Care Quality Commission

Weston Area Health NHS Trust

Weston General Hospital

Quality Report

Weston General Hospital
Grange Road
Uphill
Weston-Super-Mare
Somerset
BS23 4TQ
Tel:01934 636363
Website:www.waht.nhs.uk

Date of inspection visit: 20-22 May 2015
Date of publication: 26/08/2015

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of around 212,000 people in North Somerset, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

It has three locations that are registered with the Care Quality Commission. These are Weston General Hospital which has 265 beds, The Barn in Clevedon and Drove House which both provide special children's services.

At the time of our inspection the trust was subject to a transaction process, in which Taunton and Somerset NHS Foundation Trust was the preferred acquirer. This was at the Trust Development Authority's Gateway 2.

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it is an example of a moderate risk trust according to our new intelligent monitoring model. Our inspection was carried out in two parts: the announced visit, which took place on the 19-22 May 2015, and the unannounced visits, which took place on 30 May and 5 June 2015.

We judged that the hospital overall required improvement. There were serious concerns with respect to safety within urgent and emergency care services and medical services. Throughout the hospital we saw staff providing care and treatment to patients in a caring and compassionate manner. The service for children and young people was outstanding overall and in particular with respect to the caring and responsive approach of staff.

Our key findings were as follows:

Safe:

- Overall we rated the safety in the hospital as inadequate. There were serious concerns with respect to safety within urgent and emergency care services and medical services were also rated as inadequate. Safety within surgery services and critical care required improvement and in all other areas was rated as good.
- Within the emergency department we found that at times when there were a higher number of people attending the emergency department, patients were not always assessed or prioritised in a timely manner. This meant they were not protected from the risk of avoidable harm. Whilst they were waiting in the corridor to be admitted to the department (for sometimes longer than an hour) patients were not adequately monitored by hospital staff, although ambulance staff were with them. There was no initial assessment on arrival to determine patients' priority in relation to others waiting and those already in the department. Patients did not receive assessment in line with College of Emergency Medicine guidance. We observed that under normal conditions patients were assessed within College of Emergency Medicine guidance.
- Self-presenting patients were not always assessed within 15 minutes in accordance with College of Emergency Medicine guidance. This meant that staff were not able to promptly identify or rule out serious or life-threatening conditions and prioritise patients accordingly.
- We wrote to the provider to inform them of these concerns and required them to inform us of the action which they would be taking to rectify these issues. The response that we received showed that the trust had taken urgent action to deal with the risks identified.
- Medical staffing within the hospital was a concern, particularly within medical services, surgical services and urgent and emergency care. There was a significant deficit in the number of consultants against the funded establishment, which resulted in unsustainable consultant rotas and reduced support for junior doctors. Junior doctors within medical and surgical services reported that they were undertaking tasks, unsupervised, for which they felt ill prepared or competent to perform.

Summary of findings

- In the area known as the high care unit on Harptree ward, there were insufficient numbers of appropriately qualified and skilled nurses deployed to care for high dependency patients. We raised this as a concern with the trust during our inspection and subsequently required, in writing, additional evidence to demonstrate what had been put in place to ensure that patients were not at the risk of harm. We received information which demonstrated that the trust had taken action to resolve the immediate concerns raised.
- Although incident reporting was slightly above the England average, we found that feedback to staff about incidents reported often did not occur. This meant that staff, particularly medical staff, were not encouraged to report incidents. Some junior doctors reported they had been discouraged from reporting due to the negative response of some consultants. Reporting of incidents by junior doctors was low. The trust had identified that feedback on incidents was an area which required improvement and they were reviewing processes and updating the electronic reporting system to enable improvements. In some services, learning or improvements made as a result of incidents were not monitored or documented.
- Nursing staffing was mostly safe in numeric terms, although there was a reliance on bank and agency staff to ensure that shifts were covered.
- The trust had the lowest midwife to birth ratio in the country although midwives provided antenatal and postnatal support to approximately 1,500 women a year. All women were provided with one-to-one care when in labour. The supervisor of midwives to midwife ratio was above (worse than) the recommended level of 1:15. However, the trust had recruitment in place to improve this number.
- The hospital was clean, despite some areas requiring refurbishment. Refurbishment of the theatre department was ongoing at the time of our inspection. Hand hygiene was seen to be good, with staff washing their hands, using alcohol gel as appropriate and observing the “bare below the elbows” policy. Most areas of the hospital had achieved the 95% compliance rate with infection control audits and those which had not were showing an improvement over time. Despite this, there had been a number of outbreaks of Norovirus in the hospital, which was attributed to a high prevalence within the community. There had been a higher number than expected cases of Clostridium difficile in the hospital in 2014-15, although this had reduced towards the end of the year and at the time of our inspection the trust had not had a case in 90 days.
- There was a high incidence of pressure ulcers within the hospital, although the trend had decreased by 20% over the year prior to our inspection. The trust had been actively working to reduce the incidence of pressure ulcers. There were also improved rates of harm-free care within the hospital at the time of our inspection.
- There were two never events in the hospital in the 12 months prior to our inspection. We identified a third never event took place in our review of information provided to us. This had not been reported as such. We asked the trust to look into this with the North Somerset Clinical Commissioning Group.
- There were concerns regarding the audit of the use of the World Health Organisation surgical safety checklist. There was no policy or protocol regarding the carrying out of the audit. Within main theatres, the audit was not carried out adequately and there was not consistent improvement as a result of the audit. Despite this we observed good practice with adherence to the checklist protocol. There were concerns, however, regarding the debrief (which was not audited) where full attendance of staff was required but at the time of our inspection, this occurred only 78% of the time.
- Staff were aware of their obligations under the new Duty of Candour regulation which, from November 2014, required organisations to inform and apologise to all relevant parties about specific patient safety incidents. We noted that this had not been applied in one instance where it should have been.
- Safeguarding processes were clear throughout the hospital, including in services for children and young people. Training in safeguarding in most areas was below the compliance rate of 90% set by the trust. Staff training on the children’s ward was however, above the compliance rate.

Effective

- The hospital overall required improvement in the effectiveness of services.
- There was a comprehensive programme of nursing audit in the hospital.

Summary of findings

- Although in most areas there was a programme of clinical audit, there was no evidence that actions had been followed-up, the details of learning identified or that this had been disseminated. Within medical services there was limited evidence that patient outcomes were measured or monitored or that care and treatment was provided in line with evidence-based guidance or best practice.
- Within maternity and gynaecology services; children and young people's services and end of life care, there was evidence that care was provided in line with best practice.
- There was good feedback about the provision of training for nursing staff. However, the support, training and supervision of junior doctors was reported to be poor. This was supported by the director of medical education in the trust. The General Medical Council survey of junior doctors in 2014 also confirmed these concerns and the results of the survey for 2015 (released the week following our inspection) were worse than for 2014.
- Patients' length of stay was higher than the England average within surgery and critical care, due to difficulties with discharging patients from the hospital, although in most medical specialities it was better than the England average.
- Most patients within the hospital reported that pain relief was provided promptly when requested. However, there was no dedicated pain management team in critical care.

Caring

- Patients and relatives throughout the hospital reported that staff were compassionate and caring. Within services for children and young people we judged that caring was outstanding.
- Feedback from patients was overwhelmingly positive. Friends and Family tests throughout the hospital showed mostly high levels of patient satisfaction.
- Patients said they were kept informed about their condition and treatment and we observed all staff speaking with patients in a dignified manner, using clear language.
- Patients and those close to them were provided with support to help them cope emotionally with their care, treatment or condition.
- We saw that patients' privacy and dignity was maintained.

