (BAPM) because they could not always provide 1:1 and 1:2 care for babies who required intensive care or high dependency care. Because of this the neonatal caseload has been reduced by 0.34%.
- The failure to comply with the neonatal toolkit in respect of medical cover overnight and the potential risk to the neonatal intensive care service had been recognised as a risk on the women's and children's risk register.
- The South West Neonatal Network recorded neonatal daily staffing levels across the South West and the trust was comparable in terms of levels of neonatal staffing with other units in the South West.
- The children's service confirmed that they were not compliant against the Royal College of Paediatrics and Child Health (RCPCH) consultant staffing standards because of insufficient consultant cover between the hours of 5pm and 10pm. Additional cover was planned to prevent and reduce avoidable admissions for children through the availability of paediatric advice and guidance to the emergency department and to GPs.
- Best practice staffing guidance within children's services was not fully implemented. Staffing within the children's service, although currently considered as being safe by the senior management were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance.
- The trust said funding for the two-bedded high dependency unit (HDU) was proportional to bed occupancy and monitored through the South West Specialist Clinical Network. The funded staffing establishment was 4.71 wte trained nurses. Staff vacancies meant that the majority of time the HDU was staffed by band six nurses who had completed the HDU course; however, there were occasions when an experienced band five nurse who did not have the HDU course would work in the HDU area.

Services for children and young people

- The neonatal unit was compact with limited space around the cots in the special care unit.
- There were shortfalls in staff attendance at level three children's safeguarding training. The trust had set a target of 90% compliance in level three safeguarding training which they hoped to achieve by July 2016.
- Children's records were not always stored securely and we found information gaps in some children's records.
- We found gaps in the daily monitoring checks of resuscitation equipment.
- There were shortfalls in staff attendance at mandatory training; in basic and intermediate paediatric life support training attendance by nursing staff. For medical staff attendance, we saw that 100% of medical staff had attended PILS training.
- Staff told us the band seven ward sister was advanced paediatric life support (APLS) trained and that other nursing staff who worked within the high dependency unit had completed their European paediatric life support (EPLS) training. However, staff had not attended training updates which meant their skills had not been updated in this area. Staff told us there was not a nurse with either APLS or EPLS training on each day and night shift, however, we were told that medical staff were trained to this level.
- There were shortfalls in the management and storage of some medication in the neonatal unit and child development centre. This was escalated to the nurse in charge and matron during the inspection. Appropriate actions were taken following these escalations.

However we also found:

- Generally good infection control practices were observed by staff, however, we observed on occasion that some staff did not always use protective equipment such as aprons on entering and leaving cubicles identified as being under protective precautions.
- The service had identified guidelines and protocols to assess and monitor patient risk in real time, and react to changes in risk level.
- Staff knowledge of the incident reporting process was good and incident reporting processes were robust.
- Performance data about safety and harm-free care was captured monthly within the children's and young people's safety thermometer dashboard.
- We checked some equipment throughout the service and saw that each had stickers with dates confirming that maintenance checks had taken place.

Incidents

- Information relating to incidents was provided over a ten month period from 1 April 2015 to 1 February 2016 in which there were 164 incidents across the service.
- Additional information provided which related to incidents over a five month period from June 2015 to November 2015 identified a total of 67 incidents which related to children's services and 32 incidents which related to the neonatal unit. Each incident identified the impact of the incident. Two of the main incident themes included 10 medication errors and eight communication failures.
- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incidents and significant events were discussed at ward meetings, governance and paediatric improvement group meetings in association with the risk register.
- Medical and nursing staff confirmed they knew how to report incidents and had received feedback from the incidents they reported. Staff said that incident feedback was cascaded through staff meetings, daily safety briefings, in the communication book and by email. Staff told us that safety alerts were circulated via email, the general manager and risk department; relevant alerts were discussed at the directorate governance meeting.
- We tracked two medication incidents; a recent incident and one classified as a near miss. One incident was one of five similar medication incidents which had occurred. We saw the incident reports completed for each incident. The medication incident theme for the five similar medication incidents related to a batch of antibiotics. The outcome of the investigation into the second incident resulted in the withdrawal of a batch of antibiotics and identified lessons learnt. Following the investigation into the five medication incidents, each parent was contacted in writing and informed of the outcome of the investigation. We reviewed one of the letters, which was sent to some parents. We were told that a safety alert was circulated within the trust to ensure that this batch of antibiotics was withdrawn from use and staff were informed of the learning from these incidents through a newsletter.

Services for children and young people

- We tracked the one serious incident, which occurred in April 2015. We saw that internal and external investigations had taken place and the safeguarding team informed of the incident. The investigation report was reviewed by a healthcare professional from another NHS trust. Learning had been identified which had resulted in policy development and a system was put in place to manage and monitor stored drugs. The investigation was shared with social workers attached to this family and with the father under duty of candour. The investigation was ongoing and as such, formal feedback to staff was still to take place.
- The trust incident policy (8 January 2016) was in line on 'Being Open' and 'Duty of Candour.' The 'Duty of Candour' is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. In addition, a risk-scoring matrix identified a traffic light system in relation to risk levels. These were, green, orange and red, which was the highest, risk category.
- 'Duty of Candour' was integrated into the incident reporting and complaints processes. During the incident reporting process should an incident score greater than three (this is an amber rating) then the duty of candour box appeared on the incident form so that duty of candour could be applied to this incident. Discussions with two staff confirmed that incident forms asked the staff member whether the parent or carer was informed of the incident and the staff member who completed the form would respond to this question.
- We spoke with eight staff about the 'Duty of Candour' regulation. Of these three clinical staff demonstrated some knowledge about the 'Duty of Candour' regulation. The other five other staff were aware of this regulation, but did not know the detail of the regulation, except that it was about openness.
- We asked four staff whether they had received training on the 'Duty of Candour'. Three said they had not received any training around the 'Duty of Candour,' whilst, one staff member said they had completed e-learning training but when asked were unable to identify what was involved in the 'Duty of Candour.'
- The children's service and neonatal unit had mortality and morbidity review meetings. This is a forum that has traditionally reviewed in-hospital deaths. We requested

minutes from the mortality and morbidity meetings and were told that the meetings were not minuted. We were told that mortality and morbidity were discussed at the paediatric improvement group (P.I.G) and the quarterly paediatric high dependency unit and adult intensive care unit joint meetings. Perinatal meetings with neonatologists and obstetricians take place where cases are reviewed. All child deaths were subject to a child death review.

Safety Thermometer

- The NHS paediatric safety thermometer is a national initiative, which uses a local improvement tool for measuring, monitoring, and analysing patient harm, and harm free care. It provides a monthly snapshot audit of avoidable harm including performance in identifying the deteriorating patient and escalation in care.
- Performance data about safety and harm-free care was captured monthly within the children's and young people's safety thermometer dashboard. Staff told us they could access this information, therefore keeping them informed of performance indicator outcomes.
- We reviewed seven audit results, which related to children surveyed from August 2015 to November 2015. Three of the audits included information on the proportion of patients with an early warning score (EWS) completed, triggered and not escalated, the proportion of patients with an early warning score (EWS) not completed for each set of observations in the last 12 hours and the proportion of patients with harm free care.

Cleanliness, infection control and hygiene

- Each clinical area had an infection control 'link' staff member. Staff told us that they could easily contact the infection control team, which meant appropriate professional advice was available.
- Generally good infection control practices were observed by staff, however, we observed that some staff did not always use protective equipment such aprons on entering and leaving cubicles identified as being under protective precautions. Two parents and one young person identified concerns that staff did not wash their hands, wear aprons or gloves. An example was given where a nurse had cleared up vomit and proceeded to see another child without washing their hands.

Services for children and young people

- We observed good infection prevention practices by staff whilst on the neonatal unit. These practices included hand washing and the use of hand gel between patient contacts.
- We saw cleaning schedules in place, which identified the tasks and frequency of cleaning in each area. These cleaning schedules were completed with signatures and dates to confirm the respective tasks were completed. Discussions with staff confirmed that nursing and ward assistants had specific roles in relation to cleaning duties.
- Staff received infection prevention and control training as part of their induction and as part of the annual mandatory training. Staff confirmed completion of yearly on line infection control training. The children's service training statistics as of January 2016 confirmed 82% of nursing and midwifery staff and 69% of medical and dental staff within the children's departments had completed infection prevention and control training. The neonatal department training statistics as of January 2016 confirmed that 97% of nursing and midwifery training staff had completed infection prevention and control training.
- Specific neonatal training compliance was provided from April to November 2015 against hand hygiene and cleanliness statistics. We observed 100% compliance for hand hygiene and 99 to 100% compliance for cleanliness scores.
- Monthly directorate infection control performance reports from April 2015 to October 2015 reported on 15 different areas, which included antibiotic prescribing guidelines, cleanliness and hand hygiene. The risk matrix was identified through a red, amber and green compliance rating. Green was 95% and above, red (high risk) was identified as 90% and below. Two results from the October 2015 report for hand hygiene and cleanliness were 93 % (Acorn ward) and 100% (Somerset neonatal unit).
- The children's unit comprised of 27 beds which included a two-bed high dependency unit, a dedicated adolescent bay; two cubicles with ensuite facilities for children with oncology conditions.
- In the neonatal unit special care area, we observed there to be limited space around the baby's cot area. This meant there was limited room for parents to carry out care for their baby and potentially could compromise confidentiality when discussions took place.
- In the neonatal unit, we observed that some resuscitation equipment was out of date, despite daily checks taking place. The out of date equipment included, one guedel airway – size 00 (11/2015), two blood bottles (11/2014) and one blood bottle (12/2014). This equipment was given to the nurse in charge to arrange replacement of these items.
- On the children's wards, the equipment on the resuscitation trolley which was out of date included airways, a paediatric oxygen mask, a breathing filter, bag valve mask and a tracheostomy connector. Some of this equipment was dated 2014. The bag valve mask or ambu bag is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.
- A book was present to sign; however, there was no list of equipment identified. We observed that the last check had taken place on the 25 January 2016, which listed the equipment checked. No reference was made to the out of date equipment we found on the trolley. We observed that the checking of the resuscitation equipment was sporadic from the documentation of checks we reviewed. An example included a period in August 2015 where there had been three weeks between resuscitation equipment checks. We asked senior staff what the policy was in relation to the monitoring of resuscitation equipment and were told that the aim was to complete daily checks and that staff were informed of the frequency of resuscitation equipment monitoring. We reviewed the trust resuscitation policy and noted there to be no written guidance on resuscitation equipment monitoring. We escalated this to senior staff who identified that it was the nurse's duty to check the equipment, which was documented on the nursing handover sheet daily.
- Limited resuscitation equipment was kept in the child development centre. The equipment included oxygen, suction, and a small and large ambu bag. Staff told us

Environment and equipment

- Equipment suitable for babies, children and young people was seen in all clinical areas.
- We checked some equipment throughout the service and saw that each had stickers with dates confirming that maintenance checks had taken place.

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that in a resuscitation situation the fully equipped resuscitation trolley would be brought from Oak Ward. We asked whether a risk assessment had been completed as the fully equipped resuscitation trolley was shared between three clinical areas and were told that a risk assessment identifying potential risks was not completed. We escalated this practice to two senior staff on the children's ward.

- In the children's outpatient department we observed that the ambu bags which had oxygen, tubing attached were not stored in individual bags. The nurse was unable to tell us when this equipment had last been used and arranged for their replacement. On returning to the children's outpatient department, we were shown the newly replaced equipment.
- In the adult intensive care unit, we observed out of date resuscitation equipment on the children's resuscitation trolley. The equipment included, two guedel size one airways, and the sister on the unit was informed. We also observed that the resuscitation trolley was not locked.
- The milk kitchen fridge on the neonatal unit was identified as having daily checks. We reviewed the checklists for the milk kitchen fridge and observed there had been occasions when it was not checked. For example, checks had not taken place on the 23, 25 and 27 January 2016.
- We observed that the door (room 29/4) to the staff room in the child development centre did not close. We escalated this to the nurse in charge who reported this to the relevant maintenance department.
- On Oak Ward in bay three, behind bed three we observed some window edging to be broken. A temporary repair had been applied.
- Appropriate measures were in place to maintain security within the children's ward areas and neonatal units. Security cameras were located throughout the building and people either had to ring a bell to enter the clinical environment or use password access.

Medicines

- Medicines management was mainly in line with trust policy, for example medicines were locked in cupboards; the nurse in charge carried the controlled drug keys. We reviewed seven drug charts and no gaps were seen against the entries.
- We saw gaps in medicines management practises. On the neonatal unit, the lockable drug fridge was

unlocked. We asked staff whether it was normal practice to leave the drug fridge unlocked and were told it was. We escalated this practice to the matron. We noted that daily drug fridge checks had taken place and were documented. We also observed that with the exception of two days in January 2016 the drug fridge was checked daily. This meant that the efficacy of medication could not be assured.

- On the neonatal unit, we observed that two medications, which were, opened on the 5 October 2015 and the 16 December 2015 still in use despite both expiring within one month of being opened. The use of this medication was escalated to the nurse in charge and later to the matron. The medication was immediately removed from use by the nurse in charge.
- In the child development centre, the resuscitation drugs container was not sealed and no checklist was available to identify what drugs should be in the container. No monitoring records were available. The resuscitation drugs were kept in an unlocked cupboard in a room where the door had been left open. We asked the nurse whether this was normal practice and whether any of the resuscitation drugs were missing. The nurse was unable to tell us what resuscitation drugs should be present and confirmed that the door to the room should be kept locked. Following this, the nurse contacted the paediatric pharmacist and arranged for the resuscitation drugs container to be replaced by pharmacy; the resuscitation drugs container was replaced the same day by pharmacy.
- Two dedicated pharmacists provided support for the neonatal and children's services.
- Nursing and medical staff received medicines training at induction.
- Medicine audits had taken place, for example, the daily clinical pharmacy audit (27 January 2016) data highlighted errors in two prescriptions. The Pharmacist reviewed the prescriptions of all 10 patients and performed 4 medicines reconciliations. The errors in the prescriptions were raised with the prescriber on the ward who completed the missing information. The pharmacist also used this opportunity to remind the prescriber of the importance of ensuring that their prescriptions were always clear and complete.
- Quarterly controlled drug audits had taken place; we saw the completed 'Controlled drugs - Storage and reconciliation report' audit dated the 19 March 2015 for

Services for children and young people

Acorn ward which had been carried out by the pharmacist. Two actions from this audit were identified and communicated to the nurse in charge who signed to say they had read and agreed the report.

- The results of an antibiotic prescribing audit (December 2015) identified 95% compliance.

Records

- We observed records were stored in an open notes trolley in the neonatal unit. One mother from the children's ward identified concerns regarding children's notes being left out on desks, which meant people could read them without staff noticing.
- We reviewed a mixture of 13 sets of medical and nursing notes. On the children's ward, we observed information gaps existed within four children's records. One example included a child's nursing admission booklet, which had not been fully completed. The sections related to the STAMP screening tool for the assessment of malnutrition and liability for loss of property was not completed. The child's tube feeding care plan did not identify the frequency of weight monitoring and the care plan was not dated. We reviewed a child's medical notes, which were disorganised, had 21 loose papers in the file and some dates and times were missing from the entries
- We checked three surgical safety checklists for children collected from theatre and saw that the anaesthetic section was not completed for the time out section in two of the three checklists.
- On the neonatal unit, we saw that risk assessments were in place, which reflected what was identified on the baby's care plan. The care identified in the baby's care plan reflected the decisions made by the medical staff. Care plans were individualised to the baby's needs and identified potential risks. Guidelines relevant to the baby's care were in place, for example, gastric feeding tube guideline and guidance on baby's position was identified on the neonatal unit-positioning chart.
- Reviews of children's care had taken place by the multidisciplinary team and changes documented in the baby's notes.
- Children's care plans were pre-printed, standardised plans. Some had been individualised and were relevant to the child's care.
- Weekly medical and nursing notes audits had taken place, which explored demographics, the use of black

ink and dating all inputs and timing. The week 14 (18 January 2016) audit confirmed 100% compliance in the use of black ink and dating entries, whilst timing and the recording of demographic information scored 90%.

Safeguarding

- The children's service had a dedicated children's safeguarding team who worked closely with the adult safeguarding team. The named nurse was supported by a named doctor, a deputy named doctor and band six safeguarding link nurse from the clinical areas. A separate community safeguarding lead also formed part of and communicated with the hospital safeguarding team. The team was part of the South West Safeguarding team with whom they attended quarterly meetings.
- Safeguarding reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide. The assurance of safeguarding practice in the trust is reported via the trust safeguarding committee bimonthly. Governance is provided through the paediatric departmental clinical risk group and directorate governance committee. An annual children's and young people's safeguarding report was produced by the named nurse and named doctor for safeguarding children and was presented to the trust board.
- Weekly meetings took place involving all lead staff for children's safeguarding. These included the named nurse for children's safeguarding, the named midwife for safeguarding, the Matron for children's services, named doctor and deputy named doctor for children's safeguarding. The team was supported by a teenage pregnancy midwife lead, and senior midwives.
- Staff told us they had effective working relationships with the local children's safeguarding teams and other healthcare professionals such as health visitors. We were told that safeguarding personnel from the trust also attended the quarterly meetings with the local children's safeguarding board and the health advisory group.
- Staff demonstrated knowledge of the safeguarding guidance to follow. They knew what to do and who to contact should a concern be raised. For example, children with challenging behaviours. Staff confirmed that feedback was received and lessons learnt from individual safeguarding incidents.

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- Staff told us that concerns about safeguarding issues were also recorded in a safeguarding handover book. We observed that some of the concerns recorded did not have actions identified.
- The 'Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3)' recommended qualified staff groups be trained to a level three standard in safeguarding. Staff attended child safeguarding training, initially at trust induction and then during annual mandatory training. The trust identified that there had been difficulties accessing multiagency level three safeguarding training for staff groups due to limited availability of this training. This had been identified this as a risk on the women's and children's risk register. The trust provided enhanced safeguarding training at level three as an ongoing programme, led by the Named Doctor for Safeguarding. This meant that staff requiring it within the children's unit received this advanced level of training. This was in addition to e-learning modules on domestic abuse, fabricated or induced illness, sexual exploitation and female genital mutilation.
- The trust had set a target of 90% compliance in level three safeguarding training which they hoped to achieve by July 2016. Progress will be overseen by the trusts safeguarding committee, with any areas of non-compliance addressed through the trusts performance assurance framework process. Level three training was identified in the safeguarding annual report which was discussed at the trusts governance board sub-committee (1 October 2015).
- The latest trust training statistics provided on the 'CQC Safeguarding Children return' (11 April 2014) identified that 68% (23 out of 34) of paediatric medical staff had completed level two safeguarding training. Whilst, 25% (four of 16) medical staff had completed all four level three safeguarding modules during 2015/2016.
- Level two safeguarding training attendance was between 50 to 86% for children's palliative care, children's day surgery, children's diabetes team, children's outpatient department and the children's unit. This meant that the trust had been unable to comply with the intercollegiate safeguarding training guidance ((March 2014, v3).
- Level two safeguarding training attendance at 100% was identified for women's and children's management, the Somerset neonatal unit, homecare and community nursing teams.
- Staff could access level three e-learning modules hosted on an online learning platform which were provided as an alternative due to the difficulties experienced accessing face to face training. The modules included domestic abuse, factitious and induced illness, female genital mutilation and child sexual exploitation. The 2014 / 2015 annual child safeguarding report confirmed that 100% of staff who required this level of training had completed this training during 2014/2015.
- The latest trust training statistics provided on the 'CQC Safeguarding Children return' (11 April 2014) identified that 75% (9 of 12 nursing staff) had completed the four level three safeguarding modules in 2015 /2016.
- The 'CQC Safeguarding Children return' (11 April 2014) identified staff groups potentially requiring enhanced / level three training in 2016 / 2017. For paediatric specialities these were, medical and dental – 15 of which two (13%) had completed the four safeguarding modules. For nursing and midwifery the headcount was 98 of which 68 (69%) had completed the four safeguarding modules.
- A poster advertised monthly safeguarding supervision sessions for staff from July to December 2015. However, senior staff told us that there had been limited staff interest for these sessions.
- The safeguarding team liaised with the specialist midwifery team when a pregnant young woman was admitted to the antenatal maternity service. Systems were put in place to support the young woman. Safeguarding teams had supported families whose infants were placed under a 'child at risk' order prior to birth. Following the baby's birth, the multi-disciplinary team had been involved in the discharge planning process to ensure that appropriate measures and support were put in place for the baby and family.
- If a child did not arrive for an appointment, the clinician covering the clinic reviewed the child's notes and made a decision, usually to send out another appointment. Guidance was also available for staff to access on the trust intranet for this situation.

Mandatory training

- We spoke with members of staff of all grades, who confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, paediatric resuscitation, fire safety, manual handling, infection control, and safeguarding.

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- Mandatory training was identified as essential learning and included training sessions in information governance, equality and diversity, safeguarding adults and children – level 1, dementia, counter fraud, major incidents and fire. The mandatory training target was to achieve 92% or above, this was rated green against the traffic light system developed by the trust to identify compliance levels. Training statistics for the 2015 - 2016 training year period confirmed attendance by 100% of neonatal staff, whilst in the children's department 89% of nursing and midwifery staff and 66% of medical and dental staff had attended mandatory training. These training statistics confirmed shortfalls in staff attendance at the mandatory training sessions provided through the trust for the current year.
- Staff told us the band seven ward sister was advanced paediatric life support (APLS) trained and that other nursing staff who worked within the high dependency unit had completed their European paediatric life support (EPLS) training, however, staff had not attended training updates which meant their skills had not been updated in this area. Staff told us there was not a nurse with either APLS or EPLS training on each day and night shift, however, we were told that medical staff were trained to this level.
- This meant that the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the RCN (2013) staffing guidance, although 79% of nursing staff did carry the PILS qualification for paediatric life support.
- We received additional information following the inspection on staff completion of paediatric life support training. The figures provided confirmed that 94% of nursing staff had attended basic paediatric support training, whilst, 79% of nursing staff had attended the paediatric intermediate life support (PILS) training. For medical staff attendance, we saw that 100% had attended PILS training.
- The trust identified that all doctors at specialist registrar grade had completed either European Paediatric Life Support or Advanced Paediatric Life Support training. The training figures provided by the trust identified that 74% (20) of the medical staff had completed these training sessions and their qualifications in this area were in date.
- 83% of Healthcare assistants completed yearly update training in paediatric basic life support.

- Training statistics for the adult critical care team confirmed that 100% of medical (six) and nursing staff (11) had completed European paediatric advanced life support (EPLS) or APLS training. In the last 12 months, four medical staff and 13 nursing staff from the critical care unit had completed PILS training.