Responsive

- Overall the hospital needed to improve in its responsiveness to patients' needs.
- Bed occupancy within the hospital was high and bed capacity and patient flow were a constant challenge. This had impacted on the emergency department where the trust was consistently failing to meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of arrival.
- There were occasions where patients at the end of their life were moved between wards to accommodate new admissions and there were occasions where a side room could not be provided to a patient at the end of their life.
- There were long delays in discharging patients at the end of their life to their preferred place of dying because of delays in obtaining ongoing packages of care within the community. Staff in the hospital completed rapid discharge documentation quickly.
- Patients in the emergency department regularly queued in the corridor because there were insufficient cubicles in the department. This impacted on patient safety, comfort, privacy and dignity. Actions were being taken to improve patient flow within the emergency department, which seemed to work well during the day. However, out of hours staff did not recognise the risk posed to patients in the corridor.
- All expected admissions to the hospital were referred through the emergency department which increased pressure on the department.
- Patients did not always receive care and treatment on the most appropriate ward and some patients were moved several times during their inpatient stay, sometimes at night.
- Patients were not discharged from medical, surgical or critical care wards and units in a timely manner, partly due to staffing issues and partly due to with difficulties in arranging suitable care packages in the community.
- Premises were not always fit for purpose. Accommodation in the ambulatory emergency care unit and the medical day case unit were not appropriately laid out or equipped to ensure patient's comfort, privacy and dignity.

Summary of findings

- Within outpatients and diagnostic imaging, referral to treatment times were meeting national targets and monitored regularly. If delays for appointments occurred, extra clinics were arranged in the evenings or at weekends. However, there were high levels of cancellation of outpatient appointments which were not monitored by the department.
- There were no barriers to making a complaint. However, in a number of areas, there was little evidence of learning being shared or improvements made as a result of complaints being monitored. A notable exception was within services for children and young people.
- Services for children and young were tailored to meet patients' individual needs. They were delivered in a flexible way and at a time that suited the child or young person and their parents.

Well led

- Nursing leadership within the hospital was strong. All staff we spoke with referred to the visibility and support provided by the nursing leadership.
- In contrast, medical leadership within the hospital was poor. There was significant discontent expressed by junior doctors and a lack of confidence in medical leaders to either recognise or resolve their concerns. In medical services the culture did not support openness and challenge.
- Governance in a number of areas within the hospital required improvement. There were improvements in risk management within some areas of the trust. However, risk registers were not always used proactively. There was visibility of the quality of nursing care throughout the hospital. However, data was lacking in some key areas, particularly within urgent and emergency care where there was a lack of visibility of the time to assessment of patients arriving in the department, for example. Within surgery, critical care and medical services, there was a lack of monitoring of improvements as a result of audits, incidents and complaints. In some cases these were not identified.
- As a result of the transaction process, there was no long term vision. However, there was a focus on maintaining safe and high quality care to patients which all staff we spoke with were passionate about. The organisational values were known by some staff but not all.
- Within services for maternity and gynaecology, children and young people, end of life care and outpatients there was evidence of positive cultures, innovations and actions taken to make service improvements.
- Operating theatres were not running efficiently and were under-utilised. There was insufficient planning to avoid last minute changes and competing priorities.

We saw several areas of outstanding practice including:

- There was an outstanding example of caring shown to a patient with a learning disability who was coming into the day-surgery unit for a procedure. One of the staff had contacted the patient's care home and discussed the best way to manage the appointment for the patient. The arrangements were then made to reduce the anxieties of the patient, and allow one of the main carers to be with the patient as much as possible during the procedure. An 'easy read' booklet about coming into hospital was send to the care home to go through with the patient in advance of their visit. This showed a good depth of knowledge and sensitivity for people with different needs.
- In medical services there were regular and effective multidisciplinary board rounds which ensured a coordinated and focussed approach to care planning, including discharge planning.
- In medical services, nurse leadership was frequently praised by nursing and medical staff. Nurse leaders were described as visible, approachable and focussed on improving the quality and safety of patient care.
- There was an outstanding staff newsletter produced each month. It included 'celebration of success awards' which were running for their second year. There were messages from public bodies, such as Public Health England, awards and recognition for staff and wards, updates on new staff, messages from patients, training and policy updates, and charity news and updates.
- The patient risk midwife was responsible for the majority of governance and quality measures and had outstanding processes in place. This person demonstrated a clear oversight of all current issues. We saw there were thorough processes and audit trails in place for risk, governance and quality information. We saw evidence of how information was thoroughly interrogated for service and safety improvements.

Summary of findings

- There was outstanding care for children, young people and their families.
- The outpatients' manager responded and developed improvements as a result of incidents that originated outside the outpatients department. For example, problems had been caused by plaster casts that had been applied in other wards and departments. In response, the senior plaster technician in the orthopaedic clinic had devised a teaching programme to improve the skills of other clinical staff. This had been rolled out across the hospital and no further problems had occurred.
- Following manual handling training in 2014/15 medical records staff had become concerned about the weight of boxes of records that they needed to lift. As a result, scales had been installed throughout the hospital to ensure that no boxes heavier than 11kg were lifted by staff. One of the medical records managers told us there had been a decrease in musculo-skeletal injuries since this change.
- At the beginning of 2015 the imaging department had gained full accreditation with the Imaging Services Accreditation Scheme (ISAS). This is a patient-focussed assessment that is designed to ensure that patients consistently receive high quality services. The ISAS website states that ,as of May 2015, only 20 departments in the UK had achieved this accreditation

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

Importantly, the trust must:

- Take action to improve medical staffing levels and skill mix in the emergency division (particularly within medical services) to ensure that people receive safe care and treatment at all times.
- Ensure that junior medical staff in the emergency division (particularly within medical services) are appropriately supported, supervised and trained to ensure that they are competent to fulfil their role.
- Ensure that the ambulatory emergency care unit and medical day case unit are appropriately staffed and equipped at all times.
- Ensure that patients who attend the ambulatory emergency care and medical day case units are accommodated in areas which are fit for purpose and ensure their comfort, privacy and dignity.
- Continue to take steps to reduce the incidence of avoidable harm as result of pressure ulcers, falls and medication incidents.
- Ensure that patients arriving by ambulance are fully monitored and assessed for priority when in the corridor awaiting admission to the department.
- All patients receive timely assessment in line with College of Emergency Medicine guidance to ensure that they receive suitable and timely treatment.
- Ensure that all staff are aware of and work to standard operating procedures relating to the safer management of controlled drugs.
- Ensure that there are suitable numbers of staff with the qualifications, skills and experience to meet the needs of patients within the high care unit.
- The audit and use of the whole range of the World Health Organisation surgical safety checklists must be improved and evidence provided to show it is being followed at all times. The hospital must ensure there is approval at board level for how the checklist is being used and audited.
- Competency tests around the use of equipment in operating theatres must be improved to demonstrate it is vigorous. Considering there had been a high rate of medicine incidents, competency training must be introduced for medicines' management. There must be an approved protocol for how competency is assessed.
- The main operating theatres must ensure the management of all used surgical instruments is such to be assured the risk of cross-contamination is eliminated.
- The hospital must ensure the medical cover in surgery services, out-of-hours, and specifically at night, is safe and the staff on duty meet the requirements of the out-of-hours policy.
- The number of discrepancies in prescriptions in surgery services must be addressed and errors eliminated.

Summary of findings

- The hospital must ensure patient confidential records are secured and stored in such a way as they cannot be seen or removed by unauthorised people.
- Staff in surgery services must get up-to-date with their mandatory and statutory training and meet trust targets.
- The hospital IT systems must be improved to enable staff to extract and be able to use data about all aspects of theatre and surgery services.
- As with most NHS hospitals, the hospital must improve the access and flow of patients in order to reduce delays from theatre for patients being admitted to wards, enable patients to be admitted when they needed to be, and improve outcomes for patients.
- The governance of the surgery service must improve so there is a clear process for assessing and monitoring the safety, effectiveness and responsiveness of the service. The governance team must be able to demonstrate continuous learning, improvements and changes to practice from reviews of incidents, appropriate use of the risk register, mortality and morbidity reviews, formal clinical audits, complaints, formal feedback to staff, and using reliable data and information.
- As with most NHS hospitals, the hospital must improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards; reduce the unacceptable number of discharges at night; enable patients to be admitted when they needed to be; ensure patients were not discharged too early in their care; and improve outcomes for patients. The full consideration of critical care must be taken into account in hospital escalation plans and staff in the unit closely involved with day-to-day strategic planning.
- The governance of the critical care service must improve so there is a clear process for assessing and monitoring the safety, effectiveness and responsiveness of the service. The governance team must be able to demonstrate continuous learning, improvements and changes to practice from reviews of incidents, appropriate use and review of the risk register, mortality and morbidity reviews (including overarching mortality ratios), formal structured clinical audits, complaints, formal feedback to and from staff, and useful feedback from people who use the service.
- Staff in the critical care service must get up-to-date with their mandatory and statutory training and meet trust targets.

In addition the trust should:

- Ensure it follows the Duty of Candour regulations at all times.
- Take steps to increase staffing levels in physiotherapy, occupational therapy, speech and language therapy and pharmacy so that patients' care and treatment and discharge are not delayed.
- Ensure root cause analysis reports in surgery services identify, acknowledge and act upon all causal factors identified in the investigation of the incident.
- Improve the utilisation and organisation of the operating theatres to make the services more efficient for patients, staff and hospital revenue.
- Ensure that surgical-site infection data is captured internally and provided in governance reports.
- Address the security of operating theatre areas to avoid unauthorised people getting access to areas that otherwise should be secure.
- Ensure that trolleys for resuscitation equipment in surgery areas are secured in such a way to highlight to staff if they had been opened or used between daily checks.
- Ensure there is an appropriate and safe level of equipment in main theatre operating areas, including the recovery room.
- Take steps to improve record keeping. In particular, particular nursing staff on Uphill Ward should ensure that they consistently document when they re-position patients and check cannula sites. Medical staff in medical services should ensure that DNACPR records clearly indicate the timeframe for the decision documented. The medical staff in critical care should review their entry to patients' notes and ensure they provide a comprehensive, contemporaneous record to both records used on the unit and those used for patient discharge to the wards.
- Ensure that patients' notes are filed securely so that they do not become lost or put in the wrong place.

Summary of findings

- Ensure that patients on surgery wards should have all their repositioning in beds or chairs attended to when it is required so that pressure ulcer damage reduced and safely managed.
- Establish a dedicated pain team in accordance with the Royal College of Anaesthetist standards.
- Review staffing levels and the use of bank and agency staff and look for ways to reduce the impact this is having on patients and substantive staff.
- Review ward round arrangements on surgery wards to reduce this to a manageable and safe level.
- Review the operational policy for theatre to ensure that it follows the latest Royal College or other relevant guidance.
- Review hip-fracture surgery for patients to increase the number of procedures meeting the best-practice tariffs.
- Improve the provision of in-house training and development for surgery staff, particularly in theatres.
- Review the risk register in surgery services so it is a true and current reflection of specific risks within the service. The document should be proactive and discussed as a standing agenda item in governance meetings so all staff are aware of the risks within it and their responsibilities for reducing or mitigating them.
- Review local management arrangements on the critical care unit. The unit should be run by all staff in a collective approach, so each can contribute to the management of the service and support one another. There should be a multidisciplinary approach to the running of the unit in the same way as there is to the care and treatment of the patient.
- Ensure the rota for the critical care consultants is sustainable in the longer term and review the cover by junior doctors against the guidance of the Faculty of Intensive Care Medicine Core Standards.
- Review the critical care services risk register so it is a true and current reflection of specific risks within the service. This should include entries to describe where the unit does not meet the Faculty of Intensive Care Medicine Core Standards and the Department of Health building standards for critical care. The document should be proactive and discussed as a standing agenda item in governance meetings so all staff are aware of the risks within it and their responsibilities for reducing or mitigating them.
- Ensure that trolleys for resuscitation equipment in critical care should be secured in such a way to highlight to staff if they had been opened or used between daily checks.
- Review the provision of technical support for equipment cleaning, set-up and maintenance in critical care.
- Review the process for critical care obtaining non-stock items from the pharmacy in order that the patient's prescription drug chart does not need to leave the unit.
- Improve pion of in-house training and development for critical care and ensure the guidelines of the Faculty of Intensive Care Medicine Core Standards around use of a clinical nurse educator are met.
- Review staffing skill mix to ensure there is supernumerary cover by senior staff on duty at all times, including weekends.
- Ensure the protocol used for applying Deprivation of Liberty Safeguards in critical care follows the provisions of the Mental Capacity Act (2005) and any deprivations would be applied with in line with the legal requirements of the Safeguards.
- Review the use of some of the more recent developments in critical care support, such as the patient diary, follow-up clinic, and professional psychological for patients and their relatives.
- Improve the provision for visitors to critical care and look at ways to improve the experience for families and friends.
- Review the ratio of supervisor to midwives to ensure compliance with the recommended ratio of 1:15.
- Ensure are be compliant with the trust's mandatory training targets of 85%.
- Ensure that midwives are compliant with the trust's annual appraisal target of 85%.
- Improve the uptake of the Friends and Family Test in all maternity areas to give more consistent and reliable data.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	There were concerns identified at our unannounced inspection about the timely monitoring, assessment and treatment of patients arriving in the department during periods of high levels of attendance. Patients arriving by ambulance were not protected from the risk of avoidable harm. This was because while they were waiting in the corridor to be admitted to the department (for sometimes longer than an hour) and they were not adequately monitored by emergency department staff although ambulance staff were with them. There was no initial assessment on arrival to determine patients' priority in relation to others waiting and those already in the department. Patients did not receive assessment in line with College of Emergency Medicine guidance. This meant that they did not always receive initial treatment within timescales which increase the potential for a positive outcome. We observed that under normal conditions patients were monitored and assessed within College of Emergency Medicine guidance. We wrote to the trust to inform them of these concerns and required them to inform us of the action which they would be taking to rectify these issues. The response that we received showed that the trust had taken urgent action to deal with the risks identified. Discharge letters were sent automatically to patients GPs. However, a problem with the software in the emergency department meant that the information GPs needed was not automatically included in the letter. Following complaints from GPs the trust was aware of this issue and had put measures in place to resolve the issue. At the time of our inspection, this was still a concern. Staff were aware of how and when to report incidents and we saw evidence that the department learnt from incidents. Infection control processes were good. Staff used personal protective equipment appropriately and the department was visibly clean throughout out inspection. The patients we spoke to also told us that the department was always clean and tidy.

Summary of findings

There were suitable numbers of nursing staff. However, the medical staff rota was not sustainable and medical staff had been difficult to recruit. Junior medical staff were not always well supported.

The department participated in national audits of clinical practice and patient outcomes. However, performance was variable and there was a lack of action following audit to ensure improvements were made over time. We saw little evidence that there were clear action plans in to improve performance, although the new clinical lead for the emergency department had already identified this.

All the feedback from patients, relatives and carers was overwhelmingly positive. Patients spoke highly of the staff and of the care they received. Relatives told us they were kept well informed by staff.

Patients did not always receive timely care and treatment. The emergency department was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival. Patients regularly queued in the corridor because there were insufficient cubicles in the department. This impacted on patient safety, comfort, privacy and dignity.

All expected admissions to the hospital were channeled through the emergency department and this increased the pressure on the department.

The service lacked a clear strategy and vision because of the transaction process.

The workforce was passionate about patient care and committed to the delivery of safe and high quality care and treatment. Staff told us they enjoyed working within emergency department and for the trust. Staff also told us they felt valued and supported by the emergency department and divisional management. Medical leadership in the emergency department had not been consistent. Nursing leadership within the department was seen to be highly effective. However, governance systems and processes required improvement. The issues we identified during our unannounced inspection had not been identified as risks; the risk register did not record all risks and had not been regularly updated. Areas for improvement had not been identified and actions had not been taken.

Summary of findings

Medical care

Inadequate

There were insufficient numbers of suitably qualified and experienced staff employed consistently to ensure that patients were protected from the risk of avoidable harm. Staff shortages across medical, nursing and allied health professional groups posed a risk to patients' safety. An acute shortage of consultant physicians impacted on their accessibility and the level of support they were able to provide to junior medical staff. Junior medical staff experienced high levels of stress and work overload. They were not always well supported in relation to their workload and ongoing training and development. They were frequently asked to perform tasks outside of their level of competence or without adequate supervision.