Assessing and responding to patient risk

- The service had identified guidelines and protocols to assess and monitor patient risk in real time, and react to changes in risk level.
- The paediatric advanced warning score (PAWS) and the neonatal early warning score (NEWS) were additional tools used to monitor children and babies who may be at risk of deterioration by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. We were told that 'sepsis six' information was being integrated into the PAWS chart.
- The NEWS tool was used to assess babies who were cared for in the low dependency unit; it was completed once per shift and escalations were triggered according to the score.
- Risks to babies on the neonatal unit were identified during their initial assessment and identified within care plans. These risks were reviewed daily or as required. At the shift handover, safeguarding issues when identified were communicated.
- We saw that reminders relating to assessment processes were circulated through staff newsletters. The May / June 2015 children's newsletter identified that staff should complete children's paediatric advanced warning scores with every reading and that scores of three and above were to be escalated to the medical team. If unable to contact the doctor within one hour, proceed to call the consultant on call. It was documented that this escalation process also applied to children on the 'Sepsis 6' care pathway.
- Retrieval services for children and neonates are provided by Wales and West Acute Transport (WATCH) in the south of the region whilst the 'Newborn Emergency Stabilisation Team' (NEST) provided the equivalent service for the north of the region. Their role was to transfer sick babies and children to the paediatric intensive care units based in Bristol and Cardiff. .
- A two-bed high dependency unit (HDU) was based on Acorn Ward. The trust stated that funding was provided for the paediatric high dependency unit (HDU) to meet

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the requirements in line with bed occupancy over the year. This was monitored through the South West Specialist Clinical Network. Limited funding for the paediatric HDU had affected the numbers of staff employed to provide this part of the service. Band six nursing staff who worked in the HDU were managed and supported by a band seven nurse who was HDU and APLS trained. Staff told us there had been occasions when three to five children who required care in the HDU had been cared for in the ward area as the HDU area was full.

- Staff told us of a risk assessment system in place for services attended by children and young people outside of the children's service. We were told that each service, for example, outpatients and the emergency department had a risk assessment completed and regular meetings had taken place with staff in these areas. Twelve risk assessments had been completed for each area children and young people may attend.
- The World Health Organisation (WHO) five steps to safer surgery checklist (SSC) is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. Surgical safety checklist (previously referred to as WHO audits) audits had taken place. The audit was completed to show compliance with the World Health Organisation (WHO) surgical safety. However the move to a new electronic system meant that accurate data was not available. Previous audits showed that 99% of checklists were completed.
- Staff told us that paediatric 'sepsis six' was introduced 12 months ago. The sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with severe infections. Staff received in-house training on 'sepsis six' and how to use it. The trust confirmed that 74 staff which included nurses and doctors attended this training.
- A paediatric 'Sepsis 6' flowchart had been developed which advised on the signs of sepsis and the treatment route to take should sepsis be suspected. An audit to determine whether 'sepsis six' criteria had been implemented in practice took place in January and February 2015. Eleven children's notes were reviewed to determine whether the 'sepsis six' criteria was considered within 60 minutes for all children suspected of severe sepsis. Findings identified that 'sepsis six' in 60 minutes was not completed in two out of three cases. Three recommendations were made which would be

used to inform a future audit as well as regular reminders and revision of 'sepsis six' and the inclusion of this training at staff induction. There were no children on the paediatric unit currently on the sepsis six treatment pathway during our visit. The three children's notes we reviewed did not identify that the child's condition met the criteria for sepsis six treatment.

Nursing staffing - Children's service

- The children's service confirmed that all registered nurses within the children's unit were trained in accordance with The Nursing and Midwifery Council (NMC) requirements to care for sick children.
- We reviewed the funded nursing establishment against the actual (staff in post) staffing establishment which identified practically a full establishment of staff. In total 16 wte band six nursing staff were in post, against a funded establishment of 15.5 wte band six staff. In addition, 1.9 wte band seven nursing staff worked Monday to Friday. One band seven nurse held a children's high dependency course qualification and had responsibility for the operation and staffing of the two paediatric high dependency beds. Staff confirmed Monday to Friday from 8am until 6pm a supernumerary nurse, the ward manager, took charge of the ward areas.
- The children's service had an identified bleep holder per shift who was a senior children's nurse at band six or band seven. A senior band five bleep holder role had been introduced two years ago; however, we were told that not all band five nurses were willing to carry out this role. Staffing shortfalls were escalated to the lead children's nurse as necessary and through to the site on call system. We were told that there was no formal nursing on call system in place; however, ward managers would come into the hospital to provide support when required.
- Staff told us that an acuity tool was not used to determine staffing needs. The potential risk was mitigated by reviewing patient acuity and staffing at each shift to ensure staff were placed in the most appropriate clinical area. Information provided by the children's service identified the plan was to assess and test a locally developed acuity tool. They confirmed that nurse patient ratio was assessed on the number of inpatient children and incoming emergency admissions, condition of each child, treatment level of care and

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nursing input required, for example, safeguarding aspects and mental health issues. We were told that annual budgeting for staffing was based on bed capacity and number of staff requirements per shift.

- The 23 September 2015 report to the trust board provided a six monthly appraisal of the trust's status for the provision of nurse and midwifery staffing levels, and provided the trust with assurance of the work in progress to monitor and manage safe staffing levels of nursing and midwifery staff in the trust. Because of the lack of a recommended tool, formal workforce planning with a nationally endorsed evidenced based tool was not undertaken within children's services at the trust. In the interim, ongoing informal benchmarking with three other trusts within the South West (Yeovil, Exeter and Bristol) had taken place and provided assurance that the trust achieved comparable levels with similar paediatric units.
- Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance. Discussions with staff confirmed that generally, staffing levels were safe and staff were replaced when there was staff sickness. However, best practice staffing guidance within children's services was not fully implemented. One staff member said that on occasions, when staff were replaced following sickness, the staffing skill mix was affected especially when new bank or agency staff worked on the ward. Roles, which included the administration of intravenous medication, could not be given by these staff groups.
- Staff said agency nursing staff were rarely used. This comment was corroborated by a senior manager who confirmed that one agency nurse had been employed in the last 12 months. Where agency medical and nursing staff were used they were given an induction to the ward area. This ensured that they were aware of emergency procedures. We saw one of these orientation programmes, which had been completed by a staff member before they started on the unit. A bank nurse completes a shadow shift on the unit before their first shift working as part of the team.
- One staff member said that they had completed three staffing incident forms when there had been insufficient staff to safely staff the ward. Despite this, they felt that the staffing shortfalls had not improved; however, they recognised that senior staff supported them on these occasions.
- We reviewed the four week rota for the children's wards from 18 January 2016 – 14 February 2016 and noted that all the day shifts and all but one night shift had band six nursing cover.
- The trust said funding for the two-bedded high dependency unit (HDU) was proportional to bed occupancy and monitored through the South West Specialist Clinical Network. The funded staffing establishment was 4.71 wte-trained nurses. Eight band six nursing staff (not all of which were full time) worked in the HDU and were managed and supported by a band seven nurse who was HDU and advanced paediatric life support (APLS) trained.
- We were told that the majority of time the HDU was staffed by band six nurses who had completed the HDU course; however, there were occasions when an experienced band five nurse who did not have the HDU course would work in the HDU area. We spoke with one staff member who had worked in the HDU. This nurse was not HDU trained. They said there had been occasions recently when there had not been HDU trained nurses on shift so the support they had received was through contact with the adult intensive care unit.
- We reviewed the HDU staffing rota for month commencing the 18 January 2016 and noted shortfalls of band six nurses on six day and nine night shifts. Nursing staff had access to outreach support when necessary for advice and support.
- Staff told us that during the daytime there was always an oncology-trained nurse on shift to provide care for children with oncology conditions. A paediatric nurse practitioner (0.2 wte) also supported the service.
- Staff told us that when children who self-harmed were admitted they approached the children's and adolescent mental health service (CAMHS) team to provide nursing support for the child or young person. Staff told us there had been occasions where difficulties were experienced getting a registered mental nurse (RMN) through CAMHS for children requiring one to one

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care, however, this was now improving. We saw from agency bookings made from the 12 January – 15 January 2016 that an RMN had recently been employed through CAMHS to care for a young person.

- A paediatric nursing community team of 10 children's nurses supported the children's and neonatal service throughout the Somerset region. Nurses within this team specialised in areas such as home care, palliative care, continence, babies nursed on home oxygen, epilepsy, attention deficit disorder and behavioural issues and, cystic fibrosis.

Neonatal staffing

- Neonatal staffing did not fully meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011) (BAPM) because they could not always provide 1:1 and 1:2 care for babies who required intensive care or high dependency care. The staffing report (1 April 2015 – 26 January 2016) confirmed that 32% of shifts were not compliant against the neonatal staffing toolkit. Because of this the neonatal caseload has been reduced by 0.34%. The failure to comply with the neonatal toolkit in respect of staffing and the potential risk to the neonatal intensive care service had been recognised as a risk on the women's and children's risk register.
- The failure to comply with the neonatal toolkit in respect of medical cover overnight and the potential risk to the neonatal intensive care service had been recognised as a risk on the women's and children's risk register.
- The South West Neonatal Network recorded neonatal daily staffing levels across the South West and the trust was comparable in terms of levels of neonatal staffing with other units in the South West.
- Neonatal nurse practitioners worked on the Somerset Neonatal Intensive Care Unit (SNICU) and the nurse in charge of the neonatal unit was the ward manager. The ward manager post was currently job shared by two band seven nurses. The band seven nurses confirmed that they worked Monday to Friday from 8am to 4pm.
- An advanced neonatal nurse practitioner (ANP) worked on the registrar rota, whilst a paediatric nurse practitioner (0.2 wte) also supported the service. The nurse practitioner's role was to assist the medical staff. A second ANP was due to complete their training and an additional two more were due to commence ANP training.

- A senior manager confirmed that the neonatal service met the qualified staff in speciality (QiS) 70:30 ratio of 70% registered to 30% unregistered staff. QiS nurses currently employed made up 76.78% of trained staff. The trust confirmed that 85% of staff were qualified in speciality as neonatal intensive care nurses.
- Escalation pathways were in place for neonatal staff to use.
- We observed a nursing handover on the neonatal unit, which identified how many babies were in the unit, including level of dependency, care and treatment needs and investigations due to take place for each baby. Social and discharge updates were identified.

Medical staffing

- The children's service confirmed that they were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity. This additional cover was planned to prevent and reduce avoidable admissions for children through the availability of paediatric advice and guidance to the emergency department and to GPs.
- The service employed seven consultants within the acute children's service, two community consultants and five neonatal consultants.
- On the 27 January 2016, we saw that a consultant undertook the registrar role in this person's absence. Discussions with five medical staff identified that consultant staff had frequently taken on the registrar role due to current staff sickness.
- Staff from the neonatal unit identified concerns that the service had three vacancies at registrar level. Medical locums were used to fill these vacancies.
- A consultant coordinated a teaching programme for medical staff. So that medical staff could attend teaching sessions, the consultant would hold the junior doctors bleeps. The medical staff confirmed teaching was available to access, for example, the journal club on Tuesday morning and again Tuesday lunchtimes where children's cases were discussed. GP trainees said they also attended a GP training session on Wednesday afternoons.

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- The trust had a designated paediatric surgeon responsible for children's surgical services.
- Staff told us that there was a good medical presence and support throughout the service. In addition, the out of hours support provided by consultant level staff was described by staff as supportive. Junior medical staff told us they had been able to access consultant or registrar level doctors when needed. Two consultants provided out of hours cover for the service.
- Anaesthetic consultant and intensivists were available out of hours to provide anaesthetic advice and support for children's services.
- We observed one of the paediatric handovers led by the consultant paediatrician and one neonatal medical staff handover and saw they were thorough. The discussions included details of overnight admissions presented by the nurse in charge. The junior doctor presented individual children's cases, whilst the consultant and other doctors contributed to the discussion.
- We observed a ward round on the neonatal unit. Once the medical team had completed a review of each babies care the registrar documented the treatment plan and investigations required into the baby's medical notes. We observed an example of good practice when the registrar generated and completed a 'My plan for the day' document for each baby. This plan identified the shared tasks for the day and allocated responsibilities. The medical staff also documented their tasks into their respective workbooks.

Major incident awareness and training

- The trust had a business continuity plan, which ensured critical services were delivered in exceptional circumstances.
- A trust major incident plan (version 1, 2016) which was supported by action cards for each clinical area was in place. This plan identified staff specific roles and the measures to be put into place should a major incident take place. During normal working hours the matron is the link between wards and the control room team, and all communication should be via this route. Out of hours, the clinical site management team are the link to the control room team.
- In the event of an incident children are admitted to the children's ward. The plan identified that 'Families should be kept together as far as is practical, paediatric trained staff should become involved as soon as possible. Children requiring admission, who do not need ITU/

HDU, will be admitted to the paediatric department. Children who do not require admission, but are separated from their families, should be cared for in the TOPS Day Nursery. This will be staffed by TOPS staff or paediatric nurses, depending on availability. Paediatric Social Workers may need to be involved.

- The last major incident exercise, which involved the children's service, took place in 2014.

Are services for children and young people effective?

Good



We judged the effectiveness of children's and young people's service as good.

- The service provided evidenced based care as identified within evidenced based clinical guidelines. Monitoring of clinical guidelines had taken place; however, we observed a number of clinical guidelines to be out of date. We could not be assured of how effective the monitoring of guidelines had been.
- The neonatal service were working toward stage one UNICEF Baby Friendly accreditation.
- Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for children and young people.
- Improvements in children's and outcomes were monitored and in some areas showed a worsening in outcome. In response to this audits had taken place.
- Training was in place for staff who worked in areas outside of children's services into services to which children may be admitted, for example, adult critical care unit.
- The children's service identified they had some transition arrangements in place for young people entering adult services, for example the diabetes service.
- Effective working relationships between CAMHS professionals and paediatricians existed.
- Good multi-disciplinary team working existed, which was supported by information sharing.
- Transition between adult and children's services was being developed; guidance was in place and the standards monitored through the transition dashboard.

However we also found:

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- Staff were not able to verbalise clearly the guidance surrounding the Frazer guidelines and Gillick competence. One of four staff we spoke with demonstrated some understanding of this guidance and how they implemented it in practice.
- Trust appraisal statistics confirmed shortfalls in medical staff yearly appraisal. Staff told us their training needs were supported and they had received development appropriate to their needs. However, we noted shortfalls in staff training which related to children with mental health issues.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care. We reviewed a selection of evidenced based guidelines and saw a sample of two children's guidelines (gentamicin and sucrose) were within their review by dates and were evidenced based. We reviewed six additional medical clinical guidelines and noted that they were all out of date. During our discussions with a senior staff member we were told that, a number of children's guidelines were out of date, approximately 15 to 20. This was recognised by the service and the guidelines were in the process of being updated.
- We reviewed a random selection of nine nursing guidelines and noted that all but one guideline were within their review by date. The guideline related to the referral route of surgical patients to and within paediatric wards; review date was identified as 2015. However, this guideline was currently being updated by the paediatric anaesthetist.
- Monitoring systems were in place to ensure that clinical guideline and policy reviews took place. We saw this in practice in the minutes of the paediatrics and neonates meeting (16 September 2015). However, it was not evident how effective these monitoring processes were due to clinical guidelines being out of date.
- Evidenced based guidance was in place for the 'Antibiotic management of neonatal sepsis on the neonatal intensive care unit, including prevention of early onset neonatal infection.' (August 2014).
- Discussions of the national safety standard for invasive procedures (7 September 2015) and its implementation took place at the paediatric and neonatal departmental meeting in October 2015. The outcome was to incorporate two sections into the local guidelines; this work was identified as in progress. The standards were developed to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures and allows organisations delivering NHS-funded care to standardise the processes that underpin patient safety.
- The paediatric diabetes multidisciplinary team had adopted network agreed clinical guidelines, which were available on the trust intranet. The neonatal guideline group met monthly.
- An evidenced based 'Paediatric and Adolescent Generic Transition Guideline' (1 June 2015) based on national guidance was available for staff to follow.
- Senior managers and staff we spoke with confirmed that guidance was in place for nursing staff on how to care for children who self-harmed. We saw the guidance in policy format for staff to access, for example 'paediatric deliberate self-harm with suicidal ideation and / or overdose (1 March 2013)' and 'Overdose (1 March 2013).'
- We were shown a completed template document which confirmed compliance against the Royal College of Surgeons children's standards for surgery. The document used a traffic light system to rate its self against each surgical standard. The trust identified each standard was in place as part of its grading exercise. However, we observed that the document although dated as October 2015 did not identify the name of the trust on the top of the template.
- The service's transition dashboard related to the standards of care for young people transitioning from children's to adult services. A traffic light system was identified (Red, Amber and Green (RAG)) which confirmed the services compliance against each standard. We saw that the service had RAG rated six areas as red. Two red examples included, the involvement of young people in patient led assessments of the care environment (PLACE) and staff training. Current practice was there were informal consultations with young people regarding PLACE assessments rather than young people taking part in the PLACE assessment.

Pain relief

- The trust pain management team provided help and advice on pain management issues and were contactable by bleep.
- We tracked two children's pathways who were admitted for surgery; part of the pathway related to pain management. We observed pain management

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discussions with one child's parents prior to surgery. For the second child the nursing staff had assessed the child for pain postoperatively to determine whether the child required any further pain relief. We reviewed a sample of children's pain charts and saw that children's pain scores were escalated as per trust guidance.

- Babies, children and young people had access to a range of pain distraction techniques and pain medication. If babies were unsettled or appeared to be in pain, this observation was discussed with the doctor to determine whether pain relief was required.
- The assessment tools used to assess children's and young people's pain responses include a smiley face tool and a 1-10 tool. Reassessments of children's pain took place following medication given to relieve the child's pain to ascertain whether the medication had provided effective relief.
- Pain protocols were available for staff to access, for example, paracetamol and ibuprofen, codeine for the over 12's and oromorph for the under 12s. However, one young person told us that although they had told nursing staff they were in pain the nursing staff had not given them pain relief.
- Out-of-hours an anaesthetist was on call and structured pain relief was in place for each child. Surgical and oncology medical trainees had received training to enable them to prescribe patient controlled analgesia.

Nutrition and hydration

- The July 2015 children's newsletter identified that the care improvement team had reviewed nutrition by undertaking a walk about of the children's unit. The outcome had resulted in positive feedback and some suggestions. The suggestions were to protect meal times between 12 – 2pm and 5pm – 6pm, encourage young people to wash their hands before eating, deliver dessert separately from the main course and signpost parents to the boards, which displayed the menus.
- A variety of food choices was available to children and young people. Special diets, for example diabetic, gluten free, renal, textured and allergy diets were available. Specialised milk formulae were provided through pharmacy.
- A selection of basic foods were kept on the children's wards which could be provided outside of the main meal times.
- All mothers on the neonatal unit had lunch provided and was confirmed by the mothers we spoke with.

- Paediatric dietitians were involved in undertaking nutritional assessments in children. We saw dietetic involvement in some children's care had taken place when we reviewed children's medical notes. Nutrition plans were developed and reviewed by the dietician where required.
- Infant feeding sisters support the promotion of breast feeding and feeding initiatives in the neonatal service.
- The 'Baby Friendly Initiative' is a worldwide programme. The Organisation and UNICEF established in 1992 to encourage maternity hospitals to implement the 'Ten steps to successful breastfeeding.' The neonatal unit was working towards the 'World Health Stage One Baby Friendly Accreditation' in 2014. Stage one of the programme involved the service developing baby friendly policies and procedures to support the baby friendly standards.
- Children were weighed on admission and a stamp assessment completed to determine malnutrition status were carried out. However, one child's notes, which were reviewed, did not show that the STAMP assessment had been completed despite that child having regular nasogastric feeds.

Patient outcomes

- The Care Quality Commission pre-inspection document for children (27 November 2015) summary of analysis identified that the paediatric diabetes audit 2013/14 showed a higher percentage of patients, 34% had controlled diabetes compared to the England average of 18%.
- The diabetes service underwent a paediatric diabetes team peer review and national benchmarking data peer review in September 2014. The peer review self-assessment was rated 100% for hospital measures for children's and young people's services and 94% for children and young people diabetes multidisciplinary team. The network compliance results showed Musgrove Park Hospital was rated top against the remaining hospitals in the network for the first measure and joint lead for the second measure. The outcome of the peer review was very positive and identified no immediate risks or serious concerns. Two concerns were identified which related to ensuring the level of funding was maintained to ensure a good quality of service to patients was maintained and a recognition that some pump and meter download facilities were reliant on charitable funding.

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- We were told of an audit which had been undertaken relating to readmissions of children cared for in day surgery and children who were inpatients following surgery. The audit was carried out by the ear, nose and throat department in relation to paediatric day case and inpatient tonsillectomies. Inpatients had increased readmission rates when compared to day surgery patients due to pain and bleeding. The action plan was to roll out the post op analgesia guideline used in day surgery to the ward. The analgesic protocols are now standardised and the trust plan to re-audit 6 months post guideline introduction. This timescale was agreed due to the recognition that readmission rates are low.
- The neonatal unit audit programme for 2015 – 2016 identified named audits against six identified areas. Some of these audits included the neonatal audit programme (NNAP), reduction in term admissions and the senior review within 24 hours of admission. Rolling audit of compliance and documentation.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The neonatal service had the following 'Commissioning for Quality and Innovation' (CQUINs) identified for 2015 – 2016. Retinopathy of Prematurity (RoP), Breast-feeding, Temperature recording and Term admissions above 37 weeks of age admitted to the neonatal unit.
- The CQUIN data for quarter two for term admissions identified most term admissions were unavoidable in the current set up of maternity and neonatal services. A proposal to set up a transitional care ward was identified as a priority.
- The neonatal medical team had undertaken a number of 'rapid audit's' to determine progress against specific CQUIN targets. One example was an audit undertaken in January 2015 relating to babies less than 32 weeks – the theme related to a target identified within the neonatal audit programme (NNAP). The target was 'discussion with named senior member of staff (consultant, registrars and advanced neonatal nurse practitioner) within the first 24 hours for all admissions.' The audit showed that seven out of eight parents were spoken with which was a compliance score of 87%. Documentation of the discussion in the medical records was 25% (two of eight records) and electronically was 75% (six out of eight records). The results showed

improvements were required documenting the conversation and the action proposed was to highlight the need to record these conversations and that repeat audits would take place to monitor this. The audit was repeated in October 2015 and showed a reduction in compliance of 61% against this specific NNAP target. The requirement data for completeness was identified as 90% in 2015 and 95% in 2016.

- Shortfalls identified within the national neonatal audit programme (NNAP) 2013 said that the hospital had not achieved on all five items. For example, there were outliers for screening of 'Retinopathy of Prematurity' by NNAP on 2013 data. However, the trust identified that the shortfalls in compliance had been a result of data recording failures not of failing to comply with standards.
- We saw that the trust had improved against all but the target relating to mother's milk at discharge from the latest 2014 NNAP data published on the 5 November 2015. This meant that outcomes for babies were improving. An action plan had been developed to address the 2014 NNAP data, which identified the monitoring, and timeframes in place against each of the five target areas.