Risks in relation to medical staffing had not been effectively mitigated. Medical leadership was weak. Junior doctors felt unsupported but there was a lack of insight and empathy for the widespread concerns they expressed and this issue was not identified as a risk on the division's risk register. We were also concerned about a culture in which some junior medical staff felt unable to speak up for fear of recrimination.

Lack of workload capacity impacted on doctors' ability to participate in audit activity and there was limited evidence of learning from audit and incidents. A shortage of therapy staff meant that patients' treatments were sometimes delayed and their length of stay increased, particularly at weekends. A shortage of pharmacy staff caused inefficiency in the discharge process and patients' medicines were not consistently checked to ensure that they were correct during their stay.

Patients did not always receive care and treatment in the right place at the right time. Patients were not always cared for on the most appropriate wards and some patients experienced numerous ward moves, sometimes at night. Patients' discharges were often delayed, sometimes because their treatment was delayed and sometimes due to difficulties in arranging appropriate packages of care in the community. The management team was taking steps to reduce delays and improve patient flow. There was a competent patient flow team

Summary of findings

which worked well with the rest of the hospital and external health and social care partners and maintained an overview of bed availability and patient flow.
We observed nursing, therapy and support staff to be responsive and attentive. Patients appeared comfortable and well cared for, with plenty to eat and drink and they were encouraged and supported in their recovery. However, patients with complex needs did not always receive the level of care they required. Although reducing, the incidence of falls and hospital acquired pressure ulcers remained too high because appropriate care pathways were not consistently followed. The ambulatory emergency care unit and the medical day case unit were not located in appropriate premises so that people's privacy and dignity were protected.
Patient feedback about medical wards and departments was overwhelmingly positive. Patients told us staff were caring, compassionate and supportive and we saw many examples of this during our visits.
We saw excellent multidisciplinary working on medical wards. Staff across all disciplines worked cohesively to provide effective and seamless care for patients. Regular multidisciplinary board rounds were structured and focused on a plan of care and discharge for individual patients.
There was a strong and visible nursing leadership and nursing staff felt well supported. Senior nurses understood, and were focused on quality and on risk. There were detailed action plans in place to mitigate risks to patients, for example by reducing the incidence of falls and pressure ulcers, although further work was required to ensure that improved practice was embedded and sustained.

Surgery

Requires improvement

We have judged the surgery services at Weston General Hospital as requiring improvement overall. Within this service there were, however, some areas judged as inadequate and others judged as good.
Patient safety requires improvement. There were some elements within safety judged inadequate and others were good. Improvement is needed in audit and use of the surgical safety checklist in main theatres; competency tests for theatre staff; the removal of used surgical instruments; medical

Summary of findings

cover out-of-hours; errors in prescriptions; patient record confidentiality; and staff mandatory training. There was a high use of agency and bank staff, and this, the trust determined, had led to a rise in avoidable patient harm. Cleanliness and infection control in most areas was good and patient records were well maintained. Risks of deteriorating patients were responded to appropriately and there was good support for patients from the allied health professionals.

Effectiveness of surgery services requires improvement to demonstrate patient care was delivered in accordance with best practice. The policies used in the main theatres were not using the latest guidance of the royal colleges and some policies, such as infection control, and use of the surgical site checklist did not exist. Audit work needed to demonstrate the effectiveness of care with actions taken and lessons learned improving care. Patient length of stay was affected by delays in being able to discharge patients. Patients were well supported with nutrition, hydration and pain, but there was no specialist acute pain team. Staff had the skills, knowledge and experience to deliver effective care and treatment through training and appraisals and revalidation of their competence, although there was limited professional development of nursing staff. Staff teams worked well to deliver effective patient care. People's consent was being sought in line with legislation and guidance.

The caring by staff was good. Feedback from people, including patients and their families, had been mostly positive. Patients said staff were kind, treated them with dignity and respect, and demonstrated compassion. Patients, their family or friends were involved with decision making. People were able to ask questions and raise anxieties and concerns.

The responsiveness of surgery services was good. There was good provision of the number of operating facilities and emergency surgery scheduling to meet the needs of the local population for both main and day-case operations. The hospital was meeting referral to treatment times in March 2015 for surgery patients, and had been for most of the last six months. The hospital

Summary of findings

met the needs of patients and their families and visitors well in relation to attention to equalities and diversities. A high bed-occupancy contributed to making last-minute changes or emergency admissions hard to manage. Bed pressures meant frequent delays in discharging patients.
The leadership and governance of surgery services requires improvement. The governance framework did not ensure quality performance and risk were well understood. It was unclear how review of audits, incidents, complaints and other key information was used to learn and make changes to practice. The theatre IT system did not provide staff with the tools to look at surgery outcomes and a wide-range of governance data. The operating theatres were not running efficiently and were under-utilised with insufficient planning to avoid last-minute changes or emergency admissions hard to manage. There was mostly a good level of support for staff, but frequent staff changes in main theatres had been difficult for a staff team who worked in a high-pressure environment. There was, however, a strong and committed and experienced group of core staff. Staff were dedicated to their patients and one another and we were impressed with their loyalty and attitude. There were a number of excellent nurses recruited from overseas who had impressed patients and other staff alike.

Critical care

Requires improvement

We have judged the critical care services at Weston General Hospital as requiring improvement overall. Patient safety required improvement overall. We had serious concerns about nurse staffing levels and skill mix to support high dependency patients on the high care unit on Harptree ward. Appropriate nurse to patient ratios were not consistently provided and staff did not have the necessary competencies to care for level 2 critical care patients. We raised our concerns immediately with the trust executive management team. They subsequently confirmed they had taken immediate action to ensure that appropriate nurse to staff ratios were maintained. However, we did not receive assurance that all nursing staff deployed to care for high dependency patients had all the necessary skills.

Summary of findings

On the critical care unit there were good comprehensive patients notes produced by the nursing staff and allied healthcare professionals, although the medical notes required improvement. Infection control was good with low infection rates, despite some poor quality décor showing signs of age and wear. Risks to patients were assessed; their safety was monitored and maintained. There were sufficient nursing staff and trainee doctors who had good support from the consultants, although medical cover was being stretched and reliant upon the goodwill of the existing consultant team. There was a safe level of equipment, and although the unit did not meet some of the modern safety standards, it was being safely managed. Medical staff were not meeting trust targets for undertaking mandatory training updates. There was insufficient evidence of the use of incidents to learn lessons and drive improvements.

Effectiveness of critical care services required improvement to demonstrate patient care was delivered in accordance with best practice. Audit work needed to demonstrate the effectiveness of care with actions taken and lessons learned improving care. Mortality rates on the unit were higher than expected levels, and this had not been examined or reviewed overall. Patient length of stay was affected by delays in being able to discharge patients, although some patients were discharged earlier than optimal. Patients were well supported with nutrition, hydration and pain, but there was no team or clinician available to manage specialist acute pain conditions. Staff had the skills, knowledge and experience to deliver effective care and treatment through training and appraisals and revalidation of their competence, although there was limited professional development of nursing staff. People's consent was being sought in line with legislation and guidance.

The caring by staff was good. Feedback from people we met, including patients and their families, had been overwhelmingly positive. Patients said staff were kind, treated them with dignity and respect, and demonstrated compassion. Patients, their family or friends were involved with decision making. People were able to ask questions and raise anxieties and concerns. There were, however,

Summary of findings

few of the more recent developments in critical care being provided. There was, for example, no use of patient diaries or follow-up clinics. There was little provision of professional emotional support for patients.
The responsiveness of critical care services required improvement. As with many NHS hospitals there were bed pressures in the rest of the hospital. This meant a significant number of patients on the critical care unit were delayed on discharge to other wards and too many were being discharged at night. Critical care and some of the most unwell patients were not being considered sufficiently within bed planning in the hospital, and not being moved to critical care when they met the criteria for admission. Patients on the high care unit on Harptree ward were accommodated in a mixed sex bay with no separate toilet or shower facilities. There were very limited facilities for visitors or patients in the critical care unit. The critical care unit took account of the needs of different people including those in vulnerable circumstances. Complaints and concerns were listened to although it was unclear how they were being used to improve the quality of care.
The leadership and governance of critical care services required improvement. The governance framework did not ensure quality performance and risk were well understood. It was unclear how review of audits, incidents, complaints and other key information was used to learn and make changes to practice.
The clinical leadership did not provide sufficient support to the nursing team with management of the unit. There was, however, a strong and committed and experienced group of core staff. Staff were dedicated to their patients and one another and we were impressed with their philosophy, loyalty and attitude.

Maternity and gynaecology — **Good**

Overall we have judged safety, responsive, effective, caring and well-led to be good for maternity and gynaecology services. Patients' and relatives' feedback was positive regarding all care and

treatment. Patients said they were consulted and involved with their care. We saw discussions of consultations and records of the patient's choices and preferences documented in records.
Midwives followed comprehensive risk assessment processes from the initial booking appointment through to post natal care. There were clear escalation policies which were followed and all care was provided in line with national guidance and policy. The centre worked closely with St Michaels Hospital, Bristol which received the majority women with high risk pregnancies. The Head of Midwifery managed both services but was based at Bristol.
The national recommended ratio of Supervisor of Midwives (SoM) to midwives is 1:15, and this was not being achieved (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). The ratio of SoM to midwives at Weston General Hospital was 1:21. This was due to SoM caseloads being shared between Weston General Hospital and St Michaels Hospital, Bristol. Three additional SoM were being trained.
During January 2015 Ashcombe Birth Centre was closed for three days, and the 10 post natal beds were used by medical patients for a further seven days. This was in response to intense trust wide service pressures. The beds were redeployed to medical patients during this time.
There was good communication between the medical and nursing staff, and maternity support workers. Team working was described as effective and good. The ratio of supervisors to midwives (SoM) did not meet recommended guidelines but plans were in place to address this. There were comprehensive risk, quality and governance structures in place. There was evidence to show incidents were interrogated for service improvements and systems were in place to share information and learning. Midwives said they were positively supported and there was a good and open culture.
Gynaecology was a small consultant led service; the majority of treatments provided were for hysterectomy and diagnostic procedures. There had been one never event for wrong site surgery during June 2014. This had been investigated and

subsequent actions and learning put in place. Audit processes during 2014, had identified the service had not been compliant with regulations to submit termination notifications to the Department of Health. This had resulted from an administration staffing review. New procedures and staff training had been put in place.

Services for children and young people

Good

Services for children and young people were judged to be good overall.
The caring and of the service was rated as outstanding, and safety, effectiveness, responsiveness and leadership were rated as good.
Treatment and care were delivered in accordance with best practice and recognised national guidelines. Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the highest quality of care were encouraged and acknowledged.
Children, young people and their families were respected and valued as individuals. Feedback from those who used the service had been exceptionally positive. Staff went above and beyond their usual duties to ensure children and young people received compassionate care. Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families.
The leadership and culture of the unit drove improvement and the delivery of high-quality individual care.
All staff were committed to children, young people and their families and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the unit as a place to work. They spoke highly of the culture and levels of engagement.
There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.
The unit was clean and well organised and suitable for children and young people. Staff adhered to infection prevention and control policies and protocols.

Summary of findings

End of life care

Good

Overall we rated the end of life service provided by the trust as good.
Following the withdrawal of the Liverpool Care Pathway the trust had developed its own policies and strategies around delivering care consistent with the latest nationally agreed guidance. The team have developed a range of tools to support these objectives. This included individualised end of life care plans which included new documentation such as symptom based observation charts. Better information for patients and relatives had been developed and action taken to get improved feedback from bereaved relatives. There was a hospital Specialist Palliative Care Team (SPCT) that supported staff on the wards by responding to referrals. They also provided some training.
There was an improvement plan and strategy in place for end of life services and leadership was provided on this. Members of the specialist palliative care team were clear about their objectives of their services, where improvements needed to be made and were well respected throughout the hospital. Staff were positive about the responsiveness of the team to referrals and the quality of advice and support that was provided.
We found there was inconsistency in the completion of the documentation relating to end of life patients. In some patient records there was limited recording of personalised care plans and little or no recording of spiritual needs. We found that not all ward staff were fully familiar with requirements of recording a patients end of life wishes. A new format was being implemented across the trust which was being positively received by staff but there were sections of the new documentation that were not being fully completed. There was also inconsistent knowledge amongst staff about the process and use for advanced care planning for patients who had life limiting illnesses but were not expected to die within the next few days. There was insufficient understanding on the wards that “end of life” includes those expected to die in the next twelve months, and so these patients were not being well identified or their needs assessed.
There was a problem for some patients of delayed discharge of, up to six weeks in some cases. Whilst

the hospital staff were efficient in processing and preparing patients for discharge, problems with local provision of care packages caused delays. This meant that some patients died in hospital when their preferred location would have been home. There were occasions when patients receiving end of life care were moved within the hospital and died shortly afterwards. These were the result of the pressures of high bed occupancy and the so called "black" escalation as result of the pressure of admissions through the emergency department. Staff tried to ensure that no patient died alone but we told that there were times when this had happened due to the pressure of work the ward staff were under.

Whilst many staff demonstrated they had excellent understanding of the aims, objectives and principles of end of life care, training for this area was no longer mandatory.

The specialist palliative care team provided input on the junior doctors course and also attempted to provide short "bite size" training for staff on the wards. On several of the ward there were nurse "end of life champions" who provided advice and support but the training they had completed was run three years previously and was not currently planned to be repeated.

There were many examples of excellent professional multi-disciplinary working with staff exchanging information and providing advice and support. The chaplaincy service was well organised and included in the palliative care multi-disciplinary team meetings. However we found that the expertise of the service was not fully utilised within the hospital and there was a lack of clarity for some staff around the role of the service and the defining of a patients spiritual needs.

Outpatients and diagnostic imaging

Good

We rated outpatient and diagnostic imaging services as good in the safety, caring and well led domains. We rated the responsive domain as requiring improvement. We have reported on the effectiveness of outpatients and diagnostic imaging services. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients department.

Summary of findings

Patients found staff to be friendly, professional and caring and were happy with the outpatients and imaging services provided by the hospital. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was learning from incidents and this led to improvements in patient safety.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking and service accreditation.

Information about effectiveness was shared and was understood by staff. It was used to improve care and treatment and people's outcomes. Staff had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.

We observed people being treated with dignity, respect and kindness throughout our inspection. Staff anticipated people's needs and addressed them in a compassionate manner. People's privacy and confidentiality was respected at all times.

Waiting times and delays were kept to a minimum and managed appropriately.

Appointment cancellations were high but the department did not monitor this and as such the reasons for this were not understood.

Most services ran on time and patients were kept informed of any disruption to their appointments.

The leadership of the outpatients and imaging departments promoted safe, high quality, compassionate care. They encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.

Weston General Hospital

Detailed findings

Services we looked at

Urgent & 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 & Diagnostic Imaging

Detailed findings

Contents

Background to Weston General Hospital

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of around 212,000 people in North Somerset and around 47,000 people in North Sedgemoor, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

It has three locations that are registered with the Care Quality Commission. These are Weston General Hospital which has 265 beds, The Barn in Clevedon and Drove House which both provide special children's services.

In 2013/14 the annual turnover (total income) for the trust was £96,732,000, the full cost was £101,415,000 which mean the trust had a deficit of £4,683,000.

At the time of our inspection the trust was subject to a transaction process, in which Taunton and Somerset NHS Foundation Trust was the preferred acquirer. This was at the Trust Development Authority's Gateway 2.

Deprivation in North Somerset is lower than average. North Somerset is ranked 201 out of 326 local authority districts across England in the Indices of Multiple Deprivation. However, pockets of deprivation exist in and around the coastal areas.

According to the last census in 2011 97.3% of the population of North Somerset was white with the Black and Ethnic Minority Group accounts for 2.7% of the population. 51.4% of the population is female and 48.6% is male.

North Somerset performs in line with or better than the England average on a wide range of public health data including children's and young people's health, adult health and lifestyle and disease and poor health. It performs worse than the England average in just one indicator, drug misuse

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a moderate risk trust according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The trust is not a Foundation trust and is due to be acquired by Taunton and Somerset NHS Foundation Trust later in 2015.