Competent staff

- Formal processes were in place to ensure medical and nursing staff received role specific training and an annual appraisal. Nursing staff told us they received yearly appraisals and training specific to their needs. Information provided by the trust confirmed that 92% of nursing staff and 61% of medical staff in paediatrics had an appraisal by the end of December 2015. Neonatal appraisal compliance was 90% by the end of December 2015.
- Staff had received training sessions in equality and diversity training to inform their clinical practice and decision-making. We saw that this training was provided through the essential training provided by the trust of which 91% of nursing and 78% of medical staff had attended.
- Staff told us that training was provided for staff but the uptake by staff was poor, despite staff being given time back for attendance at training courses.
- Six nursing staff had completed the Bristol based paediatric high dependency unit (PHDU) course. In addition, two nursing staff were waiting to attend the

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PHDU course. Discussions with individual staff confirmed attendance at the PHDU course, annual HDU training days, attendance at the oncology course and oncology study days.

- Following a yearly review, a decision was made to rotate ten nursing staff from within the service into the paediatric HDU to improve and enhance staff skills in this area. We were told that four of the ten staff also had the paediatric HDU course. However, we did not see the documentation confirming this.
- Some neonatal staff had attended external study days, for example, the breast-feeding nurse had attended breast-feeding training. Other staff had taken on extended roles, for example, cannulation and taking blood gases. Training had been provided by the trust,
- Medical and nursing staff confirmed attendance and satisfaction with their corporate and local inductions. Corporate and local inductions were in place for new staff throughout the service, For example, a local induction on the neonatal unit for one nurse included spending half a day with the ward manager and two weeks supernumerary status on the unit. In addition, the nurse worked with a senior nurse mentor during their induction, this ensured the induction was personalised to their needs.
- We saw a plan of medical staff 'Paediatric Educational / Clinical Supervision' for December 2015. Each doctor had an allocated consultant to support them identified. All medical staff were clinically supervised - by the hot week or on-call consultant.
- Staff told us that clinical supervision was not in place, however, where staff required support through this route it would be provided on request. Debriefing had taken place following incidents.
- The mentor map schedule (May 2015) confirmed there were sufficient mentors to meet student nurse's needs. The mentor may be older or younger, but have a certain area of expertise. It is a learning and development partnership between someone with vast experience and someone who wants to learn
- Senior staff told us that quarterly training had been provided by a local mental health NHS Trust for staff working within the children's service on how to manage the care environment. The trust confirmed that training was organised throughout the year but cancelled on a

number of occasions by the mental health NHS Trust. The training that took place was on 21 October 2015 with 10 nurse attendees which meant that 10 nursing staff had now attended this course.

- The trust confirmed that some adult critical care staff, theatre and recovery staff had received paediatric based training which included the paediatric high dependency module (10 staff), paediatric critical care module (2 staff) and two staff had attended refresher training days in Bristol. The training statistics identified that senior band 5 staff had access to this training as part of their development and in 2015 ten staff had attended the in house paediatric training day.

Multidisciplinary working

- Staff identified there were effective working relationships between children and adolescent mental health service (CAMHS) professionals and paediatricians. The trust policy had been produced in consultation with a consultant paediatrician, emergency department consultant and the CAMHS team.
- The CAMHS liaison team was available five days a week for direct input, however at weekends it was necessary for the adult psychiatric liaison team to be contacted to address child mental health care needs. The CAMHS liaison nurse had daily contact with the children's unit on weekdays. A staff member from the children's unit contacted the CAMHS Liaison Nurse Practitioner if there was an inpatient child on the unit. Staff told us that should a child or young person be admitted at the weekend, they were not seen by the CAMHS team until the following Monday. The Trust was aware of and involved in work that was ongoing to progress toward a seven day CAMHS.
- When a young person was between the ages of 16 and 18 years, the adult psychiatric team may be involved. Information provided by the service confirmed that regular psychiatric and social work involvement with CAMHS children had taken place until the child was discharged to their placement.
- For any challenging patient issues, the children's unit matron met with the security lead on an individual basis. Should issues be identified they were discussed at the bed meetings twice-daily where both the matron and security staff attend.

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- Discharge planning for the child or young person involved all members of the multidisciplinary team involved in their care, for example, nurses, community teams, continuing care team, GP, social care professionals and therapists.
- Nursing staff from the paediatric high dependency unit worked alongside their adult trained nursing colleagues in the adult intensive care unit (ITU). This meant adult staff were supported by the paediatric staff when caring for children in the ITU environment. The paediatricians provided joint care with their colleagues in the adult ITU when a child was admitted there.
- The matron for children's services planned to attend local county council meetings to integrate the transition system with what young people want when they come into hospital. The first meeting was due to take place in February 2016.
- Dieticians confirmed attendance at multi-disciplinary meetings and identified this process as good.
- Children's community nursing staff attended the 8am nursing handovers Monday to Friday. The senior children's community nurse liaised with school nurses for children of school age requiring treatment in hospital or the community.
- The 'Standards for Children's Surgery' were presented at a divisional governance meeting.
- All safeguarding referrals of children and young people were discussed and attended by members of the multi-disciplinary team.
- Meetings had taken place with the children's and adolescent mental health service (CAMHS) team to discuss pathways of care. CAMHS were also involved in monthly service development meetings with the trust. The trust identified that the outputs of multi-disciplinary team meetings were recorded per case discussed (by hand) and filed in individual patient records.
- Quarterly transition steering group meetings were held with trust executive and governance representation. Minutes of the January 2016 transition group meeting confirmed attendance of the multi-disciplinary team and discussion of factors affecting transition.
- The paediatric diabetes multi-disciplinary team (MDT) met monthly. Trust staff also attended the 'South West Paediatric Diabetes Network' meetings and the trust wide management group so that information was shared about young people's transition amongst the team regionally and at trust level.

- Weekly multi-disciplinary handover meetings took place to discuss babies currently receiving support.

Seven-day services

- Staff told us that CAMHS support was not available out of hours, which was identified as a serious concern. This shortfall in support was currently being explored with Bristol Children's Hospital to see whether a joint service could be provided between both hospitals.
- Twenty-four hour paediatric and neonatal consultant support was in place. The consultant rotas provided details of which consultants to contact that week. Consultant presence was from 9am – 5pm and on call consultant cover was provided from 5pm – 9am. Medical and nursing staff said they could access consultants out of hours and described the consultant team as supportive.
- Staff said they could access out-of-hours investigations, for example, urgent laboratory tests. On call pharmacy support and pharmacy access was available during specified times at the weekend.
- Radiology services were provided; however, not all radiologists were trained to perform ultrasounds on children.
- A children's community team provided on-call support at weekends to the ward staff should a child be discharged home requiring community nurse support.

Access to information

- Staff said that information was shared with health visitors and social work staff to update them and involve them in discharge planning processes of new mothers who had experienced mental health issues.
- A 'Paediatric and Adolescent Diabetes Transition Guideline' (issued: 1 May 2013) was available for staff to access which identified the requirements to ensure all young people with diabetes (15-19 years) received a quality service when transitioned from child-centred to adult-orientated services.
- The service used the 'Ready, Steady, Go' transition documentation identified for young people. Transition processes were in place for diabetes and oncology specialities, which meant that all the information required for young people's care was shared in a timely way.
- Joint diabetic clinics had taken place with adult and paediatric team involvement. Some of these clinics had

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taken place in the evening. Monthly transition clinics took place in Taunton and Bridgwater. A weekly clinic took place in Taunton whilst monthly an all-day clinic operated in Bridgwater.

Consent

- Staff demonstrated through discussion that they were informed of and understood the consent process. Staff explained the consent process was completed by surgeons for children requiring surgery and that written consent was obtained prior to this.
- Neonatal staff said that the majority of time parents gave verbal consent, however, on occasion written consent would be requested, for example, when a baby was to have a hearing test.
- We asked four staff about their understanding regarding the Frazer guidelines and Gillick competence in relation to consent processes for children and young people. One of four staff we spoke with demonstrated some understanding of this guidance and how they implemented it in practice.
- Gillick competence refers to the assessment that doctors could make in regards to whether a child under 16 years has the capacity to consent to treatment without parental or guardian consent. We saw three examples of completed consent forms in babies and children's notes; for example, consents for photography and the insertion of a venous access line.
- We reviewed children's and babies notes for evidence of consent processes and saw completed consent forms for specific investigations, for example, prior to surgery.

Are services for children and young people caring?

Good



We judged caring as good because the service provided compassionate care to the local population.

- Children, young people and their parents had generally received compassionate care with good emotional support.
- The majority of parents and young people were fully informed and involved in decisions relating to their

treatment and care. However, we received feedback from three parents and one young person about individual staff attitudes on Oak ward and difficulties experienced being listened to.

- Parents' feedback had resulted in changes to the parents' accommodation in the neonatal unit.
- Support had been provided by the multi-disciplinary team during the child's admission, stay and in preparation for their discharge home.

Compassionate care

- Throughout our inspection, we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers. Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.
- We spoke with eight parents of children using the service who told us they had generally been happy with the care and support they and their children had received. However, two parents told us that it had been difficult getting the nursing and medical staff to listen to them.
- Parents from the neonatal unit told us that staff always introduced themselves, had found out their needs and what they as the parent wanted to do.
- Satisfaction surveys were carried out in the acute children's service. Staff told us that parents, adolescents and children had completed satisfaction surveys. The 'Children's Survey 2014' for Taunton Hospital identified two areas for improvement. These were the play area not open 24/7- the trust response was that funding was being generated to allow this to happen. Parents do not have beds beside the child if they wish to stay; camp beds are being brought to provide this option.
- Feedback cards and comment boxes for parents to use were available throughout the service. We saw positive feedback about their experiences given by parents on cards displayed throughout the service.
- Information was also captured from children, young people and their parents through the survey monkey. An action plan was developed to address the issues raised by children and their parents. At the time of our inspection only one action had yet to be completed. The trust informed us that this was completed in February 2016.

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Understanding and involvement of patients and those close to them

- We spoke with eight parents and one young person about their experiences. The majority of parents told us that they had been involved in and were happy with the care and treatment their children had received.
- One young person told us that some nursing staff on Oak ward had not introduced themselves to them when they were initially admitted to the ward. They said that the nurses would carry out tasks such as changing their intravenous fluid tube without explaining what they were going to do.
- On the neonatal unit we observed staff interactions with parents, individually and as part of ward rounds. During a ward round, we saw that the doctor explained the treatment and progress of the baby to the mother and answered the mother's questions respectfully. The conversation was low in tone to maintain confidentiality. We observed the medical staff to have good listening skills with responses given to each question raised by the mother.
- We observed good staff interaction with communication tools and strategies for one child with learning disabilities in the theatre environment.
- A patient member had just been appointed to be involved in transition meetings. The trust also provided the document outlining an initiative called 'Fixers.' This is something being considered by the Trust as a part of wider regional discussions. Fixers has helped over 18,000 young people aged 16 to 25 year to find creative and powerful ways to give voice to the issues they are facing.

Emotional support

- The needs of new mothers were re-evaluated regularly, demonstrating that appropriate emotional support was available for both mother and baby. For those mothers who experienced mental health problems they would receive additional emotional support through the multi-disciplinary team. Health visitors and social workers would be involved in their care and to ensure sufficient support was in place discharge planning for home would commence on admission to the neonatal unit.

- Parents and families could access spiritual support through the multi-faith service provided by the chaplaincy within the hospital. Chapel and multi-faith facilities were available for families to access.
- We accompanied a child to theatre who was accompanied by their mother and a play specialist. We observed that the play specialist was supportive of both the child and mother. Whilst in the anaesthetic room the play specialist provided distraction with an IPAD. Following the child's anaesthesia, we observed the play specialist continued to be supportive of the mother by explaining what happened next. She then accompanied the mother from the theatre to get a drink.
- We observed the interactions between a nurse and child on the children's ward. The child was upset; the nurse got down to the child's level and spent time reassuring the child, which resulted in calming the child.
- One mother told us that she had received a lot of support from staff following her baby's admission to the children's ward. She said the staff had looked after her needs as well as her babies, ensuring that she ate and had regularly asked if she needed anything.

Are services for children and young people responsive?

Good



We judged responsive as good as the service provided responsive services to the local population.

- The children's, young people and families' service had good support from tertiary centres.
- Service planning and delivery considered children's and family's needs which meant changes to the service and how it was delivered benefited children and their parents.
- There was generally good access and flow to services, which met children's and young people's needs.
- The 18-week referral to treatment (RTT) performance showed data for "referral to treatment – incomplete and stopped pathways" confirmed that RTT targets were not always achieved in all specialities. The trust identified that actions had been implemented to improve compliance and that some shortfalls had been caused through patients not arriving for their appointment and delays associated with patient choice of date.

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- Specialities where waits exceeded 18 weeks included cardiology, psychology and referral behaviours for behavioural difficulties. Actions were in place and / or discussions had taken place with commissioners to reduce these waits.
- Parents and staff told us that care had been delivered in a variety of settings including outpatient clinics at times that had generally met their needs.
- The trust confirmed they could access Tier 4 CAMHS beds locally, although there were examples of patients needing transfer out-of-area due to a problem with availability of suitable specialist mental health placements more locally. The trust is currently monitoring 'delayed discharges' of CAMHS patients.
- Learning and changes to practice had resulted from complaints.
- Transition between adult and children's services was being developed.
- Care and support was provided through the neonatal outreach team to mothers, babies and their families in the community.
- Transitional care provision in the post-natal wards was being discussed and a business plan was being developed for this proposed service.
- Commissioners were involved with the neonatal regional network. The neonatal service was affiliated to this group. Finance, CQUIN targets and service provision were discussed amongst the multi-disciplinary team so that service planning and delivery met each patient group needs.
- The inpatient children's ward had a dedicated bay comprising of three beds which was used for young people coming into hospital. Thereby, allowing this age group to be cared for in an area specifically for them with young people of a similar age.
- We were told that parent's feedback had resulted to some adjustments to the environment in the parent's accommodation on the neonatal unit. These changes resulted in the development of an accessible shower room where the mirror had been lowered to accommodate parents who used wheelchairs.
- The children's service worked closely with other trusts and acute providers. Joint clinics took place with a local children's hospital where the consultants conducted clinics locally in Taunton, for example, diabetes clinics.
- The service was working with four local GP practices delivering primary care clinics which helped reduced the number of referrals into the paediatric service. Additional funding had been granted to expand this service, which was to be developed throughout 2016 – 2017.
- Where required local children had joint care arrangements in place between a local paediatrician and specialist consultant from a hospital in Bristol.

Service planning and delivery to meet the needs of local people

- Members of the multi-disciplinary team within the children's service had attended an 'Improving Children's Services' morning recently to discuss future service planning and delivery. We saw the power point presentation delivered at this event which encouraged staff participation in developing the way forward. Minutes of the event had not been finalised and were not available to us.
- The service has a reciprocal agreement with the children's and adolescent mental health service (CAMHS). If there was an immediate concern about a child, an urgent review would be requested within 24 hours, which would be precipitated by a referral from the child's consultant. The service did not provide confirmation that they had had formalised agreement with CAMHS.
- Staff told us the children's service was working with the clinical commissioning group in relation to children with behavioural needs.
- Staff from the neonatal service identified changes, which had been adopted to ensure that service delivery met the needs of their patient group. These included, parents accompanying their baby(s) from labour ward to the neonatal unit, the acquisition of more breast feeding equipment and the provision of free lunches.

Access and flow

- Neonatal occupancy was 71.6% in 2015 – 2016 which is below the accepted limit (85%) at which care can be affected.
- The paediatric high dependency unit occupancy figures from October 2015 until January 2016 ranged from 17 to 54 occupied bed days. These figures equate to 29% to 65% bed occupancy on the paediatric high dependency unit.

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- The service identified that all children and young people had been admitted to the children's unit, where the age of the young person fell between 16 years to 18 years, the young person was given a choice of either a children's or adult environment.
- Half term surgical holiday slots were reserved for young people approaching important education examinations.
- Information provided by the trust in relation to 'Increased out-patient postnatal support for babies identified with feeding difficulties and or weight loss' showed that in comparison to other units nationally, with regard to the rate of readmissions of infants, the unit was identified as an outlier (worse than) due to its higher readmission rate. Statistics from April 2015 to November 2015 identified there were between four to 14 readmissions of babies fewer than 28 days with feeding difficulties. An action was identified to provide a breastfeeding maternity support worker with a specialist interest and training in breastfeeding to be available between 9am to 5pm Monday to Friday. Ongoing monitoring was to be in place. A recommendation was proposed in January 2016 to commence this as soon as possible initially for a month to establish if this intervention made a difference. We saw that approval and additional funding was required for this initiative.
- The children's service 18 week referral to treatment performance data (31 January 2015 to 31 December 2015) for "referral to treatment – incomplete pathway's" confirmed that during the 12 month period children's 'weeks waiting' over 18 weeks was between six to 28 weeks.
- Following the inspection we received additional data for 'Paediatric RTT incomplete pathway performance 31 January 2016.' The data showed that the trusts compliance against named paediatric specialities ranged from 83% to 100% for children seen within 18 weeks. The RTT target the trust must achieve is 92%. The specialities which did not achieve their target included, community paediatrics / neuro-disability, paediatric surgery and urology, cardiology, general paediatrics and paediatric gastroenterology. The breaches in these areas ranged from one to 32 weeks.
- A total of 64 children waited over 18 weeks. The main reason in 16 of the 64 was due to patient's not arriving at their appointment. The trust has a policy related to safeguarding for the management of missed outpatient appointments for children. The other significant issue related to 'to come in's' (12 of the 64); which included delays associated with patient choice of date (for example timing operations to take place in school holidays).
- The referral to treatment data – stopped pathways for 'weeks waited' during the 12-month period from 31 January 2015 to 31 December 2015 was four to 15 weeks. Average waits were between 6 to 9 weeks waited. The data originally provided by the trust did not identify specific specialities.
- The 'Taunton & Somerset NHS Foundation Trust - Referral to Treatment - Stopped Pathway's - Paediatrics - January 2016' showed that 22 children had waited more than 18 weeks for their first definitive appointment. The specialities where children had waited from one to 12 weeks after the 18 week referral to treatment target included, epilepsy, paediatric surgery, general paediatrics, cardiology and community paediatrics / neuro-disability.
- The waiting times reported on the monthly diagnostic return for young people less than 18 years of age identified the average 'weeks waited' from 1 to 6.5 weeks. The highest average waits were for sigmoidoscopy (6.5 weeks) and cystoscopy (6.3 weeks) for data provided for the 30 June 2015.
- For surgical RTT waiting times, all long wait patients had been reviewed in weekly meetings.
- Senior staff within the service confirmed that there was a backlog of cardiology patients waiting to be seen by the visiting cardiology teams from Bristol and Cardiff. To mitigate this a plan had been put in place. In cardiology there had been a change in general paediatric and cardiology staff which affected capacity as fewer cardiology appointments were available which led to longer appointment times being required. Recently a paediatric cardiologist had been employed for one day each week to manage and bring down the referral to treatment times. The trust identified that this situation would be resolved within six months. Ten cardiology clinics had been identified up to the 12 April 2016 to see 60 children.
- Psychology waits existed because the trust had been unsuccessful at recruiting to a vacancy. The job description had since been recently redesigned, the pay band increased and psychology job re-advertised. There were currently 13 newly diagnosed diabetic patients

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who had been waiting since August 2015 to see a psychologist; in addition there were a further 11 diabetic children waiting. A business case was waiting to be finalised and was to be discussed in February 2016.

- The trust is currently working on the autism referral to treatment targets with the Clinical Commissioning Group (CCG). The CCG had agreed that autism is one of the conditions that benefited from a longer assessment and analysis period, which does not necessarily complete within 18 weeks.
- Children with mental health issues could access services. The trust confirmed that 331 children with mental health issues were admitted to the children's unit from January 2015 – January 2016. A senior manager confirmed in 2015 - 2016 admissions of young people with mental health issues included those with mental health disorders (3-4), self-harming (300) and eating disorders (6-10).
- Staff told us that occasionally difficulties and delays had occurred when discharging children to tier four beds or to an alternative placement, (these are specialist mental health beds) due to a lack in social service provision in the community. A statement from the trust confirmed they could access Tier 4 CAMHS beds locally although there were examples of patients needing transfer out-of-area due to a problem with availability of suitable specialist mental health placements more locally. They identified a period in 2015 where these beds were closed (about 4 months) due to staffing difficulties. To mitigate this they worked closely with the CAMHS team and commissioners to put a plan in place where CAMHS staff supported children in the trust. If a bed was needed for over seven days, a child was transferred elsewhere. The trust was currently monitoring 'delayed discharges' of CAMHS patients.
- Children with long-term conditions had open access to the service.
- Staff told us that when the children's ward was at or approaching full capacity the escalation plan was activated. Additional beds were opened on Woodlands ward, which is used as an overflow ward, and additional nursing staff would be brought in to staff these beds. In addition, the paediatric matron attended trust bed management meetings twice daily to keep the rest of the trust informed of activity within the children's service.
- A designated paediatrician was responsible for ensuring that children and young people with mental health (CAMHS) needs care needs were met. The trust confirmed that up to eight children per annum were admitted as a place of safety to the service should those children be at risk of self-harm. Approximately one child had been admitted to the service monthly due to children and young people with mental health (CAMHS) issues, for example, anorexia and self-harm. However, there had been some delays in finding an appropriate placement for the child once they were medically fit.
- Children with long-term conditions care was provided by paediatricians who specialised in areas such as immunology, cardiology, gastroenterology and renal.
- The 'Ready, Steady, Go' booklet was used to prepare young people for transition to adult services.
- The children's diabetes service provided information, advice and support to children and families. Families could contact the service Monday to Friday through the diabetes help line, by email, fax or through dedicated diabetes dieticians.
- An adult learning disability team offered advice as required to staff, parents, children and young people. Support for children and young people with learning disabilities was also provided from the education service and social care. In addition, a specialist nurse was in post to advise and support children with attention deficit disorder type conditions.
- When a baby of parents with special needs was admitted to the neonatal unit, the care was tailored around the needs of the parents and baby.
- A lead nurse, designated doctor, bereavement nurse specialist and two palliative care nurses were available to support parents and staff when there was a child or baby death. The child death review nurse had attended neonatal unit meetings.
- Staff told us that memory boxes were composed for those parents whose baby had died.
- Play staff provided one to one and facilitated group play activities formally or informally to support children and young people dealing with grief and bereavement issues.
- Teaching staff, one play leader and three play specialists worked Monday to Friday within the service. The play staff worked with teaching staff before the admission of children who have complex needs so that they can ensure the child's communication needs were met.