The inspection team inspected the following eight core services at Weston General Hospital

- Urgent and emergency services
- Medical Care (including older people's care)
- Surgery
- Critical care

Detailed findings

- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

and

- Community health and mental health services for children, young people and their families provided through The Barn and Drove Road.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Retired Divisional Director, University Hospitals Bristol NHS Foundation Trust

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

The team included 12 CQC inspectors and a variety of specialists including: A chief operating officer, two medical directors, a consultant cardiologist, consultant vascular surgeon, consultant physician, consultant obstetrician/gynaecologist, an anaesthetic and critical care consultant, a paediatric palliative care consultant, a junior doctor, a head of nursing for immunology, a head of outpatients, a theatre nurse specialist, an emergency care lead, a head of midwifery/supervisor of midwives, a critical care nurse, a paediatric psychiatrist, a CAMHS nurse specialist, a specialist advisor in end of life care and two experts by experience.

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included the local clinical commissioning group, the Trust Development Authority, the local council, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges.

We held a listening event just outside Weston Super Mare on the 5 January 2015. People who were unable to attend the event shared their experiences by email, telephone and our website.

We carried out an announced inspection on 19-22 May 2015 and two unannounced inspections on Saturday 30 May and Friday 5 June 2015. We held focus groups and drop in sessions with a range of staff in the hospital including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

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

Facts and data about Weston General Hospital

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of around 212,000 people in North Somerset.

In 2013/2014 the trust had 18,347 inpatient admissions, including day cases, 145,344 outpatients attendances (both new and follow up) and 57,790 attendances at accident and emergency department,

At the end of 2013/14 the trust had a financial deficit of £4,683,000.

Bed occupancy was over 90% for the majority of 2013/14 reaching a high of 99.2% in the second quarter of the year. It was above England average (85.9%) all year and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

The trust had a relatively stable executive team at the time of our inspection, the majority having been in post

Detailed findings

for at least 2 years. However, the chief executive was scheduled to leave the trust at the end of June 2015 prior to the completion of the transaction process. Recruitment for a chief executive to see the trust through this transitional period was in place at the time of our inspection. There were four non-executive directors in place at the time, one of whom had been appointed as the chair the week prior to our inspection. They had been with the trust for some time.

CQC inspection history

Weston Area Health NHS Trust has had a total of 13 inspections since registration. Eleven of these have been at Weston General Hospital. There were significant concerns found at the inspection in April 2013 when we found patient's privacy and dignity were not always respected and the welfare and safety of patients was not always ensured. As a result we took enforcement action protect the health,

Safety and welfare of people using this service. Since then we have undertaken a further two inspections at Weston General Hospital and all standards inspected were found to be met.

Inspections have also been undertaken at Drove House and The Barn in September 2011 and October 2011 respectively at which all standards inspected were found to be met.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Surgery	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The Emergency Department (ED), otherwise known as the Accident and Emergency Department (A&E) was based at the Weston General Hospital. It served as the main emergency department for a local resident population of over 203,000 people as well as the 3.3 million day trippers and 375,000 staying visitors that visited the area each year. The emergency department provided care to approximately 57,790 (10,400 of which are children and young people under the age of 16) patients each year.

The emergency department was not a designated trauma unit and therefore severely injured trauma patients were usually taken by ambulance to a trauma unit or trauma centre in Bristol or Taunton depending on the location of the incident.

Patients received care and treatment within the emergency department in three main areas, the main waiting area with triage rooms, minors and majors. Self-presenting patients with minor illness or injury were assessed and treated in the minors' area. Direct admissions from GP surgeries were seen in the minors' or 'majors' area. There were four cubicles, a waiting area and a dedicated children's cubicle within minors. The majors' area was accessed by a dedicated ambulance entrance and the resuscitation room was located within the majors' area.

The department does not provide a service to children who require emergency admission overnight. These children are automatically diverted to the specialist children's hospital in Bristol or the children's unit at Musgrove Park Hospital in Taunton.

We visited the department over two and a half weekdays, and undertook a further unannounced visit on a Friday evening. We spoke with 32 staff including nurses, doctors, managers, support staff, therapists and ambulance staff. We also spoke with 28 patients (seven of them children) and 12 relatives of patients being seen within the emergency department. We observed care and treatment and looked at care records. Prior to and following our inspection, we reviewed performance information about the emergency department and information provided to us by the trust.

Urgent and emergency services

Summary of findings

There were concerns identified at our unannounced inspection about the timely monitoring, assessment and treatment of patients arriving in the department during periods of high levels of attendance. Patients arriving by ambulance were not protected from the risk of avoidable harm. This was because while they were waiting in the corridor to be admitted to the department (for sometimes longer than an hour) and they were not adequately monitored by emergency department staff although ambulance staff were with them. There was no initial assessment on arrival to determine patients' priority in relation to others waiting and those already in the department. Patients did not receive assessment in line with College of Emergency Medicine guidance. This meant that they did not always receive initial treatment within timescales which increase the potential for a positive outcome. We observed that under normal conditions patients were monitored and assessed within College of Emergency Medicine guidance.

We wrote to the trust to inform them of these concerns and required them to inform us of the action which they would be taking to rectify these issues. The response that we received showed that the trust had taken urgent action to deal with the risks identified.

Discharge letters were sent automatically to patients GPs. However, a problem with the software in the emergency department meant that the information GPs needed was not automatically included in the letter. Following complaints from GPs the trust was aware of this issue and had put measures in place to resolve the issue. At the time of our inspection, this was still a concern.

Staff were aware of how and when to report incidents and we saw evidence that the department learnt from incidents. Infection control processes were good. Staff used personal protective equipment appropriately and the department was visibly clean throughout out inspection. The patients we spoke to also told us that the department was always clean and tidy.

There were suitable numbers of nursing staff. However, the medical staff rota was not sustainable and medical staff had been difficult to recruit. Junior medical staff were not always well supported.

The department participated in national audits of clinical practice and patient outcomes. However, performance was variable and there was a lack of action following audit to ensure improvements were made over time. We saw little evidence that there were clear action plans in to improve performance, although the new clinical lead for the emergency department had already identified this.

All the feedback from patients, relatives and carers was overwhelmingly positive. Patients spoke highly of the staff and of the care they received. Relatives told us they were kept well informed by staff.

Patients did not always receive timely care and treatment. The emergency department was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival. Patients regularly queued in the corridor because there were insufficient cubicles in the department. This impacted on patient safety, comfort, privacy and dignity.

All expected admissions to the hospital were channeled through the emergency department and this increased the pressure on the department.

The service lacked a clear strategy and vision because of the transaction process.

The workforce was passionate about patient care and committed to the delivery of safe and high quality care and treatment. Staff told us they enjoyed working within emergency department and for the trust. Staff also told us they felt valued and supported by the emergency department and divisional management. Nursing leadership within the department was seen to be highly effective. However, governance systems and processes required improvement. The issues we identified during our unannounced inspection had not been identified as risks; the risk register did not record all risks and had not been regularly updated. Areas for improvement had not been identified and actions had not been taken.

Urgent and emergency services

Medical leadership had not been consistent although a new clinical lead had been appointed prior to our inspection.

Are urgent and emergency services safe?

Inadequate

Staff were aware of how and when to report incidents and we saw evidence that the department learnt from incidents. However, feedback from incidents was not always provided to staff. Infection control processes were good. Staff used personal protective equipment appropriately and the department was visibly clean throughout out inspection.

During the day we saw that patients received timely assessment and treatment. However, during our unannounced inspection in times of surge we saw that patients with potentially serious conditions were left in the corridor with ambulance crews without assessment from emergency department staff. We told the trust about the concerns we had and they took swift action to improve patient safety following our inspection.

Although medication was stored securely, staff were not aware of standard operating procedures for the safer management of controlled drugs and records of controlled drugs not administered and destroyed were not always maintained.

We were informed that the emergency department was appropriately staffed with nurses. However, medical staff had been difficult to recruit and rotas were not sustainable. This was partly because of the ongoing transaction process.

Incidents

- Staff were encouraged to report incidents. Staff reported incidents via an electronic database. The matron for emergency department was notified of each incident and allocated them to staff for investigation. The majority of incidents reported in the department related to patients presenting with community acquired pressure sores. We saw records which showed the immediate action taken in response to all incidents reported. However, of the incidents occurring within the department the “actions taken to prevent reoccurrence” and “lessons learned” were not always identified.
- There were 42 serious incidents in the emergency and urgent care directorate between April 2014 and February 2015. Of the five serious incidents requiring investigation

(SIRI) reported to the trust board in January 2015, two were in the emergency department. One was a report of a patient remaining in the department for over 12 hours and the second was an inappropriate discharge from the department.

- We were informed that incidents are discussed at the departmental and governance meetings, including lessons learnt. We saw evidence from the meeting minutes that this was the case. We saw that incidents were discussed in the daily quality and leadership meeting in the department.
- Staff told us they felt feedback from incidents needed to improve. To support better feedback, staff now recorded when feedback was given. This prompt on the database acted as a reminder for staff that feedback should be given. New sessions had been held for incident feedback and a file had been placed in the staff room with information on lessons learnt etc. as a means of sharing learning amongst the staff
- The trust held learning events in order to ensure learning was shared across all specialities. The matron told us she had participated in these, presenting cases studies from the emergency department.

Cleanliness, infection control and hygiene

- During our inspection the emergency department was visibly clean and tidy. Cleaning was in progress at all times throughout out visit. We spoke to some of the domestic staff who showed us the cleaning schedules they followed. They also explained cleaning was checked daily by their manager to ensure cleaning was up to standards. The cleaning schedules included daily running water audits to prevent the risk of legionella forming. Environmental audits in the emergency department for February, March and April 2015, showed that the department had attained over 90% compliance over these months although there areas which were dusty and required additional focus.
- We observed staff adhering to the trust infection prevention and control policy which required them to be 'bare below the elbow'. Staff were also observed washing their hands frequently. The department had achieved 100% in the hand hygiene audit for March 2015. Antibacterial hand gel was available and signs were in place reminding staff and visitors to use them.
- Protective clothing and equipment, such as gloves and aprons, were available and staff were observed using them appropriately. However, during our unannounced inspection we observed one member of staff carrying dirty linen to the dirty utility room without the use of gloves or an apron. From our observations and what staff and patients have told us, this appeared to be an isolated incident
- The department had two cubicles available to use in the event of a patient attending the department requiring isolation. The design of these rooms was such that staff had a room to one side to allow them to safely de-robe before leaving.
- In the CQC A&E survey 2014, when patients were asked if the emergency department was clean, the trust scored 8.7 out of 10.

Environment and equipment

- The resuscitation room was an extension of the major treatment area and the cubicles were the same size. This meant that there was insufficient space for the additional staff and equipment needed for resuscitation procedures. As a result, a large amount of resuscitation equipment was stored in two storerooms in a corridor outside the resuscitation room. Staff told us they needed quick access to the contents and for that reason they were not kept locked. We were told that the corridor could only be accessed by emergency department staff and ambulance crews. However, during our unannounced inspection we met a member of the public walking down the corridor, looking for reception. This meant equipment contained within the rooms could be tampered with. In addition, equipment in the storerooms could cause harm to people if not used correctly. There were poor lines of sight in the waiting area, which meant that waiting patients were not adequately observed at all times. The area was covered by CCTV cameras which were viewable from the reception desk, however at times the reception desk was unmanned, all be it for very short periods of one to two minutes. At night reception was covered by a lone receptionist.
- There was a separate waiting area for children. The area could be seen from the main waiting area because the door always remained open. The children's waiting area had CCTV camera coverage but limited line of sight from

the reception area. In addition there was no means of parents summoning attention within the children's waiting area. This meant parents would need to leave the child to summon help in an emergency.

- Security arrangements were adequate. In CQC's 2014 A&E survey, the department scored 9.6 out of 10 when patients were asked if they felt threatened within the department.
- The minors area of the department had a separate cubicle for children. It had been designed as child friendly, with a range of information for parents and contained equipment was suitable for children and young people.
- We checked a range of equipment, including resuscitation equipment. Resuscitation trollies were all in order and appropriately stocked. Regular checks were documented; however we noted that trollies were not sealed following these checks to ensure that they were tamper evident. We checked four defibrillators. These had been checked and tested every day.
- There were appropriate arrangements for the segregation, storage and disposal of waste and we saw emergency department staff complied with guidance in this respect.

Medicines

- Medicines were stored securely in cupboards and rooms that only staff had access to. However, we noted a lack of statutory warning signs in place where oxygen cylinders were stored. This was raised with staff and the sign was immediately found and put in place. In addition, we also observed eight small oxygen cylinders that were not secured. This could cause injury to staff accessing them.
- Controlled drugs were stored appropriately and suitable records were kept. However, at times, morphine was prescribed as a variable dose. Records did not should how much was administered or what happened to any unused drug. Staff we spoke with were not aware of any standard operating procedures regarding this in line with the Safer Management of Controlled Drugs legislation.
- Some medicines needed to be stored in fridges. Fridge temperatures were recorded but records we reviewed showed the maximum temperature was often too high. Recorded temperatures between 4 and 15 May 2015 showed a maximum temperature of 15.5 degrees Celsius.
- We noted a number of incidents had been reported since October 2014 where patients' medication had been missed or not given in the department. We reviewed the medication charts belonging to four patients who had waited in the department for longer than four hours. Patients' normal medications had been prescribed and given at the correct times.
- Some take home medicines were dispensed from the department when required. A copy of the prescription was kept to ensure stocks were replenished as necessary. Prescription pads were also used to allow patients to collect medicines from other pharmacies. We found these to be stored securely.
- In CQC's 2014 A&E survey the department scored 9.7 out of 10 when patients were asked if the purpose of new medicines was explained before they left the department.

Records

- The emergency department used paper records. Staff told us there had been incidents of records being lost, although these were described as isolated incidents.
- We looked at 20 records and found them to be well completed, clear and legible. Entries were signed and dated appropriately and in accordance with each professional body's guidance.
- Staff told us that existing patient records were easily accessed at all times.
- GPs were sent electronic discharge letters following a visit to the department. For patients who were not resident in the local area, letters were printed off and posted to their permanent GP. However GPs had complained of receiving blank discharge letters. This had been investigated and actions put in place to ensure information was correctly gathered and sent out. The directorate management team however, seemed to be unaware of the extent of the problem.
- We reviewed the discharge summaries for nine patients. None contained details of the presenting complaint or comments from the emergency department clinician. Only one contained a diagnosis, procedures undertaken

in the department and medicines given. This meant GPs were not always adequately informed of the diagnosis and treatment of patients who attended the department.

Safeguarding

- There were processes in place for the identification and management of adults and children at risk of abuse (including domestic violence). Staff understood their responsibilities and were aware of safeguarding policies and procedures. The contact details for all relevant children and adult safeguarding organisations were on display within the department along with safeguarding flow charts which were located at all the nurse's stations and the reception areas. For staff to follow. There was a safeguarding lead nurse in the emergency department.
- Locum medical staff received reminder sheets on induction into the department. These included the relevant contact numbers for safeguarding leads as well as points to consider when caring for children.
- We observed staff also considered safeguarding issues for children when adults (with children) presented to the department with drug or alcohol overdose and in cases of domestic violence.
- A safeguarding reference file was available for all staff. This was a comprehensive file containing relevant policies and protocols as well as information relating to different injuries seen in abuse and specific information on trafficking and child sexual exploitation.
- A protocol was in place for any child or young person under 16 years of age who did not wait to be seen.
- There was a process in place to ensure health visitors, school nurses and GPs were informed of all children and young people seen within the emergency department. And care records were reviewed to see if children had protection plans in place.
- We reviewed care records for several children who had been admitted with various injuries during the previous few weeks before our inspection. Records were comprehensive and demonstrated awareness by staff of safeguarding issues. Explanations of the injury had been sought including listening to what the child had said. Where necessary appropriate referrals had been made.
- Safeguarding training was up to date for all medical staff and 97% of nursing staff had achieved level 3 training in safeguarding children. Plans were in place for those members of staff still needing to update their safeguarding training.