Meeting people's individual needs

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- Access to interpreters or a language line service was available. One play specialist and one play assistant were trained in sign language communication skills to enable them to assist where needed when communicating with children and young people who communicated by these methods.
- Information was displayed throughout the service for young people and their parents. This information was in English; however, staff confirmed that this information could be provided in different languages and formats on request. Parents from the neonatal unit confirmed that they had been given written information to inform them such as that on breast-feeding and baby hearing tests.
- We saw that new parents to the neonatal unit were given a 'Baby welcome pack', which contained useful information about the unit and the new born infant.
- Parents told us when they had required additional support and teaching when breast-feeding their baby, meetings with the breast-feeding nurse had taken place which allowed them to ask questions about breast feeding their baby. In addition parents had received additional support and training through attendance at a Tuesday morning parents group.
- Mother's dignity was maintained on the neonatal unit whilst they were breast-feeding through the use of privacy screens.
- Parents could access free parking. Additional support provided in the form of meal vouchers, snack boxes and access to information and associated social care support was provided to families whose child or baby was receiving long-term health care.
- The neonatal unit had four parental bedrooms, a kitchen area and bathroom facilities for parents. Parents from the neonatal unit could also stay in the bungalow and in one of the parents rooms located in the children's unit when available.
- A schoolroom and playroom were located on the children's unit. The children's unit parents' facilities included a kitchen, seating area, toilet and shower room facilities (x3) and three double bedrooms. The 16 cubicles had parental beds. The trust had an onsite bungalow, which can be used.
- Information provided through the service identified the paediatric transition service as a developing service, which was led by a medical and nursing lead for

transition. A 'Your welcome' self-assessment team was completed for each young person. The use of this tool was monitored through the transition dashboard by the 'Southwest Transition Group.'

Learning from complaints and concerns

- The trust complaints policy (1 December 2015) aligned to the 'Being Open' policy.
- Information provided by the children's service confirmed that they had received 22 complaints for the period 1 April 2015 to 29 January 2016.
- Staff told us that part of their complaints quality assurance process included discussions of the complaint's completed actions prior to its closure at the paediatric governance meeting.
- Staff told us that they had been encouraged to be transparent in their communications and that complaints were referred to the ward sister or PALS.
- Parents and visitors could raise concerns and complaints locally, through the Patient Advice and Liaison service (PALS) or the trust complaints department. Parents we spoke with said they felt comfortable raising concerns or complaints. Information on the PALS including a contact telephone number was available for parents in the hospital map and information leaflet.
- One parent told us of some concerns they had raised through the PALS and that following this they now had weekly meetings with the matron, which had helped.
- Staff said they had received feedback from managers following complaints investigations and that on occasions debriefing of staff had taken place following complaints.
- We reviewed one complaint with a member of staff and saw that the concerns were investigated, learning identified and changes in practice identified. These changes were discussed at a clinical governance meeting and at the patient improvement group (P.I.G.) meeting. The agreed change was to keep parents fully informed so that parents are aware of what will happen next. We asked for the minutes of the clinical governance and P.I.G. meetings to be sent, however, these were not received. We were told 'duty of candour' had been applied during and following this investigation. We reviewed the final investigation letter sent to the parents and saw that each concern had been addressed with a response and actions identified to prevent a reoccurrence of this event. An apology had

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been issued as part of this response. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.

- Surgical staff said they were aware of themes relating to complaints as they had been discussed at multi-disciplinary team meetings. The learning from some complaints had resulted in the development of a preoperative assessment document.

Are services for children and young people well-led?

Good



Overall, we rated the leadership of children and young people's service to be good.

- Service strategies, which were supported by action plans, were in place.
- Governance, risk and quality measurement processes were in place. Updates were given to staff. A risk register was in place which identified most of the risk we also identified.
- A clear leadership structure was in place within the service. Individual management of the different areas providing acute children's services, were well led.
- Public and staff engagement processes captured feedback from both groups which was generally positive.
- There was evidence of ongoing innovation and improvement that had taken place within the service which meant that service provision had been focused towards the needs of the child's and the surrounding community's needs.

However we also found:

- We could not be fully assured of the effectiveness of some monitoring processes because of the shortfalls we found in the monitoring of clinical guidelines.
- Staff awareness and understanding of the children's service vision and values was limited despite being invited to input on the strategy for the service.

Vision and strategy for this service

- We requested details of the paediatric strategy and action plan showing progress to-date against actions. Details of the 'Paediatric Service Strategy' session, which took place on the 27 November 2015, were provided. The service strategy session explored the key issues currently affecting the service, key themes, directorate wide issues and the different elements of the paediatric service. These elements were identified as long-term conditions, community / behaviour, neonates and psychology / psychiatry. Work areas were identified within these different elements.
- An action plan was in place, which identified three work streams; progress to date, further action required and outcomes. The work streams related to primary care clinics, consultants working until 10pm and consultant support in the emergency department. We asked five staff whether they had been involved in developing the paediatric strategy. One senior staff member had, the remaining four staff had not been involved, although, some staff commented that they had received an email asking them for their involvement in developing the strategy.
- We asked four staff whether the children's service had identified vision and values and what they knew about them. These staff were unable to provide any detail of the service vision or values.
- Staff on the neonatal unit identified that the neonatal unit vision and strategy centred on supporting the parent and baby, to promote a safe environment and to identify a parent lead. The staff member we spoke with said they had not been involved in developing this strategy. An action plan was in place to address the 2015 neonatal unit strategy. The strategy identified the three core areas, key persons for each area and periods. We observed that one area was fully implemented. The Somerset Neonatal Intensive Care Unit Strategy for 2015 – 16 first of three objectives identified measures to improve parental experience. The supportive measures included increasing parental accommodation upgrading the current bathroom, free parking for parents and transitional care. During the inspection, we were shown the upgraded parents accommodation and, parents we spoke with confirmed free parking provision.

Governance, risk management and quality measurement

- The organisational diagram for the trust board showed that governance, quality assurance and specialist topic

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meetings / leads were closely aligned with the executive board and directorate governance meetings and boards. Compliance was overseen at directorate level, for example, policies, guidelines and key performance indicators. Assurance of compliance with basic standards trust-wide fell within the directorate governance committee remit that was accountable to the operational board.

- The directorate governance committee reviewed governance processes in line with the agreed directorate governance programme, for example, monthly and quarterly reviews of the risk register and incident reporting, quarterly reviews of best practice guidance and the safety alerts broadcast system.
- Monthly discussions of risk and quality had taken place at a number of forums. For example, trust board, governance and paediatric improvement group meetings. However, we observed shortfalls in monitoring of clinical guidelines so could not be fully assured of the effectiveness of some monitoring processes.
- Quality, risk and governance information updates were discussed through team meetings, newsletters, senior nurse meetings and morbidity and mortality meetings. Some of the staff we spoke with confirmed they had received feedback and emails following incidents and governance issues.
- The service performance assurance framework identified key principle's, metrics and monthly compliance scores which were identified against red, amber and green ratings. The assurance framework was divided into data relating to patients, people, operational delivery and finance. Updates against the performance assurance framework were discussed at monthly paediatric and neonatal departmental meeting sessions. Minutes from these meetings confirmed that areas including staffing, elective outpatient activity and the transitional care project were discussed from September to December 2015.
- Staff received alerts from the chief executive team regarding missing children.
- The women's and children's directorate risk register identified potential and current risks to the service. We observed that some of the risks identified on inspection were reflected by the service on their risk register. For example, the paediatric psychology vacancy, non-compliance with neonatal staffing standards and the 'Facing the Future' standards. Discussion with senior

staff confirmed an awareness of these issues. In respect of these risks we were told that a paediatric psychology vacancy was being advertised to recruit into the psychologist vacancy. With regard to the staffing shortfalls on the neonatal unit. Neonatal unit workforce plans had been completed supported by a 'Detail and costing of phased implementation plan' (dated 30 September 2015) which identified a plan for phased implementation over a four year period with estimated costs.

Leadership of service

- The service is led by a team consisting of a clinical director; a directorate manager a Head of Midwifery and Associate Director of Nursing for Children's Services. Further leadership is provided by named clinical service leads (acute paediatrics; community child health and neonatal) a deputy business manager and a paediatric matron who is a senior nurse provides support and leadership to the children's and neonatal specialities. Specialist leads in safeguarding, paediatric diabetes, children's community and clinical genetics also provide leadership and support to staff in their respective areas. In addition, the service identified professionals who led in specific areas, for example, governance and risk.
- Each clinical area had identified ward managers who provided leadership to nursing staff and the multi-disciplinary team.
- Staff told us they of the opportunities and support they had received for leadership development in 2014. One staff member said they had been mentored by the previous lead nurse of the service to assist them develop their leadership skills.
- Staff throughout the service said that the matron was visible and approachable and had visited the children's and neonatal areas regularly. Other staff we spoke with said that an 'Open Door' policy existed in the children's unit and were supported by the matron and band seven nurses.

Culture within the service

- A positive culture was demonstrated among all the teams and staff we met. Staff spoke positively about their service however, they identified concerns in relation to safe practice, staffing and daily support. For example, we were told that band five nursing staff who had worked in the high dependency unit when band six

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staff were not available had not always received the level of support they required. One staff member told us that should they need to raise a concern they felt confident and supported to do so.

- Staff described positive working relationships including those between the multidisciplinary teams and other agencies involved in the delivery of children's health services.

Public engagement

- The 'Neonatal Survey 2014' survey of parents' experiences of neonatal care involved 88 hospital neonatal units in England. An action plan was in place which identified the areas for improvement and progress made against each area.
- The 'Children's Survey 2014' for Taunton Hospital identified two areas for improvement. These were, the play area not open 24/7- the trust response was that funding was being generated to allow this to happen. Parents do not have beds beside the child if they wish to stay; camp beds are being brought to provide this option.
- Staff on the neonatal unit told us that parents were encouraged to complete exit cards on discharge from the unit. We were also told that 'one stop cards' could be completed anonymously by parents throughout children's services.
- Additional parent feedback has been gained from the parents groups, which took place throughout the region.
- Two parents were engaged with the parent forum and the NHS England group to ensure immediate feedback and involvement by parents. Another parent representative attended quarterly oncology meetings.
- The diabetes team recently had a transitional evening at a local hotel to capture feedback from parents and young people.

Staff engagement

- Staff engagement had taken place through a number of forums, for example; ward meetings, via email correspondence, development and training days and at formalised meetings aimed at various staff groups such as senior nurse meetings.
- We were told that monthly staff meetings had taken place on the neonatal unit and prior to each meeting staff had been asked what they wanted to discuss and this feedback was put on the meeting agenda.

- Staff told us that ward meetings in the children's areas had not taken place regularly.

Innovation, improvement and sustainability

- Two paediatric consultants developed an App, whose aims was to develop a single care pathway from home through to community healthcare and into hospital. The app 'HANDI Taunton' was launched in March 2015 and provided parents with 'clear and concise advice' about the six common childhood illnesses. The conditions covered included, diarrhoea, chesty baby, chesty child, high temperature, abdominal pain and common new-born problems.
- We accessed this App and saw clear guidance identified for parents, medical professionals in the community and hospital. The information included illness specific home assessment guidelines, signposts to the most appropriate healthcare setting and illness information. Each of the six common childhood illnesses had a home care plan to help parents / carers provide the best support for their child. For healthcare professionals the guidelines accessed a traffic light system to the most appropriate healthcare advice, support or referral for the child. We reviewed some of the guidelines, which could be accessed by healthcare professionals. The severe sepsis: sepsis 6 guideline identified the signs of severe sepsis and what to do should these signs be present.
- The safeguarding liaison nurse for children had input to adult services. This provided integration between the service as some adults who were admitted were also parents and the nature of their illness/admission meant that safeguarding of their children needed to be considered.
- In accordance with Facing the Future 2015, funding had been secured to provide increased senior paediatric cover until later in the evening, to match periods of highest activity. This additional cover facilitated paediatric advice and guidance to GPs and the Emergency Department to prevent and reduce avoidable hospital admission for children.
- The service was working collaboratively with four local GP Practices delivering Primary Care Clinics which helped reduced the number of referrals into the paediatric service. Funding had been secured to expand this service which was to be developed throughout 2016/17.

End of life care

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

Information about the service

Taunton and Somerset NHS Trust provides end of life care (EOLC) to patients on wards throughout the trust. The hospital's specialist palliative care team (SPCT) is based within the Haematology, Oncology and Palliative Care (HOPE) Directorate and consists of both nurses and consultant doctors. This team provides specialist advice and support for patients with complex needs. In addition, the EOLC nurse provides education and support for ward teams. The chaplaincy service, the bereavement team, the mortuary team and Marie Curie companions, who are specially trained volunteers, also provide support for patients receiving EOLC.

Between December 2014 – November 2015 there were a total of 1,064 deaths at Musgrove Park Hospital. The specialist palliative care team saw 569 patients however it was not clear how many other support services saw per year as this data was not collected by the trust.

During our inspection, we visited 16 wards where EOLC was provided. We also visited the chapel, the mortuary and the bereavement centre. In addition, we attended the SPCT multidisciplinary team meeting.

We spoke with six patients, two relatives and 45 staff, including the clinical lead for EOLC, the SPCT, EOLC nurse, chaplaincy team, bereavement team, mortuary staff, porters, Marie Curie companions, ward based sisters, nurses and health care assistants and ward based doctors.

We observed interactions between patients, their relatives and staff, considered the environment. We looked at 37 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) records, 16 medical and nursing care records and six medication charts.

Before our inspection, we reviewed performance information from, and about, the hospital

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Summary of findings

We rated end of life care (EOLC) as requires improvement because:

Patients were protected from abuse and avoidable harm. Staff we spoke with understood their responsibilities to raise concerns and report incidents. Arrangements were in place to minimise the risk of the spread of infection.

Ward teams were supported to provide end of life care by the specialist palliative care team, the end of life care (EOL) nurse and a dedicated continuing healthcare (CHC) coordinator who supported the fast track discharge of patients wishing to be cared for in the community.

All patients were assessed to identify if there was a possibility that they were in the last year of life. If they were, then doctors had honest and open conversations with them about their condition and treatment wishes.

The bereavement team provided a timely and coordinated service for bereaved families and the chaplaincy service provided spiritual and emotional support. In addition, the trust had introduced Marie Curie companions, who were trained volunteers available to provide comfort and support to both patients and families.

Patients and relatives were treated with dignity and respect and were involved in their care.

The trust had a strategy and vision for the EOLC service and there was a trust board member with responsibility for EOLC. Senior leaders showed great passion, enthusiasm and commitment in developing the service in order to provide quality care for EOLC patients. The culture was such, that staff felt engaged and positive towards providing quality EOLC.

However, mental capacity assessments (MCA) and best interest discussions were not always recorded for those patients who lacked capacity and were unable to make and communicate decisions about cardiopulmonary resuscitation.

We found few local audits had been completed by the trust for EOLC. The National Care of the Dying Audit

(2015) showed the trust performed worse than the England average in three out of the five clinical and seven out of eight key performance indicators. The trust had minimal data to demonstrate the responsiveness of the service for patients at the end of their lives.

The numbers of nurses within the Specialist Palliative Care Team (SPCT) and the number of palliative care consultants fell below the number recommended by the Commissioning Guidance for Specialist Palliative Care. The SPCT, were available five days a week, although the trust were looking at ways to extend this to seven days a week.

Systems for governance, risk management and quality measurement, were in place, but not fully developed, due to recent changes in management structure.

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Are end of life care services safe?

Good



We rated the safety of end of life care services as good.

We found that;

- Patients were protected from abuse and avoidable harm.
- Staff we spoke with understood their responsibilities to raise concerns and report incidents.
- Arrangements were in place to minimise the risk of infection.
- There was sufficient equipment to support the care of patients receiving end of life care (EOLC).
- Staff completed risk assessments, for example, malnutrition and pressure ulcers risk assessments and acted on these to reduce the risk to patients.
- Staff we spoke with understood their safeguarding responsibilities.
- Staff reported good access to the specialist palliative care team (SPCT).

However, we also found;

- The prescribing of anticipatory medicines was inconsistent.
- EOLC training was not mandatory for all staff.
- The numbers of nurses within the SPCT, and the number of palliative care consultants, fell below the number recommended by the Commissioning Guidance for Specialist Palliative Care.

Incidents

- Staff reported incidents through the trust's electronic reporting system. All staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses. Staff said they were encouraged to report incidents.
- Between June 2015 and November 2015, there had been 15 incidents reported related to EOLC. Five of these were related to missing information on the trust's treatment escalation plan (TEP) or the TEP being filed in the wrong patient's notes. The TEP form is used to record Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

- Staff were unable to discuss any specific incidents relating to EOLC, and we did not see evidence of incident being formally discussed.

Cleanliness, infection control and hygiene

- The trust had a 'care after death policy', which gave guidance regarding specific infections and how potentially infected bodies should be managed after death to minimise infection risk.
- As part of the last offices procedure (the process where the body is prepared for transfer to the mortuary) nursing staff completed a mortuary admission form. This form included information about actual or potential infections and ensured the porters and mortuary staff were made aware of any infection risks. Ward staff we spoke with were aware of the procedures to be taken when performing last offices in order to minimise infection risks.
- Clinical staff had access to personal protective equipment as needed, such as disposable gloves and aprons, and they wore these when appropriate. We observed clinical staff were bare below the elbow, in keeping with trust policy to help prevent the spread of infection.
- The mortuary viewing areas and the bereavement waiting rooms were visibly clean and tidy.

Environment and equipment

- The trust used the T34 McKinley syringe pumps for patients who required continuous infusion of medication, and we saw the policy relating to the use of these. We spoke with staff on eight of the wards about the availability of this piece of equipment. All confirmed that the T34 pumps were readily available.
- The Human Tissue Authority (regulators of human tissue and organs) performed an inspection of the mortuary in July 2015. They identified minor issues relating to the fabric of the post mortem suite and body store, for example there were cracked and broken tiles in the floor of the mortuary. We saw evidence that the trust had developed an action plan and taken steps to address the issues.

Medicines

- Anticipatory medicines for patients were prescribed for the five key symptoms in the dying phase. These symptoms are pain, agitation, excessive respiratory

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secretions, nausea and vomiting, and breathlessness. By prescribing medicines, 'just in case', before the patient actually has any symptoms, this allowed patients to receive effective symptom control in a timely way.

- The trust participated in the National Care of Dying Audit (May 2014). For prescribing of anticipatory medication, the trust scored 53%, which was slightly better than the England average of 51%.
- The trust monitored, monthly, the number of patients on the individualised end of life care plan, for whom anticipatory medicines had been prescribed. From March 2014 to August 2015, an average of 48% of patients per month had these medicines prescribed.
- We reviewed medication charts for six patients who were nearing the end of life. All of these patients had anticipatory medicines prescribed appropriately.
- Anticipatory medicines were available on the wards and staff confirmed there were no problems with obtaining these.
- Nurses from the specialist palliative care team (SPCT) were non-medical prescribers, so could also prescribe these medicines.
- Ward staff told us that these medicines were prescribed once patients had been identified as being in the last days of life and commenced on the individualised end of life care plan.
- The individualised end of life care plan prompted staff to prescribe anticipatory medicines.
- Doctors carried small reference cards, which fitted into their ID badge, so were easily accessible. These provided prescribing details of anticipatory medicines and doctors were aware that prescribing information was available on the trust's palliative care webpages.
- For patients who had chosen to return home for the last days of their life, the 'just in case' medicines pharmacy chart was used. This chart contained a pre-printed prescription, which was individualised for each patient, and ensured that patients had a supply of medicines at home, in case they needed them.

Records

- Staff from all professional groups wrote in one set of records for each patient. This helped communication between the different professional groups and promoted patient safety.
- Records were kept in secure trolleys, at the nursing station.

- We reviewed the records for 16 patients receiving end of life care. All notes were legible and up to date.
- The trust policy stated that a doctor of registrar level or above should sign the TEP form, if a DNACPR decision is made. Of the 37 TEPs we reviewed, one was not signed; one had an illegible name and designation and three were signed by a doctor below the level of registrar.

Safeguarding

- Ward staff and the SPCT we spoke with had an understanding of safeguarding. One member of the SPCT was able to describe two examples of where there had been safeguarding concerns and could appropriately describe the actions they took.
- Whilst end of life care is provided throughout the hospital and a distinction is not made to those providing end of life care medical and surgical divisions training rates were around 85%. In the HOPE division the training rates were at 89%. The trust end of year target for training was 90% of nursing staff trained in this area.

Mandatory training

- Training related to end of life care was not mandatory for all trust staff. The trust had recognised this as a gap and planned to include such training in the induction for all staff from May 2016. We saw evidence that this had been discussed at the trust end of life steering group.

Assessing and responding to patient risk

- Patient risks were assessed using national recognised tools, which were documented in the trust's inpatient care and risk document.
- We reviewed the nursing records of six patients receiving end of life care. Risks such as falls, malnutrition and pressure damage were assessed. For example, we saw the Malnutrition Universal Screening Tool (MUST) used to assess malnutrition risk and the Waterlow tool used to assess patients' risk of pressure ulcers.
- We saw evidence that nurses reviewed and repeated these risk assessments. Staff took action on the results of these risk assessments; for example, patients who were at risk of pressure damage were nursed on pressure relieving mattresses.

Nursing staffing

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- Patients requiring end of life care were nursed on general wards, throughout the hospital. Nursing staff we spoke to on these wards told us they were able to provide end of life care and would always prioritise those patients in the last hours or days of life.
- The SPCT consisted of three registered nurses, which equated to 2.2 whole time equivalent (WTE) nurses. This included a developmental band six nurse post.
- The trust recognised in their draft strategy (Caring for the dying person at Taunton and Somerset NHS Trust) that this number of specialist nurses fell below the recommendations of the National Council for Palliative Care who would suggest three WTE nurses, for a trust of this size. However, at the time of inspection there were no plans to increase the number of nurses within the SPCT. In addition to this, there was one WTE EOLC nurse.
- Without exception, ward staff told us that the SPCT and EOLC nurse were very visible on the wards and always available to provide advice and support.

Medical staffing

- The trust funded consultant palliative care cover for 1.2 WTE consultants, in partnership with the local community NHS trust, who provided cover between Monday and Friday. A telephone advice line from the local hospice was available outside of these times.
- The trust recognised in their draft strategy that this level of consultant cover fell below the recommendations of the Commissioning Guidance for Specialist Palliative Care who would suggest three WTE consultants, for a trust of this size. However, at the time of inspection there were no plans to increase the number of consultants.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents.
- The trust's major incident plan clearly identified the role of the mortuary and chaplaincy services.
- The chaplaincy team were able to describe their role and could give examples of how they would support patients, families and staff following a major incident.
- There was an additional emergency mortuary storage, with capacity of 12 spaces, located in the hospital grounds.

Are end of life care services effective?

Requires improvement



We rated the effectiveness of end of life services as requires improvement.

We found;

- Patients were at risk of not receiving effective care and treatment.
- Mental capacity assessments and best interest discussions were not always recorded for those patients who lacked capacity and were unable to make and communicate decisions about cardiopulmonary resuscitation.
- Care provided to patients did not always reflect national guidance.
- There were few local audits or monitoring of patient outcomes.
- In the National Care of the Dying Audit (2015) the trust performed worse than the England average in three out of the five clinical and seven out of eight organisational key performance indicators.
- Whilst there was end of life care (EOLC) training available, no consistent records of attendance were maintained.
- The specialist palliative care team were only available five days a week, although the trust were looking at ways to address this.

However we also found;

- Staff assessed all patients to identify if they were possibly in the last year of life. If they were, then doctors had honest and open conversations with them about their condition and treatment.
- Patients' pain was well managed and we saw evidence that patients' nutritional needs were met.
- The trust had effective multidisciplinary working in place.
- Marie Curie companions, who were specially trained volunteers, and the chaplaincy service provided a seven-day service.

Evidence-based care and treatment

- End of life care in the hospital mostly followed the National Institute for Health and Care Excellence (NICE) Quality Standards relating to best practice in end of life care for adults. However, the hospital did not comply

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with Statement 10 of those standards: 'People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.'

- The trust had responded to the national recommendations of the Liverpool Care Pathway (LCP) review in 2013 by discontinuing the use of the LCP. Following the withdrawal of the LCP the trust had introduced a document called 'guidance for developing an individualised end of life care plan', which was used to plan care for those patients who were in their last days of life. The document highlighted best practice to manage patients and reflected national guidance such as the 'five priorities for care' as recommended by the Leadership Alliance for the Care of Dying People. This document provided a checklist to help staff develop an individualised care plan for patients, which was then written in the patient's records. Nursing care was recorded on the inpatient care and risk booklet, which contained standardised core care plans.
- However, we reviewed both records and nursing care plans and found information was recorded inconsistently. For example, in 12 of the 16 sets of records there was no documented evidence that spiritual or psychological care had been considered. This meant that care did not always follow best practice. The National Institute for Health and Care Excellence (NICE) quality standard 13 relating to best practice in end of life care standard six states that people approaching end of life are to be offered spiritual and religious support.
- Staff we spoke with said the trust's individualised end of life care plan acted as a reminder; although a couple of staff told us that it lacked guidance. However, we saw that the trust had developed a second version, which did include guidance, for example on the prescribing of anticipatory medicine; this was yet to be implemented at the time of inspection.
- Doctors completed a treatment escalation plan (TEP) for all patients admitted to the trust. This form required the doctors to consider 'if they would be surprised if the patient died within the next 6-12 months.' If the answer was no, then doctors had an honest and open conversation with patients about their condition, care and treatment. It also supported doctors to have conversations with patients and families about their wishes for treatment, for example the use of artificial

feeding or admission to critical care. Decisions regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were also recorded on this form. The use of the TEP form reflected best practice, in advanced care planning, as advocated by Gold Standards Framework Centre for End of Life Care.

- We spoke to 14 staff about the use of the TEP form, all said it was useful as it promoted open conversations with patients and families, and provided clear information as to the level of intervention. Two doctors felt it was difficult to have this kind of conversation as soon as patients were admitted.
- There were few local audits or monitoring of patient care or outcomes. However, the trust did perform an audit of the prescribing of strong opioid (painkillers). As a result they introduced a small opioid prescribing card which provided guidance for prescribing these medications.

Pain relief

- We saw evidence that patients' pain was reviewed regularly, with pain scores being documented on the observation charts and on the intentional rounding chart. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.
- We saw evidence in patients' records of the SPCT regularly reviewing and appropriately changing pain relief medicines.
- We spoke with two patients about their pain. Both told us staff listened to them and did all they could to help relieve it.
- We reviewed the medicine charts of five patients who were nearing the end of life, and saw that pain relieving medicines had been prescribed and given appropriately.

Nutrition and hydration

- Results from the National Care of the Dying Audit (May 2014) showed that the trust scored significantly worse than the England average for 'reviewing the patients' nutritional requirements' (21% compared to an England average of 41%) and for 'reviewing hydration requirements' (21% compared to 50% for the England average).
- Since these results were published, the trust had introduced the TEP, which encouraged doctors to consider the appropriateness of intravenous fluids and

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artificial feeding. The revised version of the trust's individualised end of life care plan also contained the prompt to consider this, however this was yet to be implemented at the time of inspection,.

- We reviewed the records of 16 patients and saw that 14 of these had had some assessment made of their nutritional requirements and a nutrition care plan commenced. One of these patients had been seen by a dietitian as they were receiving nutrition via a tube feed. Another told us they had been supplied with a soft diet to meet their needs and had seen the dietitian every couple of days.
- We saw evidence on the intentional rounding chart that nurses regularly offered patients drinks. We saw one patient in the last days of life being helped to drink by nursing staff. One patient in the last weeks of life told us the food was excellent and they could ask for snacks at any time.
- We spoke with four doctors about nutritional care; one said they had received formal training in artificial nutrition and hydration for patients receiving EOLC.

Patient outcomes

- The trust had taken part in the National Care of the Dying Audit (2015). The trust performed worse than the England average in three out of five clinical indicators. The trust did not perform well against documented evidence of patients having their concerns listened to, the needs of the person(s) important to the patient asked about, and the evidence of a holistic assessment of the patients' needs in the last 24 hours of life.
- The trust performed worse than the England average in seven out of eight organisation indicators in the National Care of the Dying Audit (2015). Poor performance included a lack of communication skills training for staff, and a lack of face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday. However these results were recently published and the trust had not had the opportunity to review these or consider how the findings would be addressed.
- The trust had developed an action plan in response to the National Care of the Dying Audit 2014, and had implemented some of these actions. This included the introduction of the individualised EOL care plan, having a designated board member with specific responsibility for care of the dying and piloting seven day working for the SPCT.

Competent staff

- Some of the wards had link nurses, who would act as a resource for EOLC and promote good practice. However, there was no formal programme for this across the trust. The SPCT nurses told us support for the link nurses programme had been on hold for the past 18 months, this was due to long-term sickness within the SPCT, which had affected their non-clinical role. The link nurse network was due to be relaunched in March 2016. This had been recorded in the SPCT annual report 2014/2015 and in the trust's draft strategy (Caring for the dying person at Taunton and Somerset NHS Trust). Various training opportunities were available to staff, in relation to EOLC. However, most of the staff we spoke to were unaware of what formal training was available. The trust were unable to provide us with training figures for the uptake of these courses.
- We asked 23 ward based nurses and care assistants about the training they had received relating to EOLC. Eighteen of 23 staff had not undertaken any formal training, and were unsure of what was available, although five of these had received 'on-the spot' training from either the EOLC nurse or the SPCT. Staff valued this type of training and told us how beneficial it had been. The remaining five had received formal training, which varied from completing a degree level module to attending a bereavement workshop.
- The training the ward staff had received on the individualised end of life care plan was inconsistent. Some had received training from the EOLC nurse, others had not. The EOLC nurse had dedicated time within their role for the implementation and delivery of training about the care plan.
- The bereavement team ran a full day 'bereavement and loss' workshop three times a year. These were open to any member of staff working with bereaved relatives. We saw evidence that dates were planned for 2016, with sessions that included feelings around grief and bereavement and how to support patients' experiencing grief and loss.
- The trust ran two advanced communication courses, one for nurses and a one day advanced communication course for substantive doctors. The trust recognised in their draft strategy (Caring for the dying person at Taunton and Somerset NHS Trust) that the uptake was poor, and were recommending that such courses would be mandatory.

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- The SPCT provided 'shadowing' opportunities for all levels of staff. This allowed more inexperienced staff to work alongside a member of the SPCT to develop their own skills and knowledge. Throughout 2014/15, 36 staff shadowed a member of the SPCT.
- The SPCT and EOLC nurse also contributed to formal teaching of junior doctors. They provided EOLC workshops for nurses four times a year, delivered an hour long session on the dementia awareness day four times a year, as well as providing updates to staff in the A&E department every other month.
- The SPCT received clinical supervision, which is a formal process of professional support and learning, which helped staff to develop knowledge and competence by reflecting on their practice. In addition, the SPCT had started to provide clinical supervision for ward-based staff.
- The trust supplied training records for registered nurses using the T34 McKinley pumps, which showed that 92% of 288 registered nurses were trained and had their competency checked

Multidisciplinary working

- The trust had effective multidisciplinary working in place. Multidisciplinary team (MDT) meetings occurred every week. During our inspection, we observed a meeting where there were members of the SPCT, the local hospice, a specialist occupational therapist (OT) and the chaplaincy team present. We saw that all patients and their families were discussed. Effective discussions that included all aspects of symptom control and psychological, social and spiritual needs took place between members of the groups.
- The SPCT also attended other MDT meetings, such as the weekly lung, the upper gastrointestinal and cancer of unknown primary meetings and the monthly orthopaedic-oncology MDT meetings.
- Staff on the oncology ward told us daily multi-professional ward rounds occurred with the oncologists, the SPCT physiotherapists and occupational therapist.
- Consultant palliative care cover was provided by a neighbouring local community trust. This promoted partnership working between the trust and community, which supported the continuity of care for patients.
- The trust were unable to tell us how many patients known to the palliative care team were referred to and

seen by the chaplaincy team as this data had not been routinely collected. The trust are considering adding this to the current dashboard used to monitor the end of life care service.

Seven-day services

- The SPCT nurses were available Monday to Friday, between the hours of 9am to 5pm. The palliative care consultants were available Monday to Friday. They provided cover for seven sessions during the week, a session being either 9.00am to 1.00pm or 1.00pm to 5.00pm. Out of hours, staff could access advice and support from the local hospice via a 24-hour telephone help line. All the ward-based staff we spoke with were aware of this.
- The trust recognised they were not providing a SPCT seven days a week. In order to address this, the trust was running a 10-week trial of providing specialist cover, on a Saturday and Sunday, between 9am and 1pm. This pilot was running in partnership with the oncology specialist nurses, so cover would be provided by either the SCPT or the oncology specialist nurses. Additionally, the SPCT were reviewing the notes of all patients who had been admitted over a period of a month, to determine what their care needs were, and when and what time specialist input was needed. The review was underway at the time of inspection, so results were not available.
- The bereavement office was open Monday to Friday, 10am to 4pm. Viewing of deceased patients in the mortuary outside these hours was available and arranged by the clinical site manager.
- A chaplain was present in the hospital between 8.30am and 4.30pm, Monday to Friday and 8am to 12pm on Saturdays and Sunday. Outside these hours there was an on call service, which meant patients and families could see a chaplain at any time.
- Marie Curie companions were specially trained volunteers who provide emotional and practical support to dying patients and their families. This service was available seven days a week, between 9am and 9pm with flexibility according to need.

Access to information

- All the information required to deliver effective care and treatment to patients was readily available to staff. For

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example records, care plans, risk assessments were located at one location on each ward, whilst medicine and observation charts were located at the end of patients' beds.

- Information regarding patients who were known to be dying was held on the Somerset wide Electronic Palliative Care Coordination System (EPaCCs). The SPCT could access this system, which helped communication between the hospital and community. The trust told us they were developing plans to enable admissions areas, such as A&E to access this system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust policy required that all in-patients must have a recorded resuscitation status using a treatment escalation plan (TEP form). Doctors recorded if patients were for resuscitation, or if they were to be allowed a natural death, that is, have a Do Not Attempt Cardiopulmonary (DNACPR) decision made.
- From January 2015 to October 2015, the trust monitored, monthly, the number of patients who had a completed TEP form. The number of patients with completed TEP forms was increasing from 68% in January 2015 to 80% by October 2015.
- The Mental Capacity Act 2005 is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The trust's MCA policy stated that formal assessment of capacity, written in full detail using the two-stage capacity assessment form, and best interest decision recorded was needed when the decision was complex or had serious consequences.
- During our inspection, we reviewed 37 TEP forms for patients who had a DNACPR decision made, across 14 wards. Out of the 37 we reviewed, 11 patients were not considered to have capacity, that is, they lacked the ability to make their own decision because of an illness or disability.
- For three of these patients the DNACPR decision had been made in the community prior to admission. However, we found for the remaining eight patients who did not have capacity, seven did not have a MCA and

best interest decision recorded in the notes for the DNACPR decision. This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not always followed.

- We spoke with three members of ward-based staff about the MCA; all were unaware of the trust's two stage assessment form.
- The trust recognised that patients must be involved in DNACPR decisions and that it is best practice to involve families as well. This was recommended in the trust's 'Making and recording decisions related to resuscitation status & other emergency treatment options' policy. However, for nine of the 37 TEPs we looked at, there was no evidence of discussions, or reasons why it had not been discussed, with patients. There was no evidence of discussions with the family either for these nine patients. This meant the trust policy was not always followed, and patients and families may not have always been involved in decisions.

Are end of life care services caring?

Good



We rated caring in end of life services as good.

We found;

- Patients and relatives we spoke with told us they were treated with dignity and respect and were involved in their care.
- Marie Curie companions were available to provide emotional support to both patients and families.
- There was good access to the chaplaincy services and the bereavement team provided sensitive support to bereaved families.

Compassionate care

- The trust had participated in the National Care of the Dying Audit in May 2014. The results showed that the trust performed better than the England average in relation to the provision of care that promoted patient privacy, dignity and respect, up to and including after the death of the patient. The trust scored nine out of a possible nine for this indicator compared to the England average of seven.
- We observed staff talking with both patients and relatives in a kind and friendly manner. Without

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exception, all the staff we spoke with told us of the importance of treating patients and families in a sensitive manner. They gave examples of how they would extend visiting times, provide drinks to families and support families to stay overnight if they wished.

- Mortuary staff told us how they prepared relatives before viewing a body, for example explaining what the body might look like or any discolouration on the body. They told us how they still spoke to deceased patients and would often leave the lights on in the mortuary, if families did not want their loved one to be left in the dark.
- Patients told us that staff introduced themselves and always treated them with dignity and compassion. One relative told us, "They come 3-4 times a day to fluff her pillow and do her hair; that's important to her."

Understanding and involvement of patients and those close to them

- The patients we spoke with felt included in their care, and that the doctors and nurses explained what was happening.
- We spoke with one patient who told us that they had known the team caring for them a long time and felt very involved with their care. They gave an example how doctors had respected wishes regarding changing their medication. Two relatives we spoke with told us how positive their experience had been and said the whole family had been supported so well.

Emotional support

- We spoke with one patient who told us how the Specialist Palliative Care Team (SPCT) nurses had talked through things that were important to them and had provided both emotional and spiritual support.
- The trust had worked in partnership with Marie Curie to introduce trained volunteer companions to help provide emotional comfort to End of Life Care (EOLC) patients. Companions sat and listened to patients and families, listened to their concerns and worries. They acted as patient advocates and provided respite if families needed to leave for any reason. Staff identified patients to the Marie Curie co-ordinator on a daily basis when they did ward rounds and a volunteer companion could be with the patient within two hours. Volunteers would generally stay for up to three hours, although on occasions it could be longer. There was overwhelming

praise from ward-based staff about this service and we saw feedback about the service from family members. One such comment stated, "it gives me so much comfort to know she's not on her own". At the end of each visit, the companion completed a volunteer report form, an anonymous account, which described the support the companion had given. We reviewed two of these and saw that one companion had written, "Daughter raised concerns about how to tell her two young children what was happening, I offered support as able and also got relevant information and some children's books from the bereavement centre to help".

- The bereavement team provided emotional support to bereaved families, as well as practical help and advice following a death. They also accompanied families who wished to view the deceased. The bereavement team collated feedback from families following bereavement. An example of such feedback stated, "The bereavement officer was excellent and respected our views and feelings totally".
- The chaplaincy team were aware of all those patients who required EOLC as they attended the weekly Multidisciplinary (MDT) meeting where these patients were discussed. They provided emotional support to both patients and their families. We saw thank you letters that the chaplaincy service received. One such letter said, "You were sympathetic and considerate allowing me time and space." Bereaved families were invited to a yearly remembrance and thanksgiving service that was led by the lead chaplain for the trust in association with the Taunton Deane Borough Council.

Are end of life care services responsive?

Requires improvement



We rated the responsiveness of end of life services as requiring improvement.

We found;

- The trust did not consistently record patients' preferred place of care and so could not identify if they were meeting this.
- The trust were not consistently collecting data on referrals to all services which supported people at the end of their lives.

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- The service was not seven days a week and therefore there could be a discrepancy in the service and timeliness of service received by people at weekends.
- Delays in discharge were not robustly collected. This meant that the service could not be assured that patients were receiving a timely discharge.
- We could not be assured that patients would receive an individualised care plan in a timely manner.

However we found,:

- There was a dedicated end of life nurse who worked alongside staff to provide advice and training to enable them to support patients near to the end of their life.
- The bereavement team provided a timely and coordinated service for bereaved families.
- The trust provided facilities for families of patients receiving end of life care (EOLC).
- The trust had a dedicated continuing healthcare (CHC) coordinator to support the fast track discharge of patients wishing to be cared for in the community.
- The majority of patients who were seen by the SPCT were discharged to home or alternative care placements.
- Complaints regarding EOLC were reviewed to understand the issues and learn from them.

Service planning and delivery to meet the needs of local people

- The trust is working with primary care services to highlight patients who are on the EPaCCs system. This is a system where patients who are on an end of life pathway are recorded by the local community. This will allow greater access to information when the patient is admitted to hospital. There is currently an informal system of notification where the Somerset Palliative Care Coordination Centre will contact the end of life lead nurse if a patient on EPaCCs is admitted to the acute trust.
- Between April 2015 and December 2015 the specialist palliative care team (SPCT) received 569 referrals, 82% of these were patients with a diagnosis of cancer and 18% of patients had a non-cancer diagnosis. However, slightly more non-cancer patients were seen than the previous year (for 2013/14 where 87% of patients had a diagnosis of cancer). Whilst we only attended one SPCT multidisciplinary meeting, we did see that three out of a total 12 patients discussed had a non-cancer diagnosis.

- The total number of referral in 2014/15 showed an increase of 9% from the previous year.
- The source of referrals to the specialist palliative care was monitored. This showed that for the period April 2014 – March 2015 the majority of referrals were from the haematology and oncology wards at 28.5%. The second highest referrer was the acute medical wards, with 9.5% referred by the medical assessment unit, 21% of referrals were from the care of the elderly wards, and 7.5% from gastro-enterology. Coleridge ward (respiratory) was the single biggest referrer in medicine with 9% of referrals. There were 18.5% referrals from surgical the wards. One patient was referred directly by a family member.
- One band six end of life lead nurse worked within the SPCT who had a dedicated role in working alongside ward staff to deliver end of life care to patients. The lead nurse did undertake some clinical work accepting referrals from wards, but worked largely on training and supporting staff. A primary aspect of this role was to provide expert support to the care of patients with more complex needs at the end of life.
- The activity levels of the end of life nurse were not included within those of the SPCT.
- As an indication of the end of life lead nurse activity, for November 2015 and December 2015, they were involved in 70 cases: this included 39 end of life care patients and a further 31 fast track referrals. Of these, 52 were discharged from hospital to a preferred place of care and 18 died in hospital.
- Bereavement services were well organised and responsive to people's needs. Following a patient's death, bereaved families were able to make an appointment to meet with the bereavement team the following day. The team would ensure all necessary documentation and property belonging to the patient was ready to collect, arrange and support viewing if required, and provided practical information to the family. The bereavement team discussed any queries regarding the patient's care or death with families, or if unable to answer questions, would arrange for a member of the medical team to do so. Bereaved families were able to park free outside the bereavement centre and there was a dedicated waiting room.
- The trust did not have any dedicated beds for end of life care and patients were cared for on general wards throughout the hospital. However, staff told us they would always try to arrange a side room for those

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patients in the last few days or hours of life, and it was rare that this was not possible. We saw from minutes of the EOL steering group in September 2015, that there were plans to create an EOLC room on three of the wards. The aim of these rooms were to be less 'hospitalised' and more 'homely' and have facilities such as tea and coffee. We were not provided with a timescale for this project.

- The trust was committed to providing facilities for the family of patients receiving EOLC. There was a bungalow, provided by the League of Friends, which housed six bedrooms, a lounge and bathroom facilities. Families could stay here free of charge. Ward staff we spoke to were aware of this facility and said they promoted its use.
- On Beacon Ward, there was a dedicated room for families to stay, which comprised of an ensuite room with a double sofa bed, television and tea and coffee making facilities. In addition, there was also a conservatory, and a quiet room, which also had facilities, so relatives could help themselves to drinks. There was also activities to occupy children who may be visiting the ward.
- On other wards, staff told us they would support families by having open visiting and use of a camp bed, should family members wish to stay overnight. Staff said they made regular drinks for families and one housekeeper told us, she always gave breakfast to relatives if they had stayed overnight.

Meeting people's individual needs

- All wards had end of life ambassadors who championed end of life care on all wards. Staff were supported by the SPCT and the end of life care nurse to provide a responsive service to meet the needs of patients. Care was also supported through the availability of Marie Curie Companions who sat with patients who were at the end of their life to provide individualised support. This package of support meant that care could be responsive to meet the needs of the individual.
- The trust had an active chaplaincy service, to support patients' and relatives' individual spiritual and emotional needs. The service had strong links and access to local faith leaders for patients of different religious beliefs, including Christians, Muslims, Sikhs and Buddhists, as well as providing support to non-religious patients.

- The chaplaincy team, which included volunteers, visited key ward areas such as A&E and ITU every day and visited all those patients who had been placed on the individualised end of life care plans. Within the chapel, there were prayer mats and washing facilities for Muslim prayer. There were reading materials for other faiths such as Sikhs and Buddhists, as well as non-faith material.
- Mortuary staff demonstrated an awareness and sensitivity to cultural and faith practices, and could give us specific examples of when they had met specific individual requests of bereaved families. They told us how they had use a 'cooling blanket' rather than the mortuary fridge because a family did not want the deceased to be stored in a fridge, and how they would try to accommodate for the deceased to be taken straight to the funeral directors.
- Staff we spoke with could give example of how they made reasonable adjustments for patient with learning disabilities or those living with dementia. For example, one member of ward staff explained how they ensured a patient with learning disabilities was cared for in a side room so their carer could also stay.
- The trust supported patients with advanced care planning, by using a Somerset wide 'Planning Ahead' document. This guide helped patients and families to make decisions about care and practical arrangements in advance.

Access and flow

- The SPCT prioritised its response to referrals according to clinical need. This was based on the clinical information given by the referrer and on discussion with the referrer.
- The SPCT responded in a timely manner to referrals with 95% of patients being seen the same or next working day. Without exception, all ward based staff we spoke to told us the SPCT responded quickly to referrals.
- Between December 2014 – November 2015 there were a total of 1,064 deaths at Musgrove Park Hospital; 187 of these patients were known to the SCPT. This number includes only contacts with the SPCT nurses and doctors, and did not include contact with the fast track continuing healthcare nurse or the end of life care lead nurse.
- The trust's dedicated continuing healthcare (CHC) coordinator supported the fast track discharge of patients near the end of life who wanted to be home or

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in the community. This service was offered to any patients who had a prognosis of less than three months to live, and wished to be discharged from hospital. The CHC coordinator assessed patients for funding, which would be used to provide care in the community. The trust told us that there were some delays due to delays in getting packages of care. In order to address this, the trust had weekly conference calls with the clinical commissioning group (CCG) to look at ways of improving the availability of care packages.

- Some delays in discharges did occur, sometimes due to a patient's condition deteriorating, or care packages or placements being unavailable. The trust did not have a defined timeframe to describe what was regarded as a fast track discharge.
- The CHC service was available between Monday to Friday and aimed to see patients within 24 hours of referral. For July 2015 and August 2015, a total of 85 referrals were made to CHC. Of these, 58% were seen in less than 24 hours. The trust did not record the reasons as to why it took longer than 24 hours for the CHC service to see the patient. However, they told us that often this was because it was not always appropriate to speak to patients and families at that time.
- Data from January 2016 showed that patients were seen by the continuing healthcare coordinators was typically between one to two days for weekday referrals. Where referrals were made at weekends this rose to typically three to four days.
- The time taken to organise discharges varied significantly in January 2016, however the data provided did not include if there were any reasons for delays. In January 2016 there were 48 referrals for fast track discharges, of these 11 patients were discharged within 48 hours, nine discharges took over 10 days to arrange. The overall average number of days it took to discharge patients on a fast track was six days.
- The reasons for delayed discharges which took in excess of 15 days were recorded. Reasons for delays included the patient's condition changing, complex multi-agency discharges and family choices being respected.
- The trust did not routinely record the patients' preferred place of care (PPC). All patients seen by CHC had their PPC recorded on the Electronic Palliative Care Coordination System (EPaCCS). This system was county wide and not owned by the trust, so the trust were unable to provide information as to how many patients

achieved their preferred place of care. The specialist care team annual report identified that capturing this information was problematic when patients had left hospital.

- The SPCT annual report 2014/15 recorded that of the patients referred to the SPCT, 27% of patients died during their hospital admission. So the majority of patients were discharged from hospital to home or other services where their needs could be met. The average length of stay for patients who were discharged was 2.7 days.

Learning from complaints and concerns

- The trust had a complaints policy and procedure and staff knew how to support patients who wished to make a complaint.
- All complaints relating to EOLC were discussed at the EOLC steering group.
- During 2014, there had been nine complaints regarding EOLC. For 2015, there were four complaints. The main themes for these complaints were around lack of fundamental nursing care and communication. We saw evidence that the EOLC lead had reviewed the nine complaints for 2014, in an attempt to understand the issues and collate themes that would be used to plan EOLC training in the future.
- The bereavement team played an active role in identifying any concerns and referred families to the patient's advice and liaison service (PALS) if appropriate

Are end of life care services well-led?

Good



We rated the leadership of end of life services as good.

We found;

- Senior staff recognised the limitations of the service and were actively seeking resolution of these issues.
- The chief executive was the trust board member with responsibility for end of life care (EOLC).
- The trust had a draft strategy and vision for EOLC services.
- The culture was such, that staff felt engaged and positive toward providing quality EOLC.
- The EOLC steering group formally reported to the trust's patient experience committee, twice a year.

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- The trust had worked with the Marie Curie charity, to introduce the companion role, the first such role in the country.

However we also found;

- Systems for governance, risk management and quality measurement, were not fully developed, due to recent changes in management structure.

Vision and strategy for this service

- The trust had reviewed their current strategy for EOLC and had developed a new strategy called 'Caring for the dying person at Taunton and Somerset NHS Trust' however, this was still in draft format at the time of the inspection, and was due for ratification at the end of January 2016.
- This new strategy reflected national guidance such as the National End of Life Care Strategy and the National Palliative and End of Life Care Partnership Ambitions for Palliative and End of Life Care. The strategy outlined the opportunities and the short and long-term actions required for developing the service. Challenges and risks for the service were also clearly identified The Specialist Palliative Care Team (SPCT) were aware of the strategy.
- The trusts were aware of the limitations of the service and had begun to implement a trial service at the weekends to ensure that people at the end of their life were supported over the weekend. However, this was in its infancy and results from this were not yet known.

Governance, risk management and quality measurement

- The end of life care (EOLC) steering group joined the Haematology, Oncology and Palliative Care (HOPE) directorate in January 2016. Prior to this, it had not belonged to any particular directorate. Executive support for EOLC had only been in place since January 2016.
- Because of these changes in structure, the systems for governance, risk management and quality measurement, were not fully developed, however, the clinical lead for EOLC recognised this and we saw in the draft strategy emphasis being placed on building stronger governance.

- However, we did see evidence that governance issues were discussed routinely at the EOLC steering group, for example, complaints being reviewed. The EOLC steering group formally reported to the trust's patient experience committee, twice a year.
- There was limited monitoring of quality measures, for example monitoring of a patients preferred place of care in the last months/days of life. However, measures such as the prescribing of anticipatory medicines and the number of patients who had died with a treatment escalation plan (TEP) in place were recorded monthly on the EOLC monthly dashboard. However, since our inspection the trust had started to monitor the time taken to discharge patients who were referred to the continuing healthcare coordinator for fast track discharge.
- The specialist palliative care team met weekly to discuss referrals, this was used as an opportunity for professional development and monitoring of the quality of the service provided.

Leadership of service

- The chief executive was the trust board member with responsibility for EOLC, who spoke to us passionately about the vision for the service. They had only taken on this role of executive sponsor in January 2016, however they were clearly knowledgeable about the quality issues and priorities for the service and was aware of the challenges it faced. Without exception, staff within the SPCT, bereavement and chaplaincy teams felt this was a positive step and had confidence that this would help raise the profile of EOLC throughout the trust.
- Strategic leadership of EOLC was provided by the EOLC steering group. This was multi-professional and met quarterly to provide leadership for end of life care services. Membership also included mortuary, bereavement and chaplaincy staff. The group was chaired by the clinical lead for EOLC, a consultant cardiologist. We were informed the EOLC steering group chair had no dedicated time within their job plan for this role. Despite this, the chair showed great passion, enthusiasm and commitment in developing the service in order to provide high quality care and compassionate care for EOLC patients.
- There was strong leadership within the SPCT, they were highly visible and staff through the trust knew who they were.

End of life care

Culture within the service

- From speaking with staff from the SPCT, chaplaincy, bereavement and mortuary teams, it was clear they all worked collaboratively to promote high quality care.
- It was clear from the ward based staff we spoke with that the SPCT, EOLC nurse and CHC coordinator were all approachable and supportive.
- All staff within the service were committed and passionate about the work they did.
- Ward based staff we spoke with showed a positive attitude towards caring for patients at the end of life.

Public engagement

- The bereavement team provided an information pack to bereaved families, within this pack there was a questionnaire to give families opportunity to feedback on the care. We saw evidence of this feedback, which was positive in relation to the EOLC received and the role of the bereavement services.
- Marie Curie and the trust formally evaluated The Marie Curie companions volunteer service six months after it was introduced. The evaluation of the service showed positive feedback from both staff and family members.

Staff engagement

- Staff within the SPCT, chaplaincy, bereavement and mortuary teams all told us they were involved with development in the EOLC service, they felt they had a voice and were listened to.
- The Marie Curie companions were recognised for their achievement in 2015 by the trust and were awarded a MAFTA (Musgrove Awards for Tremendous Achievement).

Innovation, improvement and sustainability

- There was a clear focus on using innovation to improve the quality of EOLC.
- The Marie Curie companion service is the only one currently in the country. It uses the innovative approach of using trained volunteers to help provide emotional comfort to patients. There was overwhelming praise from staff about this service and the report of the six-month review of the service showed positive feedback from family members. The service was shortlisted for the National End of Life Safer Patient Award in June 2015.
- In partnership with the complex care GPs and a neighbouring community NHS trust palliative care consultant team, the trust had made a successful bid to the Health Education South West to develop a health improvement programme between hospital and community. The aim of the programme was to increase effective communication with regard to those who are dying. This project was ongoing at the time of inspection.
- The trust was part of a 'Fit for the Future' review with the local hospice, which aimed to improve working across the community
- The trust had an end of life poetry project. This was led by a staff member, whose aim was to help make colleagues comfortable with having difficult conversations with patients and their families.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient and Diagnostic imaging services are at Musgrove Park Hospital (MPH), with additional services provided at community hospitals including; Bridgwater, West Mendip, Minehead and Chard. For the purpose of this inspection, we visited Musgrove Park Hospital only.

The MPH outpatient service had 442,578 attendances between January 2014 and June 2015. The service provided clinics representing all the specialities within MPH supported by allied health practitioner clinics, including physiotherapy, dietetics and occupational therapy. The Clinical Support Directorate managed both outpatient and diagnostic imaging services.

The imaging department offers a range of diagnostic procedures including plain x-ray films, computerised tomography (CT), magnetic resonance imaging (MRI) and ultrasound. The department also carried out interventional procedures and supports cardiology for cardiac catheter procedures.

Diagnostic services provide imaging to the emergency department (ED) and there was a priority computerised tomography (CT) service for trauma and stroke patients. Radiology staff rotate through ED, community hospitals and the main department to aid flexible working and shared learning.

For the inspection we visited a range of clinics and services provided by the directorate including general outpatients, ophthalmology, audiology, breast care, ear nose and throat, orthopaedic (including plaster room), cardiology, maxillofacial, phlebotomy, physiotherapy and imaging.

We spoke with 15 patients, three visitors and 47 staff including doctors, nurses, health care assistants, allied health professionals, radiographers, sonographers, clinical scientists and managers. Additionally we spoke with three ambulance crewmembers and one hospital volunteer. We reviewed six sets of notes and observed updating of patient records on the electronic patient management system.

We reviewed information and data provided prior and during the inspection.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated outpatients and diagnostic imaging services at Musgrove Park Hospital (MPH) as good.

There was a positive incident reporting culture with sharing of information and learning taking place. Clinical areas appeared clean with infection control procedures followed. A new electronic patient record system had been introduced which, despite some problems was becoming accepted throughout the department.

Patient care and treatment was in line with current evidence based guidance, best practice and legislation. Staff could access information in appropriate formats in a timely manner when required to support their work. We saw good examples of cross community care with general practitioners and MPH working together to reduce outpatient attendances and improve patient's experience.

Staff in outpatients and diagnostic imaging displayed compassion and a caring attitude towards patients. The service received positive patient feedback. Patients and those close to them felt supported by staff and told us privacy and dignity was respected at all times. There were safeguarding policies and procedures in place of which staff were aware.

Patients and carers were provided with information and signposted to local support groups as appropriate.

Managers told us they were proud of the staff working within the department and their willingness to embrace change and positivity about the future. Staffing within outpatients was at agreed levels.

However, we identified issues with safe administration and storage of medication within the ear nose and throat clinic and the outpatient department did not have monitoring in place for the use of FP10SS, medication prescription pads.

Imaging services experienced additional work pressures due to vacancy rates. Staff appraisal rates were below trust target across outpatients and imaging with levels falling below 90%.

The service did not consistently achieve referral to treatment targets within outpatients and diagnostic imaging; however, there was a clear vision and transformational plan to address identified issues.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



Overall, we rated safety for outpatients and diagnostic imaging as good.

We found;

- There was a positive incident reporting culture. Staff understood their responsibilities and were encouraged to report incidents promptly.
- Within imaging specialised incident, reporting systems were in place.
- All areas within outpatients and diagnostics appeared clean and infection control procedures followed.
- Equipment was serviced and maintained and medicines were generally stored safely.

However, we also found

- In the ear, nose and throat clinic that medication was prepared in syringes without the required labelling. Additionally multi-use medicine bottles did not have 'opened on' dates, as required for safe administration.
- The outpatients department stored FP10SS, Medication prescription pads securely but did not have a system of recording usage.
- There was no personal protective equipment available for staff using liquid nitrogen.
- The resuscitation trolley had out of date items and records indicated inconsistencies in the checking procedure.
- Medical records were not always stored in a way, which protected patient confidentiality.
- The outpatients and diagnostic imaging department was not achieving the trust target for mandatory training.

Incidents

- Musgrove Park Hospital (MPH) had a positive incident reporting culture within outpatients and diagnostic imaging. Incident reporting was encouraged throughout the department and staff understood their responsibility to report incidents and could use the electronic incident reporting system. A member of staff showed us an

example of an incident they had recently reported and told us they were encouraged to report incidents promptly. Staff received a confirmation email after submitting an incident on line.

- The outpatients department reported 150 incidents between June 2015 and November 2015. The majority (145) were graded low or no harm and five were graded as moderate. A moderate patient safety incident is an incident which causes significant but not permanent harm, to one or more persons receiving NHS-funded care. In the outpatients department, incidents and learning were discussed at the daily 8:30am team brief for sharing and learning purposes. For example, a whiteboard was introduced to record when a patient was ready for collection by the ambulance service. This was in response to a patient who had had an extended wait for transport. Incident reporting was part of trust staff induction and included in the local orientation package, requiring competency sign-off. The department followed the incident investigation process as described within the trust policy. To assist, the trust provided root cause analysis training for senior staff involved in incident investigations.
- Staff were not all familiar with the term duty of candour, but understood their responsibility to be open and honest with people when an error occurred. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- The trust had a 'Being Open and the Duty of Candour' policy, review date 1st November 2018.

Radiation incidents

- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisations, including the care quality commission.
- The clinical lead presented incidents to the Safety and Environment action group for trust governance purposes. Staff escalated incidents not involving radiation at the quality improvement meeting and the risk management team.

Outpatients and diagnostic imaging

- Local rules were evidenced as required under Ionising Radiations Regulations 1999 (IRR99) and were within their review date. IRR99 are statutory rules, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom.
- The Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R procedures were in place and all documentation was available on a shared drive. This ensured only the most recent versions were available for staff to reference. All staff spoken with were aware of how to access IR(ME)R information.

Cleanliness, infection control and hygiene

- The outpatients department appeared visibly clean and uncluttered. The lead nurse completed monthly environmental cleanliness audits, which indicated 95% compliance in all areas. The findings of these audits were not displayed within the department.
- The outpatient infection control performance report for October 2015 reported 100% compliance for cleanliness. All the areas visited appeared visibly clean, although sign off sheets for cleaning schedules were not always completed.
- The majority of clinical staff had access to personal protective equipment (PPE) including disposable gloves and aprons; these were used appropriately. However, within dermatology, there was no PPE available or suitable protection for staff to use when decanting liquid nitrogen. The nurse working in the treatment room did not know where to access protective equipment. Liquid nitrogen is extremely cold and can cause burns, personal protective equipment including gloves and protective goggles should be used when handling liquid nitrogen.
- We saw staff were compliant with best practice for infection prevention and control. Staff of all specialties and professions were 'bare below the elbow' and observed to be washing their hands or using sanitising gel between patients.
- A previous inspection highlighted limited access to hand washing facilities. This remained on the risk register at the time of our inspection. Action included increasing the access to hand sanitising gel. We saw that this was readily available at the entrance and throughout the outpatients department. We saw signs reminding everyone to clean their hands. However, signage was not in an eye-catching format.
- Within radiology, local audits identified some issues with cleanliness, this included dirty gowns in cubicles, unclean floors and toilets not being checked. However, the issues had been addressed locally and a repeat audit showed 90% compliance.

Environment and equipment

- Monthly environmental risk assessments were completed. We were provided with evidence of this and they included actions to be taken where appropriate. We saw an email request for repair of an oxygen cylinder bracket had been actioned.
- There was one resuscitation trolley within the main outpatients department, which was stored within easy reach by all the main outpatient areas. The trolley appeared clean but included single use items that were out of date, and a sharps box, which contained discarded sharps and packaging. The trolley was in a public area; therefore, we considered the half-full sharps box to be a risk. This was escalated by the trust wide team, the sharps box was removed, and all out of date items replaced.
- Daily checks of the resuscitation trolley in outpatients to ensure that items were in date and ready for use in an emergency, showed inconsistencies in the checking process with frequent signature omissions on the record sheets over the preceding weeks.
- Within the dermatology treatment room, several sterile and single use disposable items were out of date. These included forceps, scissors and other specialist dermatology equipment. We highlighted this to the nurse on duty who replaced the items.
- Bariatric equipment was available for heavier patients including a dedicated room with examination couch and lifting hoist. The phlebotomy department had a bariatric chair, and each outpatient waiting area included larger seating. One set of bariatric scales had been condemned and reported as a risk however, there was another set available and staff told us they could access scales on the wards if required.
- Equipment maintained in house was labelled and dated. Electrical items were PAT (portable appliance test) tested, this is an electronic safety check.
- Clinical bins were clearly labelled and waste was segregated in line with best practice.

Outpatients and diagnostic imaging

- Trust engineers maintained X-ray equipment with annual servicing carried out by manufacturer engineers. We saw evidence of the manufacturers completed service reports.
- Radiology had an equipment quality assurance (QA) programme. However, there were gaps in the workforce and routine equipment testing was behind schedule. One computerised tomography (CT) scanner was 12 months overdue for testing by the medical physics team. However, the trust told us the scanner was being serviced quarterly through a maintenance contract and radiographers were carrying out daily checks which included any changes in radiation dosage. The inspection team did not see a copy of the daily checks. The CT scanner requires regular radiographic testing and servicing to mitigate any risks. During the inspection, 60% of equipment had been tested in the previous twelve months. A new clinical scientist had recently joined the trust and the estimated time to clear the 40% backlog of medical physics testing was six to eight months.
- Radiology had a capital replacement programme, overseen by radiology procurement, along with clinical leads for the modality and medical physics. Modality, within diagnostics is the way in which a disease or illness is diagnosed. There were monthly meetings to assess the prioritisation of equipment replacement. Top priorities were an interventional room, an additional magnetic resonance imaging (MRI) and CT scanners. Risk assessments were carried out for all new equipment or procedures.
- The radiology department appeared clean but tired, with waiting areas which were untidy. Some waiting areas were isolated and did not have a reception desk. This meant that patients could be waiting without booking in.
- Changing facilities within imaging was plentiful; however clean gowns were found hanging over handles or stored on the floor. Bags containing dirty gowns were also found in empty changing rooms.
- Two fridges in the ophthalmology treatment room were not locked and therefore not secure. Refrigerator temperatures were recorded daily and weekly. However, only current temperatures were recorded (not minimum and maximum, as required). Temperatures for both fridges were recorded on one sheet; it was therefore not possible to identify which reading referred to which fridge.
- In the ear nose and throat (ENT) clinic, we saw that staff pre-filled two syringes containing different topical creams for use within the ear. The syringes were not labelled or dated, presenting a risk of inappropriate use. Staff were not aware of documentation detailing how these products should be used. Additionally, opened bottles of in-use eardrops were stored in bowls, next to examination couches, along with the prefilled syringes. The bottles had no recorded opening date. A health care assistant (HCA) told us these were used by the doctors for multiple patients, but they would wipe the top between uses. These issues were highlighted to the ENT clinical nurse specialist. A return visit to the clinic found the items remained in place. This could be an increased infection risk for patients. This was raised with the trust, who advised us after the inspection that they had discussed this with the consultant and clinical nurse specialist. They told us a standard operating procedure describing acceptable practice with appropriate safeguards, including in the use of mixing needles, labelling and timely disposal had been drawn up.
- Medication prescription pads (FP10SS) were stored within locked medication cupboards according to national guidance, NHS Security of prescription form guidance, 2013. However, there was no prescription checking procedure or record of the identification numbers of the FP10 pads used. This meant there was no system for identifying if any prescriptions or pads went missing.

Records

- Patient medical notes were mostly available for clinics. However, staff told us notes were occasionally missing and they would report this as an incident. Reception staff would make up a temporary set of notes if required, or the doctor could access information on the electronic patient management system as per trust policy. There was not reported as a consistent problem. The trust was in the process of transferring to an electronic patient record system. During the transition

Medicines

- Medications within outpatients consisted of items specific to specialist clinic need. For example, a variety of eye drops in ophthalmology and injectable steroids in the orthopaedic clinics. The majority of medications were stored in locked cupboards according to local policy and national guidance.

Outpatients and diagnostic imaging

period, the outpatient clinics were operating a dual electronic and paper based system, with a plan to become paper free. There was an incident highlighting a problem with migrating patient information onto the new system, which may result in appointment booking errors, this was being monitored by the project team.

- Medical notes for clinics were mostly stored behind the reception desk and transportation was in open trollies. However, we did see medical notes left unattended within clinic areas and a medical notes storage room, situated on the main hospital thoroughfare, was open and unattended. We escalated this to the lead nurse who investigated and rectified the problem.
- Medical notes reviewed were tidy with legible writing. Assessments and observations on arrival were clearly documented.
- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patient radiological images and records were stored securely and access was password protected.

Safeguarding

- Safeguarding within outpatients was part of essential learning at level two. Safeguarding had three levels of training; level one for non-clinical staff, level two for clinical staff and level three for staff working directly with children and young people. Training was online and staff were responsible for accessing this. Records indicated that 86% of staff had completed safeguarding training to an appropriate level for their duties, (essential learning was training the trust considered to be essential, which may be in addition to mandatory training). This was lower than the trust target of 90%.
- There was an up to date Safeguarding Adults at Risk policy, which staff accessed through the trust intranet. Staff knew how to access the policy. Staff told us they would escalate safeguarding concerns to the nurse in charge and gave examples of two occasions when they had done this. Neither had resulted in a safeguarding alert but staff recognised their responsibility to raise any concerns and told us they felt comfortable to do so.
- There was access to the safeguarding lead for the trust but no dedicated safeguarding lead within the outpatients department.
- There was a dedicated trust paediatric safeguarding lead for advice if required.

Mandatory training

- Mandatory training rates for outpatients were below the trust target of 90%. Data from 4 January 2016 identified attendances of 85% for basic life support, 86% infection control, 86% safeguarding and 89% essential learning which included manual handling, fire safety, infection control, health and safety and information governance.
- Staff employed in all roles told us it was their responsibility to access mandatory training. This was discussed at their annual appraisal.
- Mandatory training rates within diagnostic imaging was below the trust target of 90%. Records indicated 87% of radiographers had undertaken safeguard training, 82% manual handling and 83% basic life support. There was a departmental action plan to address this shortfall, which was under regular review by radiology management.

Assessing and responding to patient risk

- Clinical staff observed patients and recorded physiological observations including blood pressure, pulse, respiratory rate and temperature, as required for each clinic. Health care assistants received training at local induction to undertake observations in addition to recording patient's height and weight. The information was recorded in the patient notes and any concerns reported to the nurse in charge or doctor in the clinic.
- The interventional radiology checklist adopted from the world health organisation (WHO) surgical checklist was used within interventional radiography. We saw evidence of completed documentation.
- Staff told us they would seek the advice of a senior nurse or doctor if a patient or visitor became unwell whilst in the outpatients department. Emergency assistance for a patient or visitor becoming acutely ill was accessed by dialling 2222. Depending on the circumstances, staff would arrange transfer to an appropriate location for further assessment and treatment. This could be admission to an acute ward or transfer to the emergency department for further assessment.
- There were emergency call bells in all patient areas within outpatients and imaging.
- CT trauma scans were prioritised. The CT team held an emergency bleep in order for them to be informed of an incoming trauma or patient with a suspected stroke this allowed time to prepare for the patients arrival.

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Nursing staffing

- There were no specified nursing establishment guidelines for outpatient departments. Nurse staffing within the outpatients at MPH was at trust agreed establishment and there were no nursing vacancies.
- The lead nurse told us recruitment was not a problem within the outpatient's department and there were staff within the trust who were waiting for vacancies in the department. The staffing levels enabled the outpatients department to manage annual leave without requiring the employment of bank or agency nurses.
- On the rare occasions that bank or agency staff were required to cover sickness or long-term leave, a local induction booklet and advice sheet was in place for staff who had not worked within outpatients before.

Diagnostic imaging staffing

- The department employed 64.2 whole time equivalent (WTE) radiographers; there was six band five, and one-band six vacancy. A recent workforce plan and review had been undertaken and recruitment of staff was underway.
- There were 14 radiologists including two part-time members of staff. There were two vacancies in breast care and cross sectional imaging. However, an increasing workload suggested a third post may be required, activity levels were being monitored.
- There were five radiologists covering the interventional radiology rota. Out of fourteen radiologists, there was a one in nine on call commitment for the general rota. This meant that there was good on call cover and no gaps in provision for out of hour's radiology.
- An additional MRI reporting radiographer had been recruited. However, due to staff shortages the radiographer was unable to fulfil the role at the time of the inspection.
- There was low sickness, staff turnover and no agency use. However, to meet demand, a small number of agency staff were to be recruited until five radiographers are in post in September 2016.
- The department was supported by a medical physics team. The team was small with 2 WTE clinical scientists and 2.45 WTE technologists. There were concerns the workforce was not substantial enough to undertake all the necessary radiation protection. However, the head of the service felt the workforce was able to cope with the demands.

Medical staffing

- There was a consultant clinical director providing clinical support within the directorate.
- Clinic cancellations occurred sometimes for theatre timetable changes, job plan changes, annual leave, study leave or professional leave. Consultants were requested to give six weeks' notice wherever possible.
- The provision of medical staffing for clinics was under the management of the specific specialities.

Major incident awareness and training

- A trust major incident policy, clearly defined the responsibilities of each department including outpatients and radiology. The lead nurse was able to describe the role of the outpatients department in the event of a major incident and the system, through which instruction would be provided.
- Major accident awareness was covered at trust induction and the trust policy was available in the staff room.
- Staff spoken to said they would stay put and await instruction from the manager on duty.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain was inspected but not rated.

We found:

- Peoples care and treatment was in line with current evidence based guidance, standards, best practice and legislation.
- Staff were competent to do their job and took responsibility for their own development.
- Multidisciplinary working was evident within outpatients and imaging.
- Systems and audits were in place to monitor patient outcomes.

However, we also found:

Outpatients and diagnostic imaging

- Staff appraisal rates were below the trust target of 90% across outpatients and imaging at 74%, with the exception of allied health professionals (Physiotherapists, Dieticians, Occupational therapists) who were 100% up to date with appraisals.

Evidence-based care and treatment

- Patient care and treatment was in line with current evidence based guidance, standards, best practice and legislation. For example: Cardiac outpatient's one stop clinic met National Institute for Health and Care Excellence (NICE) guidelines for diagnostic services following general practitioner (GP) or emergency department (ED) referral. Ophthalmology diabetic macular oedema and glaucoma clinics complied with NICE guidelines and Royal College of Ophthalmology guidelines. Patients attending outpatients had their body mass index (BMI) recorded, using the malnutrition universal screening tool (MUST).
- The trust had a radiation safety policy and all new documentation and revised procedures were ratified at senior trust management level and signed off by the clinical lead radiologist.
- Radiology clinical staff had a good knowledge of the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R and were aware of the levels and expected values for a range of examinations. However, diagnostic reference levels (DRLs) were not displayed, this was a requirement of IR(ME)R. Diagnostic reference levels refer to radiation levels for different imaging procedures.
- Referrers of patients for diagnostic imaging made use of an i-refer guidance tool written by the Royal College of Radiologists.

Nutrition and Hydration

- Areas within outpatients and imaging had water dispensers and cups, which were free to all patients and visitors.
- Snack boxes were available for patients using ambulance transport who experienced delays in collection.
- There were commercial outlets for people to purchase food and drink which were close to the outpatients department.

Pain relief

- Where patients underwent outpatient-based procedures, pain relief was available.
- Staff told us simple pain relief such as paracetamol was available within outpatients if patients had pain, this would be prescribed by a clinician.
- None of the patients we spoke with during the inspection had required pain relief during their outpatient visit. Although one patient commented that if she had pain, she would discuss this with the nurse in the clinic.

Patient outcomes

- The outpatient department completed local audits to monitor the outcomes of patients. An example was the nutritional-screening pathway in adult cardiology outpatients. This showed 81% of patients had nutritional screening within outpatients against a target of 90%. An action plan was in place to increase compliance and to re-audit (August 2016).
- The magnetic resonance imaging (MRI) department had received positive feedback from a large tertiary trust citing that the image quality of MRI scans was excellent and far superior to expectations.
- The radiology department had recently been reaccredited by ISAS (Imaging Services Accreditation Scheme). We evidenced the action plan from the accreditation team and saw audits the department had undertaken following recommendations. ISAS was a patient-focussed assessment and accreditation programme designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- Radiology had an audit plan to monitor local DRLs against national reference levels (NRLs). This reflected best practice. Medical physics had recently increased its capacity to be in a better position to support radiology in a robust dose audit programme.
- Radiation exposures were monitored for trust research purposes. Findings were communicated to the radiology team for to highlight when special attention was required. This was required under IR(ME)R and for the purpose of audit.
- Radiology had radiation exposure charts in all x-ray rooms as well as being pre-programmed on the equipment this included paediatric exposure parameters.

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- Interventional radiology and cardiology had a policy for skin radiotherapy dosage with clear guidance for patients following high dose procedures. This enabled clinical teams and general practitioners (GPs) to monitor skin erythema (reddening of the skin), following treatment. All high doses were also reported to medical physics for assessment
- Within radiology, the mortality rates for emergency endovascular aortic repair were low at 1%.

Competent staff

- Staff within outpatients had the right qualifications, skills and knowledge to do their job. The department had speciality clinics led by clinical nurse specialists. These nurses were employed within their speciality directorate with rostered time to manage outpatient clinics. We saw examples of nurse led clinics: the ear nose and throat (non-cancer) clinic was nurse led, and an ophthalmology glaucoma clinic had recently been established following the employment of a specialist nurse.
- The trust had an appraisal target of 90% for all staff over a rolling 12-month period. Appraisal rates for staff within outpatient areas was 74% for nursing and 81% for admin and clerical staff. Staff we spoke with said they received appraisals on a yearly basis and that they were informed by email regarding renewal dates. Five staff showed us their appraisal and training records.
- Staff within outpatients were encouraged and supported to manage their own development. Staff told us access to training was easy to book although some training sessions had recently been cancelled. This included dementia care and end of life training, no further dates had been provided for these sessions.
- Training was provided through e-learning and classroom attendance and staff told us they were allowed time within their working day to access computer based training as required.
- The trust had an in house leadership talent programme; the lead nurse in outpatients had attended this. There were plans to roll out the programme to other qualified nurse grades as part of continuing professional development.
- The trust had provided additional information technology (IT) training, prior to implementing the electronic patient management system, for all staff who were not confident in IT.
- Registered nurses who were approaching revalidation had been offered support by the lead nurse to ensure they gather the required evidence of practice.
- Staff appraisal rate within imaging services was 74%. However, this had been recognised and there was a departmental action plan for improvement.
- Allied health professionals, including physiotherapists, occupational therapists and dieticians within the outpatients department had 100% record for appraisals.
- We spoke to a number of junior doctors who were complimentary about radiology services. They said they received excellent support and training.
- Continual professional development (CPD) within imaging was encouraged and staff felt supported by managers. However, due to gaps in the clinical workforce staff were completing CPD in their own time. There was limited opportunity to attend courses and study days. Radiologists were actively involved with CPD and held regular audit and discrepancy meetings. One consultant we spoke with cited good professional development within the trust and said appraisals at consultant level were timely.
- We saw evidence of role development for radiographers, sonographers and health care assistants. Sonographers could perform musculoskeletal imaging, radiographers had role development in appendicular (Limb) skeletal x-ray reporting and performing computerised tomography (CT). Health care assistants and radiographers could perform intravenous cannulation and radio-opaque contrast administration.
- There were radiation protection supervisors for each controlled radiation area. Their role met the Ionising Radiation Regulations and were active in radiation protection. Imaging staff rotated to the emergency department to promote flexible working and for shared learning.
- There was preceptorship for all new staff within imaging, they were supported and integrated into the department. The preceptorship programme along with training records for all staff including agency was under review. Preceptorship is a period of practical experience supervised by an expert or a specialist in a particular field.

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- Student radiographers told us they received excellent support during their placement. One student we spoke with discussed how the department had been supportive of her personal circumstances, which had enabled her to continue on the degree programme.

Multidisciplinary working

- Most clinics we visited were managed by multi-disciplinary teams (MDT) with a range of staffing skills, roles, and levels. These included doctors, nurses, and care assistants with input from physiotherapists, occupational therapists and dieticians as appropriate.
- The pulmonary rehabilitation clinic was led by a consultant and managed by a senior physiotherapist, physiotherapy assistants and respiratory nurses.
- There was a phlebotomy service within the outpatients department working for all specialities.
- Multidisciplinary meetings were supported by a radiologist, these were built into their job plans to allow for preparation for each one. During the inspection, we observed the gynaecology MDT and considered it a robust model. The MDT had video linking to a neighbouring trust and there was a streamlined approach.
- The radiology interventional team was cohesive and multi-disciplinary with good communication and leadership. There was good methodology around reporting of discrepancies and a positive culture for learning from them.
- The medical physics team had good links with other regional physics services across the South West. This enabled them to discuss concerns, share best practice and standardise practice.

Seven-day services

- Outpatients offered a five day, Monday to Friday service 8:00am to 5:30pm although some clinics did overrun on occasions.
- The radiology service provided emergency cover across all specialities 24 hours a day, seven days a week. This included CT, MRI, Ultrasound, interventional radiology and cardiology as well as plain film imaging.
- Imaging department had extended working hours, to include weekends to meet the demand for imaging services including computerised tomography (CT) magnetic resonance imaging (MRI) and Ultrasound at the weekend.

Access to information

- Information relating to patients was available in a timely way. A new electronic patient recording system had been introduced in September 2015, as the trust was aiming to have a paper free recording system. However, during the transition period of implementing the new system paper patient medical records were also being used. One consultant told us the principle of becoming paper free was good; however, he had experienced problems accessing past medical history, inserting diagrams on the electronic system and felt there was reduced time for face-to-face consultation with patients.
- Radiology images could be accessed through a picture archiving and communication system (PACS). This meant patient images were instantly available to medical staff when assessing patients. Additionally electronic patient-reported outcome (ePRO) was used to access patient test results. All of these systems were password protected.
- It was planned that all systems would eventually be accessible through the new electronic patient management system, using one access point and password. However, at the time of our inspection, this was not the case and each system had to be accessed separately. This caused some frustration due to the time involved moving between the different systems.
- The radiology information system (RIS) and PACS systems interfaced well with one another and there was rapid access to data stored. Data extraction was manageable which had also been an issue following installation of RIS.
- Policies and guidelines were available through the trust's intranet and staff told us they had opportunities to access computers to view these. Temporary staff could be provided with access to the intranet if required, however the senior nurse on duty would provide guidance if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff requesting verbal consent from patients prior to any physical contact. For example recording of observations and taking blood.
- Staff understood patients who had capacity to make decisions had a right to refuse any treatment or intervention.

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- Staff gave an example of how care had been delivered to a patient with severe learning difficulties who was receiving end of life care. A multi-disciplinary decision that included the patient's family had been made about discontinuing a course of treatment in the patient's best interest.
- There was very little information about the Mental Capacity Act 2005 and data indicated access to training was low at 5%. Staff however, were aware of addressing the needs of vulnerable people and felt comfortable taking concerns to the nurse in charge within outpatients.

Are outpatient and diagnostic imaging services caring?

Good



Overall, we rated caring for outpatients and diagnostics as good.

We found:

- Feedback from people who use the service and those close to them was positive about the care provided by staff. Patients were treated with dignity, respect and kindness during all interactions with staff.
- The Family and Friends Test (FFT) results reflected the positive caring experience with 90% of patients saying they would recommend the outpatients department to family and friends.
- People told us they felt cared for and supported by staff.
- Patients and carers were provided with information and support whilst attending the outpatients department and signposted to local support groups as appropriate.
- Multidenominational spiritual services were available.

However we also found:

- Within radiology, there were instances where the curtain partitioning within a changing room was not sufficient. This meant privacy and dignity for the patient could be compromised.

Compassionate care

- The NHS Friends and Family Test (FFT) provided patients with an opportunity to feed back on the quality of

services received. Results were displayed throughout the outpatients department. The September 2015 results showed that 90% of patients said they would recommend the service to friends and family.

- Physiotherapy outpatients had piloted a satisfaction survey over two days, with 93 responses, 100% rated the service as good or excellent. Results were displayed in the staff room but not in the patient waiting areas.
- Within radiology, a local patient survey provided positive feedback with an overall satisfaction score of 92%. Comments included polite and caring staff and some long waiting times for appointments.
- Privacy and dignity was maintained within general outpatients. Patients arrived at reception for basic details check. Confidential information was recorded in clinic and height and weight recorded in a private room. We observed receptionists talking to patients in a respectful way and taking care to prevent other patients overhearing conversations.
- Patients told us staff were friendly, helpful and supportive whenever they visited the outpatient department.
- Patients waiting for transport remained within the outpatients department. Staff told us they ensured these patients had access to drinks and would get them a snack box if their wait went over a meal time.

Understanding and involvement of patients and those close to them

- Patients were informed about what to expect and when they would receive test results. We spoke with several patients who had received follow up appointments by post and they told us they were given adequate notice to make suitable arrangements if needed.
- There were white boards within clinic areas which were used to inform patients' of waiting times or delays within their clinic.
- Patients told us they felt cared for and supported by the staff.
- Relatives or carers were encouraged to attend with patients and were given clear instructions about what to expect whilst in the department. This was particularly beneficial for those living with learning difficulties or dementia.

Emotional support

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- There was pastoral support within the trust for all religious denominations. This could be accessed through staff who would ask switchboard to make contact with the relevant person.
- We observed a health care assistant sat holding the hand of an anxious elderly person waiting for an appointment.
- We did not observe patient consultations but noted these were in private or with a relative / chaperone if required.
- Staff described to us how they could support patients receiving bad news and we saw a suitably decorated private room available to facilitate this.

Are outpatient and diagnostic imaging services responsive?

Good



Overall, we rated responsive as good for outpatients and diagnostic imaging.

We found:

- Musgrove Park Hospital (MPH) was implementing a new electronic patient management system.
- Data indicated the department was meeting demand. There was evidence of cross community innovations to reduce demand and prevent unnecessary hospital visits.
- Complaint numbers were consistent with those of other outpatient departments of a similar size. Information about complaints was shared with staff at the regular morning brief.

However, we also found:

- Some national referral to treatment targets were not consistently achieved.

Service planning and delivery to meet the needs of local people

- Patients were provided with clear instruction, by letter prior to their outpatient appointment. This included which hospital entrance was closest to their destination and information about parking.

- Staff at reception gave directions to patients on arrival and provided them with a map of the hospital. When no one was available at the desk there was a telephone for patient and visitor use that connected with the switchboard for information.
- Signage throughout the outpatients department was in small lettering and did not provide clear direction. This meant patients with poor vision may not be able to read them clearly. One patient told us of getting lost and very upset when attending a previous appointment and being unable to find where she needed to be.
- Patients we spoke with said there was sufficient car parking on the hospital site. Payment was made prior to exit meaning patients did not need to top up payment during their visit. If clinics were delayed patients could request reimbursement of monies for the additional parking time required. This information was provided to patients prior to attending clinic.
- Systems were in place to enable the outpatient's service to meet the needs of a large rural catchment area. An electronic patient referral (e-PR) system offered GPs an advice and guidance service to allocate patients onto the correct treatment pathways. This meant some patients in the community could avoid hospital attendances. Data for September 2014 to September 2015 within gastroenterology showed an average of 60% of patients, referred through the e-PR system, did not require an outpatient appointment and 40% of patients went straight to endoscopy. This reduced the demand for a first outpatient attendance prior to investigation and reduced the time from referral to commencement on a treatment pathway.
- Additionally assessment hubs had been set up in general practitioner (GP) surgeries. Here patients could have cardiac assessments and fitted with a 24-hour tape, recording their heart rhythm. Results were transferred to MPH cardiology. This meant only patients who needed to attend hospital would receive appointments.

Meeting peoples individual needs

- There were information racks in each outpatient area containing leaflets about various medical conditions and local support services. For example, we saw information for patients attending ophthalmology clinic

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about support for those with sight loss. This information was provided in large print, black on yellow paper as recommended by the Royal National Institute for the Blind (RNIB) to aid those with poor vision.

- The majority of first outpatient bookings were made through a bookings centre external to the hospital. However, follow-up appointments and changes to bookings were carried out within Musgrove Park Hospital (MPH), this enabled the department to be flexible to local people's needs. One patient told us they were able to change an appointment without any problem.
- There was a relatively small number of non-English speaking ethnic minorities within the area served by MPH. Translation services were available for patients through a telephone translation system. This service could also provide face-to-face, written and British Sign language on request. The most commonly accessed languages were Polish and Portuguese. Staff knew how to use the service but had little experience of doing so.
- The trust had a learning disabilities nurse specialist who provided advice and guidance on request. Outpatients departments were generally advised in advance if any special arrangements were required. A carer or relative usually accompanied the majority of patients with a learning difficulty.
- In the cardiac catheter laboratory, patients were given a letter outlining what to look for and what to do if they experience skin erythema following treatment. This included a number to call for advice. The cardiac catheter laboratory was a specialised department where specific cardiac imaging or treatments were performed.
- A relative or carer usually accompanied patients living with dementia. However for further support there was a named 'dementia champion' within the outpatients department to assist patients if required.
- There was access to a multid denominational spiritual centre called 'Spiritual life', which was open twenty-four hours a day; this could be used by patients and visitors. Additionally there was access to a chapel, if required.
- There was clear chaperone guidance and staff generally accompanied patients during consultations, unless a partner or other responsible adult was present. The trust policy stated 'a chaperone would be present during any procedure that necessitates physical contact of a patient by a health professional of the opposite

gender'. This met the recommendations of the patient advisory service. However, the option to request a chaperone was not displayed in all outpatient waiting areas.

- Within radiology, male sonographers did not scan female patients' pelvic areas at weekends or in the community, as no chaperone was available at these times.
- Dogs for the blind, hearing dogs or other specially trained assistance dogs were welcomed into the department.
- There was lifestyle information providing advice on smoking, driving and alcohol consumption within the outpatients department.
- Staff, patients and ambulance crews told us there was a lack of wheelchair availability within outpatients. This had an impact on patient flow through the department. We observed one patient waiting in an ambulance transfer chair for a wheelchair for ten minutes. The ambulance crew told us that there was a reluctance to give them wheelchairs as the hospital porters needed them. There was a designated 'quiet room' available for giving bad news to patients or those who needed privacy to reflect on information they had received.
- Notice boards within outpatients had information for patients and visitors about a variety of subjects from specific medical conditions, to help available for those suffering from abuse.
- Specialist nurse clinics provided focussed support to wide range patients including cardiology, dermatology, diabetes, vascular surgery, ophthalmology, breast care and many others.
- Patients who wished to ask clinical questions prior to their radiology appointment, had access to a "highlight" radiographer who was available to discuss any preparation required. This was most commonly used by patients attending for colonography (a specialist x-ray of the colon).
- Within radiology, there were instances where the curtain partitioning within changing rooms was not sufficient. This meant privacy and dignity for the patient could be compromised.

Access and flow, outpatients

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- There were 442,578 outpatient attendances at MPH between January 2014 and June 2015. Data showed 5% patients did not attend (DNA) clinics, 27% of these were first appointments, and 45% were follow-up appointments (second or subsequent appointments).
- The trust cancelled 13% of outpatient appointments and 11% were cancelled by the patient. Trust cancelled appointments were attributed to changes in job plans, study leave, annual leave, professional leave and changes in theatre scheduling. This data reflected the local and England average for this period.
- The national standard for NHS trusts is 92% of patients waiting for treatment (at the end of each month) should receive consultant-led treatment within 18 weeks of referral by their general practitioner (GP). During the period April 2015 to September 2015 MPH performed better than the national standard in the majority of specialities, those not meeting the standard included ophthalmology and neurology. However, for October 2015 and November 2015 there was a decline in performance in November 2015 at 91%, therefore just below the national target of 92%. This was said to be due to increased demand and limited additional capacity. The trust was continuing to monitor this.
- The national cancer waiting time target is for 93% of patients, urgently referred by their GP with suspected cancer, should wait no longer than two weeks for a hospital appointment. Between April 2015 and November 2015, the service did not meet this standard for five of the eight months. However, symptomatic breast patients (cancer not initially suspected) exceeded the two-week target. The trust was monitoring the referral to treatment times closely to establish any emerging themes for action.
- Patients urgently referred by their GP with a suspicion of cancer and who are subsequently diagnosed with cancer should wait no longer than 62 days to start treatment, national standard 85%. The trust was consistently below this target at between 77% to 83% depending on speciality. This is similar to other trusts. NHS England data indicates 81% compliance for January 2016,
- The trust had exceeded the National Health Service (NHS) cancer screening service target of 90% for six of the months between April 2015 and November 2015.
- The orthotic department could facilitate the provision of prosthetic boots within 15 days following an appointment. This was considered an exceptional service as this could take several months in some areas.
- Rapid access clinics were available for patients with chest pain, suspected stroke and urology this meant patients could be referred for urgent specialist assessment and care without an appointment.
- The stroke response time in computerised tomography (CT) was excellent with patients brought directly to the scanner from the emergency department (ED) and head scans undertaken against pre-authorised protocols. This ensured rapid availability of images and early commencement of treatment.

Access and flow, Imaging

- Monitoring of new to follow-up appointments indicated the trust was consistently better than the England average of 2.3 at 1.8. The number of follow up appointments compared with first appointments influences how many newly referred patients can be seen and meet the waiting times standards. A lower ratio improves patient flow.
- Communication between the emergency department (ED) and radiology was excellent with the department being well placed for access to the ED resus.
- To facilitate flow within the imaging department there were three plain film-reporting radiographers, two CT reporting radiographers and one non-practicing magnetic resonance imaging (MRI) reporting radiographer. In addition, there were two sonographers who managed musculoskeletal (MSK) work and three radiographers who led the CT colonography studies and hysterosalpinograms (specialist bowel and gynaecological imaging).
- There were no reported delays in discharging patients due to a lack of access to imaging or imaging reports. However, MRI reported delays of up to three days in reports being available; this was due to high demand for this service.
- The imaging department utilised a third party CT reporting service for all out of hours CT and MRI scans. This service used off site radiologists to justify and report urgent and emergency scans. There had been concerns around the timeliness of reports back to the trust and some radiographers had concerns about requests for imaging being accepted when the

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diagnostic test may not have been the most appropriate. The department intended to audit inappropriate requests and referrals once the service had been in place for twelve months.

- Diagnostic imaging services had a policy and procedure to manage did not attend (DNA) appointments. If the appointment was posted to a patient who did not attend, a second appointment was posted. Following a second DNA the referral was returned to the referrer. However, if the initial appointment was telephoned to a patient and they did not attend then a second appointment was not offered. There was a high number of DNAs in ultrasound for the month of January 2016, with 80 DNAs recorded at the time of inspection. The department tried to fill appointment slots wherever possible. The department were auditing DNA statistics.
- Patients undergoing cardiac MRI and biopsies were contacted the day before an appointment to confirm planned attendances as these were seen as valuable resource slots which could be filled quickly.
- Open access for GPs to request MRI or CT scanning has not been developed yet. This would occur through discussions with commissioners and would impact on demand and capacity in the department. It was considered more effective to make appointments for all examinations following referral. There were however, five daily ultrasound appointments assigned for GPs to access for suspected deep vein thrombosis (DVT). If patients had a positive DVT scan a clear treatment pathway was in place following on from the scan to the hospital clinical teams and all results were immediately communicated back to the GP surgery.

Learning from complaints and concerns

- Information provided for patients and their families about making a complaint was displayed in all outpatient areas. There were leaflets for patients explaining the patient advice and liaison service (PALS). These leaflets were printed in normal text, easy read and pictorial format. A patient who had contacted PALS with an appointment problem told us the issue was solved very efficiently with a telephone call back within 24 hours.
- Staff were aware of the complaints procedure and told us they would try to resolve problems as they occurred and gave people the PALS information leaflet, as per trust complaints policy.

- There were five formal complaints received during the period November 2014 to November 2015 for outpatients and diagnostic imaging. Areas of concern were delays or cancelled appointments and staff attitude.
- The acting support services directorate manager signed off written complaint responses, and face-to-face meetings were encouraged whenever possible to promote local resolution.
- There were no ongoing complaints, which had been upheld by the health service ombudsman.
- The trust's handling of complaints was generally in line with other similar trusts participating in national benchmarking.
- Information about complaints was communicated to staff at the outpatients daily 8:30am morning brief.

Are outpatient and diagnostic imaging services well-led?

Good



Overall, we rated well led as good within outpatients and imaging.

We found:

- The department had a clear vision and a transformational plan
- A relatively new management team have worked well together planning the transformation and implementing change.
- Staff were appreciated and happy to be working within outpatients and imaging.
- Public feedback for the service was positive.

However, we also found:

- There was a gap between management and operational staff in terms of communication.
- There was a low response rate to surveys and no formal patient forums.

Vision and strategy for this service

- The trust informed us of a transformation project-taking place within outpatients. The trust and directorate senior team was enthusiastic about this project which aimed to improve efficiency, reduce cost, and improve patient experience. Senior staff within the outpatients

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department were aware of this. However, staff working within the clinics had limited understanding saying that they knew there were plans for the department but were unsure what they were.

- The trust had agreed values, which the majority of staff within outpatients were familiar with. However, the values were not widely advertised within the departments for patients and visitors to see.
- A change management project had been led by the directorate clinical lead to extend the working day within imaging as part of the strategy for a seven-day service. An initial reluctance to change had subsequently been seen to be a positive and productive move for the department.

Governance, risk management and quality measurement

- The governance, risk and quality was managed by the directorate management team. Some speciality teams that held clinics within the department operated under the governance of their own directorate. For example; ophthalmology, cardiology and neurology. There was good communication between the directorates relating to governance issues.
- The clinical support directorate had monthly governance meetings, which included quality assurance and risk management. Other directorates that held clinics within the outpatients department fed back into these meetings. The clinical lead attended governance meetings at board level and attended other directorate clinical governance meetings when required. Governance issues were communicated to the staff at their regular 8.30am brief.
- We evidenced the radiology risk register, which was regularly reviewed. At the time of the inspection there were risks around a new interventional room which required replacement, and ongoing concerns relating to gaps in the clinical workforce.
- The risk register for outpatients included the migration to a new electronic patient record (EPR) system, management of did not attend (DNA) and limited hand washing facilities. There were clear monitored actions in place. The lead nurse was familiar with the items on the risk register and the action plans.
- During implementation of the new electronic patient system (EPR), the trust was concentrating on meeting the national statutory data requirements. However, to ensure monitoring of service delivery local reporting

mechanisms had been put in place. These included the bookings manager and outpatient lead nurse manually checking clinic bookings, and challenging areas to ensure appropriate processes were followed for notification of cancellation. Clinic nurses were recording patient waits of over 30 minutes and the lead nurse would discuss with the clinician and establish the cause. Repeated delays were escalated to the speciality directorate manager. We were shown an example of an email raising such a concern.

- The clinical support directorate had a clear management structure led by a consultant clinical director and acting directorate manager. They were supported by speciality service managers, hospital bookings manager, outpatient's sister and an operational manager with specific responsibility for EPR. The leadership structure had been established for eight months and was effective but not fully embedded within the service.
- After recent departmental restructuring within imaging, lines of accountability were altered and numerous changes to staff roles and responsibilities were made to streamline the department. The department was restructured due to increasing demands for capacity and a shortfall in the clinical workforce. There were new leads across the modalities with a shared skill mix. The radiology service manager (RSM) was supported by a principal radiographer and a cross sectional lead, both focussed on the management of their department at speciality level. There was a lead sonographer for a team undertaking the ultrasound imaging. Each clinical area had a senior radiographer who focussed on the clinical work within the department. Due to a relatively new structure within the department, some staff spoke about a lack of understanding of their specific role and a lack of clarity for junior members regarding line management and accountability structures.
- A lead clinical scientist was the radiation protection advisor (RPA), radiation waste advisor (RWA), medical physics expert (MPE) and led the radiation protection service for diagnostic imaging, nuclear medicine as well as providing support for laser and magnet use throughout the trust. These roles provided expert advice about radiation safety and risk within the department. RPA and MPE cover was provided for peripheral hospitals where x-rays are carried out.

Outpatients and diagnostic imaging

- The department has an in-house 'Quality Management' system which allowed review, revision and audit of departmental policies and procedures
- The trust recognised early implementation problems with the electronic patient management system and provided feedback meetings to discuss issues. This was then fed back to the information technology company. A common concern was the need to have one access point to the multiple hospital systems. It was hoped that this would be addressed as the implementation progressed. The system had 'gone live' in late December 2015.
- Staff across all grades appeared motivated and said they 'loved working at the trust'. The majority of staff had been in post for many years and said they would not choose to leave.
- Staff within imaging were cohesive and supportive of each other, especially considering the staffing issues and the trusts financial constraints.

Leadership and culture of the service

- The outpatient and imaging department was managed by the clinical support directorate, led by a consultant clinical director who was supported by operational and service managers. Nurse leadership was led by a senior sister.
- Staff told us managers were visible and the matron was hands on within the department. Staff spoke positively about the support offered to them and said they felt respected in their role.
- Outpatient and diagnostic imaging management team were proud of their teams, describing them as being fantastic, hardworking, flexible, and that they provide excellent patient care.
- Senior managers in radiology had an open door policy. Staff were encouraged to talk to senior managers about queries or concerns.
- Senior staff were positive about future developments and the transformational project. However, staff at clinic level could not describe the plans for the service.
- There was a positive culture with staff saying they were very happy to work in the outpatients department. We were told some staff within the hospital were waiting for jobs to become available in the department.
- The clinical lead undertook an external leadership course to enable him to support a culture change and extend the working day.
- The radiology services manager (RSM) was extremely proud of the staff. The RSM stated the staff were a huge asset and she was proud of them for working under a new regime with a shortfall in staffing and financial constraints.

Public and staff engagement

- Response rates for the Family and Friends Test (FFT) within outpatient department reflected the national average at 20%. Staff were actively promoting the survey by placing leaflets entitled 'One Quick Question' on every seat. A pictorial version of the leaflet was available for those with learning difficulties and an electronic version at the entrance to outpatients. We saw patients and visitors reading the leaflet whilst waiting for their appointments and receptionists encouraging people to place completed surveys in the box provide.
- Breast care services provided feedback cards on their mobile units and within the department.
- Staff told us they had been involved in 'Big Conversation' events, put on by the trust to gather ideas for service improvement both locally and throughout the trust.
- Within the outpatient departments, two 'Small Conversation' events were held to identify potential improvement ideas at speciality level. There was a plan to hold 'Small Word' events within each speciality operating out of the outpatients department.
- Question cards in the staff room provided staff with an opportunity to ask questions or make suggestions anonymously.
- The development of a new electronic patient management system was selected and endorsed by the trust and clinicians based on cost effectiveness and ability to meet future needs. Outpatients' was a key area, where the new system would inform service planning and review activity on a day-to-day basis.

Innovation, improvement and sustainability

- The implementation of a new electronic patient management system had a major impact on the clinical support directorate. The management team did not underestimate the commitment from staff across all disciplines to make it successful. The system had facilitated the electronic upload of GP and other referrals to outpatients, helping to make the process

Outpatients and diagnostic imaging

‘paper light’ and work towards a ‘paper free’ system. Staff had been offered additional information technology training to help them adapt to the new technology.

- Expansion of e-booking services and advice and guidance was embraced by clinicians who provide advice to GPs on a rota basis.
- The implementation of investigation hubs within GP practices reduced the need for outpatient appointments and provided rapid reassurances for worried patients.
- Outpatients had outsourced the production of patient appointment letters.
- There were plans to pilot sending patient letters out by email and to provide text reminders for outpatient appointments within the next six months.
- Diagnostic imaging was awarded ISAS Accreditation in 2012. The department has continued to maintain the standard year on year.
- The trust had established links with an African hospital with a radiologist visiting annually. The department had been awarded a grant for this purpose.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had a Joint Emergency Therapies Team (JETT) and Older Persons Assessment and Liaison service (OPAL) which assessed all patients over the age of 75 with the view to prevent avoidable admissions.
- General Practitioners (GPs) worked in the emergency department. GPs supported management of patients in the ambulatory stream with primary care problems.
- The hospital was named as one of the top hospitals in the 2015 CHKS awards, (CHKS is a provider of healthcare intelligence and quality improvement services), and was highly commended for patient experience. The CHKS awards commended the cancer care team, in the International Quality Improvement category, for their work.
- Investors in People awarded the gold standard to the whole Haematology, Oncology and Palliative Care Directorate (which included the Beacon Centre), one of only 7% of accredited organisations to win this.
- Colorectal Specialist Nurses had been trained to use clinically developed criteria and pathways to direct patients to the relevant test or clinic thus avoiding unnecessary steps or diagnostic procedures in the patient's pathway. This improved the speed of diagnosis for patients with suspected colorectal cancer.
- We saw the use of a number of initiatives to mitigate the risks identified as a direct result of previous low staffing levels and skill mix. These included; banked Hours; clinical supervision; an on call system; the appointment of a Practice Educator and; the band five and six development programmes.
- Critical care participated in the Potential Donor Audit (PDA). PDA audit results for the reporting period April 2015 to September 2015 showed the trust as the best trust in the South West region for; approaching patients and, securing a good number of donors.
- A tracheostomy ward round, led by a consultant intensivist in collaboration with a nurse specialist for 'head and neck', took place daily to assess tracheostomy care and improve standards both in critical care and throughout the hospital
- As part of the ABCDE assessment of new admissions to critical care, the team had added F (for family) to remind staff to communicate with the family about any concerns or worries they may have.
- Local safety projects were in place to highlight current incidents and areas of concern and included the 'take note project' and, 'raising standards project'.
- One of the midwives at the service had also recently won a MAFTA award for her innovative ideas. She had designed a fabric placenta as a teaching aid and designed the "smoke free buttons" located throughout the hospital, which when pressed plays a voice recording outside to remind patients and visitors of the smoke free message.
- Two paediatric consultants developed an App, whose aims was to develop a single care pathway from home through to community healthcare and into hospital. The app 'HANDI Taunton' was launched in March 2015 and provided parents with 'clear and concise advice' about the six common childhood illnesses. The conditions covered included, diarrhoea, chesty baby, chesty child, high temperature, abdominal pain and common new-born problems.
- The Marie Curie companion service is the only one currently in the country. It uses the innovative approach of using trained volunteers to help provide emotional comfort to patients. There was overwhelming praise from staff about this service and the report of the six-month review of the service showed positive feedback from family members. The service was shortlisted for the National End of Life Safer Patient Award in June 2015.
- In partnership with the complex care GPs and a neighbouring community NHS trust palliative care consultant team, the trust had made a successful bid to the Health Education South West to develop a health improvement programme between hospital and community. The aim of the programme was to increase effective communication with regard to those who are dying. This project was ongoing at the time of inspection.

Outstanding practice and areas for improvement

- The trust had an end of life poetry project. This was led by a staff member, whose aim was to help make colleagues comfortable with having difficult conversations with patients and their families.
- The orthotic department could facilitate the provision of prosthetic boots within 15 days following an appointment. This was considered an exceptional service as this could take several months in some areas.
- The trust e-referral advice and guidance system. This enabled GPs to discuss symptoms with a specialist consultant who would advise on the preferred treatment pathway, reducing the need for hospital attendance.
- The clinical support directorate clinical lead had undergone specialist training in change management to the implementation of seven day working.
- There was priority access to imaging services for trauma and patients suspected of having suffered a stroke.
- The outpatients department worked closely with the health community setting up testing hubs in general practitioner (GP) practices. Patients could have cardiac assessments and be fitted with a 24-hour tape. Results were transferred to MPH cardiology department. This meant that only those patients who needed to attend hospital would receive appointments.

Areas for improvement

Action the hospital MUST take to improve

- Ensure all emergency lifesaving equipment, is sufficient and safe for use in all clinical areas and that there is evidence it has been checked in line with the trust policy.
- Medications were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons. The trust must ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.
- Ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department, critical care and children's ward.
- Ensure trained health care professionals triage all patients attending the emergency department within 15 minutes of arrival, and have systems in place to escalate and mitigate risks where this is not achieved.
- Ensure there are robust systems in place to assess, monitor, and mitigate risks to deteriorating patients in the emergency department.
- Emergency department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
- The hospital must improve the accuracy and timeliness of patient risk assessments. Delays present serious risks to patients who are deteriorating or seriously ill and could result in a delayed treatment.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- The medical staffing levels for the provision of advanced airway management, in the absence of the consultant, did not meet the Core Standards for Intensive Care 2013.
- The registered provider must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units

Outstanding practice and areas for improvement

- The obstetric anaesthetic staffing levels for the provision of emergency work on the delivery suite, did not meet the guidelines for Obstetric Anaesthetic Services 2013.
- Trained nurse staffing did not fully meet 'British Association of Perinatal Medicine Guidelines (2011)'. (BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance. (Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.
- The children's service were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.
- The registered provider must ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- Ensure an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- Develop a comprehensive framework for governance, risk management and quality measurement for end of life care.
- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- The registered provider must ensure that staff in the emergency department and children, and young people's services staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.

Action the hospital SHOULD take to improve

- The trust should ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance.
- The trust should ensure maternity staff report all incidents and near misses through the trust incident reporting system.
- The trust should ensure regular mortality and morbidity meetings take place in the emergency department.
- The trust should consider reorganising or amalgamating morbidity and mortality meetings to ensure learning is captured and shared across all specialities.
- The trust should ensure there are a suitable number of staff with the appropriate skill mix available in the emergency department and Jowett Ward at all times.
- The trust should ensure patients hydration levels are monitored whilst in the emergency department and this is documented in their care records.

Outstanding practice and areas for improvement

- The trust should ensure there is a screening tool in place to assess risk of physical abuse in children.
- The trust should review children's provision in the emergency department to meet the 2012 Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings.
- The trust should ensure staff consistently adhere to local guidelines available in the emergency department.
- The trust should review the way in which the treatment areas for children in the emergency department are used, to ensure they are always available to deliver care to children.
- The trust should ensure there is a robust system in place for delivering and recording the induction of locum and agency staff working in the emergency department.
- The trust should ensure the safeguarding checklist is completed on all children's records when they attend the emergency department.
- The trust should consider confidentially displaying the most recent early warning score for patients in the department on the electronic computer system.
- The trust should ensure it reviews critical care services in line with the Core Standards for Intensive Care Units 2013 to address areas where they are not meeting these standards.
- The hospital must improve the accuracy and timeliness of patient risk assessments.
- Should take measures to ensure procedures are followed regarding the safe management of sharps boxes.
- The hospital should ensure patient records are securely stored.
- The hospital should ensure, where appropriate capacity assessments are clear and visible in patient medical records.
- The trust should ensure local clinical guidelines in critical care have been monitored and reviewed to ensure consistency of practice.
- The trust should ensure there is a program of work/ time-line identified to establish when national standards (HBN 04-02) will be met in critical care.
- The trust should consider reviewing the discharge process for critical care.
- The trust should meet the OAA/AAGBI Guidelines for Obstetric Anaesthetic Services 2013 which state that that there should be a minimum of 12 consultant anaesthetist sessions per week.
- The trust should ensure staff that are recovering post-operative patients, regardless of the method of anaesthesia, should have appropriate training to comply with the recommendations of the British Anaesthetic and Recovery Nurses Association (2012).
- The trust should benchmark critical aspects of performance on the maternity dashboard to ensure staff are able to check that performance falls within acceptable levels.
- The trust should implement a system of "red flags" for midwifery staffing incidents in line with NICE NG4 guidance "Safe midwifery staffing".
- The trust should ensure that staff that have appropriate additional training in the care of the critically ill women in line with guidance from the Royal College of Anaesthetists 2011.
- The trust should ensure the provision of dedicated elective section list that is not interrupted by emergency cases or the lack of theatre staff.
- The trust should ensure that all staff have access to the trust's report and gap analysis of the Kirkup report and are aware of the recommendations and the implications for their practice.
- The service should look to provide a more cohesive service for all gynaecology patients receiving care at Musgrove Park Hospital.
- The trust should ensure that all staff have completed mandatory and role specific training and should ensure that the training record held by the service is accurate.
- The trust should consider a regular audit programme to ensure that water temperatures in birthing pools are within safe limits.
- The trust should consider the implementation of a system in maternity services that allows staff to know a piece of equipment is clean.
- The trust should ensure that they have written formal arrangements in place with the children and adolescent mental health team so that the needs of children and young people with mental health problems are met.
- The trust should review its paediatric high dependency service to ensure that it has sufficient funding and staffing in place to operate the service safely.

Outstanding practice and areas for improvement

- The trust must ensure that an experienced, senior nurse as identified within Royal College of Nursing guidance (August 2013) works during the 24-hour period to provide the necessary support to the HDU children's nursing team.
- The trust should ensure that staff have an understanding of the Frazer guidelines and Gillick competence in relation to consent processes for children and young people.
- The trust should continue the strategy to improve 18 week target referral to treatment times in those areas currently non-compliant.
- The trust's end of life strategy should be implemented as a matter of urgency.
- The trust should implement version two of the individualised end of life care plan with full educational support, so that comprehensive plans are consistently recorded in patients records.
- The trust should ensure all patients in the last days/ hours of life are prescribed anticipatory medicines.
- The trust should consider increasing the number of nurses within SPCT and consultant palliative care cover to meet the recommendation of the Commissioning Guidance for Specialist Palliative Care.
- The trust should develop a coordinated systematic approach for the provision of all EOLC training and education, including considering make end of life training part of the mandatory training programme.
- The trust should ensure DNACPR decisions are recorded in line with trust policy.
- The trust develop a comprehensive framework for governance, risk management and quality measurement for end of life care.
- The trust should take steps to ensure staff receive annual appraisals.
- The trust should provide improve the level of staff training on the Mental Capacity Act and ensure that all staff are suitably skilled and knowledgeable.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2)(a) Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment. How the regulation was not being met: • The trust must ensure trained health care professionals triage all patients attending the emergency department within 15 minutes of arrival, and have systems in place to escalate and mitigate risks where this is not achieved. • There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients, this must be addressed. • The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure. • The trust should ensure DNACPR decisions are recorded in line with trust policy. Regulation 12(2)(c) Care and treatment must be provided in a safe way for service users by ensuring the persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. How the regulation was not being met: • Ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department, critical care and children's ward.

Requirement notices

- There were insufficient numbers of paediatric registered nurses in the department to provide a minimum of one per shift.

Regulation 12(2)(e)

The registered person must ensure care and treatment is provided in a safe way.

How the regulation was not being met:

- Ensure the resuscitation trolleys, neonatal transport systems, and emergency and lifesaving equipment are checked, properly maintained and fit for purpose in all clinical areas.

Regulation 12(2)(g)

Care and treatment must be provided in a safe way for service users by the proper and safe management of medicines.

How the regulation was not being met:

- Medications were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.

Regulation 12(2)(h)

Assessing the risk to the health and safety of service users of receiving the care or treatment

How the regulation was not being met:

- Staff did not always assess and document patient risk in a timely manner, this could result in a delay to treatment.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requirement notices

Regulation 17(2)(b)

System or processes must be established and operated effectively to assess, monitor and mitigate the risk relating to health, safety and welfare of service users

How the regulation was not being met:

- Department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18(1)

Sufficient numbers of suitably qualified, competent and skilled persons must be deployed.

How the regulation was not being met:

- The medical staffing levels for the provision of advanced airway management, in the absence of the consultant, did not meet the Core Standards for Intensive Care 2013.
- The obstetric anaesthetic staffing levels for the provision of emergency work on the delivery suite, did not meet the guidelines for Obstetric Anaesthetic Services 2013.
- The trust must ensure that staffing within the children's service meets Royal College of Nursing (RCN) (2013) guidance.
- Staffing within the children's service, although currently considered as being safe by the senior management were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they said they had two less staff per shift than recommended by national guidance.
- The trust said funding for the two-bedded high dependency unit (HDU) was proportional to bed

Requirement notices

occupancy and monitored through the South West Specialist Clinical Network. We were told and saw evidence of shortfalls of nursing staff who held the HDU course, which meant that nursing staff without this training had also worked in the HDU area.

- Trained nurse staffing did not fully meet 'British Association of Perinatal Medicine Guidelines (2011)'. (BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- The service were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.
- Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.

Regulation 18(2)(a)

Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise.

How the regulation was not being met:

- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.

This section is primarily information for the provider

Requirement notices

- The registered provider must ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13(2)(3)

The registered person must ensure service users are protected from abuse and improper treatment.

How the regulation was not being met:

- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- The registered provider must ensure that staff in the emergency department and children, and young peoples services staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11(1)

When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- The provider did not ensure appropriate systems were in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- The provider must ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(c)

The registered person must ensure effective governance, including assurance and auditing systems or processes.

How the regulation was not being met:

- The registered person must ensure that an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.