Mandatory training

- We looked at the trust-wide training records which showed that ED staff were not fully compliant with their mandatory training. Performance reported in the trust performance assurance framework in February 2015 was reported as 82.5% which was rated as a red by the trust. Compliance for individual staff ranged from 87% and 8% according to the data of 21 May 2015. We raised this with the matron who told us that the figures were inaccurate. The matron was in the process of setting up her own system of monitoring because the trust wide system was not a true reflection of the training required or undertaken. Whilst the development of the departmental system was in progress there was not a complete picture of the mandatory training staff required or had attended.
- Staff told us that training could be accessed online and in person. This included training for reception staff in the department who had completed training in safeguarding adults and children and also in dementia awareness.

Assessing and responding to patient risk

- The trust used a recognised triage system (known as the Manchester triage system) for the initial assessment of walk in patients. However, the trust was not meeting the standard set by the College of Emergency Medicine who issued guidance (Triage Position Statement dated April 2011) which stated a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. This should be a face-to-face encounter which should occur within 15 minutes of arrival or registration and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- Although guidelines were used, we saw that there was no formal standard operating procedure in place for triage of patients within the emergency department. An undated one page document was in place but this was not clearly referenced.
- We looked at the triage times for all patients (those arriving by ambulance and as self-presenting patients)

who arrived from midnight until midday on the day before our inspection started. Many patients did not have triage times recorded but, of those that did, only 59% were triaged within 15 minutes.

- Risk assessments were carried out for patients. Care records of patients who attended majors showed patients received an infection control risk assessment, pressure ulcer risk assessment and an emergency checklist completed.
- Patients arriving by ambulance as a priority were taken immediately to the resuscitation area. Ambulance crews phoned through in advance in order that appropriate teams could be alerted and prepared for the arrival of the patient.
- Staff described the process for the management of other patients arriving by ambulance. This involved a rapid assessment by the nurses in charge of the major treatment area. This assessment was required in order to determine the seriousness of the patients' condition and to make plans for their on-going care. We observed the process in action. Patients arriving by ambulance were seen waiting in the corridor while one member of the ambulance crew sought out the nurse in charge. A brief verbal handover took place however the nurse in charge did not see the patient or assess them in any way. The ambulance crew then took the patient to a cubicle and were then required to seek out the nurse responsible for the cubicle. We observed this to be a consistent process, irrespective of the potential seriousness of the patient's reported symptoms.
- On occasions, the ambulance crew could not find the nurse responsible for the treatment cubicle. On these occasions, the patient was left in the cubicle without a nurse in attendance. If a nurse was available a second handover took place but we saw that this often took place 20 or 25 minutes after the patient had arrived. This meant there was a delay in initial assessment of the patient's condition.
- Overcrowding in the emergency department was a serious and ongoing risk. There was a trust-wide escalation policy which set out a range of triggers which would enable the trust to mitigate risks associated with capacity and overcrowding. Within this policy the emergency department had a separate internal escalation plan and a series of triggers which were linked to its ability to achieve key performance measures: Ambulance patients waiting in the corridor was not a trigger event and was not recognised as a risk. There was no hospital wide action to address this issue. However, trigger events that did exist indicated a red alert status existed by 8pm. There did not seem to be an awareness of this in the A&E department. We looked at the action cards for the hospital site manager for the management of a red alert status and noted most actions described could not be taken out of hours.
- During our unannounced inspection the department reached full capacity at 8:15pm. We observed patients with potentially serious conditions such as kidney failure, heart failure and sepsis, waiting in the corridor for over an hour. They were not assessed by A&E staff and could not be observed by them. Although ambulance crews stayed with these patients they did not have the equipment needed to clinically monitor these patients. This meant that patients' treatment was delayed and that their condition was at significant risk of deteriorating.
- We looked at the hospital escalation plan. Ambulance patients waiting in a corridor was not a trigger event and was not recognised as a risk. There was no hospital-wide action to address this issue.
- However, the trigger events that did exist indicated that a red alert existed by 8pm. There did not seem to be an awareness of this in the A&E department. We looked at the action cards for the hospital site manager and found that most of the actions described could not be taken out-of-hours.
- We were told that when the department was busy additional staff were identified and placed with patients in the corridor, however during the unannounced inspection this was not the case.
- Staff completed risk assessments for patients admitted following deliberate self-harm. This assessment included considerations under the mental health act, whether a nurse has been allocated to provide one to one care and an assessment of the area around the patient to make it as safe as possible. The risk assessment was included in the nurse to nurse handover.
- Receptionists told us they used their judgement and experience to recognise a seriously unwell/injured

patient who needed immediate clinical attention. There was no written guidance about 'red flag' conditions although they were able to name some of these, such as chest pain and profuse bleeding. They told us they summoned help either in person or by phone.

- The department used the same Paediatric Early Warning Score chart used by the local NHS children's hospital where ongoing care for children occurred. These were suitable for different ages of children and young people (under 1 year, 1-5 years, 6-11 years and 12 years plus). Modified paediatric coma scores were also used for children admitted with head injuries. This meant staff were able to monitor and identify children at risk of deteriorating.
- Three of the nursing staff were specially trained in children's nursing. This meant there were not enough staff to make sure one children's trained nurse was on duty on every shift. Additional training on caring for children had been provided to the other nursing staff within the emergency department. This training included how to recognise a deteriorating child, resuscitation, pain management and safeguarding. Close links were maintained with Bristol Children's Hospital. This made sure that specialist advice was always available. A dedicated resuscitation bay was available within the main resuscitation area of the emergency department. All band five nursing staff had been trained in paediatric immediate life support (PILS) and all band six nursing staff, consultants and middle grade doctors had received training in advanced paediatric life support.

Nursing staffing

- Nurse staffing was sufficient to meet the needs of the department. In the workforce review presented at the board in March 2015, the department was not highlighted as a risk with respect to nurse staffing levels. However, the nursing dashboard in March 2015 showed that the number of nursing staff whole time equivalent roles were down by 5.06 from the planned establishment for trained staff across the emergency department. . At the time of our inspection this had reduced to a vacancy rate of 1.8 whole time equivalent (WTE) within the emergency department.
- There were five registered nurses on duty from 8pm to 8.30am every night. An additional registered nurse was also available from 8pm to 2am. On the day shift eight registered nurses and two unregistered nurses were on duty. At night this reduced to five or six registered nurses and one unregistered nurse. We looked at the off-duty for March and April and these confirmed the staffing numbers were being met within the emergency department.
- Nurse practitioners worked 12 hour shift patterns and numbers, depending on the needs of the department. For the less busy days (Tuesday, Wednesday and Thursday) a nurse practitioner worked from 9am to 9pm whilst another worked from 11am to 11pm. On the busier days (Friday, Saturday, Sunday and Monday) one nurse practitioner worked from 9am to 9pm and two practitioners worked from 11am to 11pm.
- Staff told us, additional nurses were obtained when the department needed them. Where agency staff were used, an induction checklist was completed before the start of their first shift. This checklist covered orientation to the department, local procedures for emergencies, any specialist training on medical devices and handover procedures. This was signed by the agency nurse and the nurse manager.
- Sickness levels within the emergency and urgent care directorate were reported at around 4% for the whole of 2014-15 year.
- Staff turnover within the emergency and urgent care directorate was reported at 19.9% in February 2015. This had gradually increased from a rate of 14.3% in April 2014.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) states there should always be registered children's nurses in the emergency department or departments should be working towards this. There were registered children's nurses working within the department but not enough to make sure one was on each shift. All staff within the emergency department had received training from the paediatric lead for the emergency department on how to care for children and how to recognise sick children. Staff had also completed paediatric life support training. Arrangements were also in place that paediatric trained

staff could be called in should the need arise or a sick child was expected. There was a nursing lead and medical lead for the care of children within the emergency department.

Medical staffing

- Medical staffing within the department was a concern. The workforce and recruitment update presented at the trust board in March 2015 stated that of the six consultant posts, three were filled by permanent locums. There were four middle grade doctor vacancies three of which had been appointed to but had not started.
- The trust was unable to fill all consultant posts within the department. There were a total of six whole time equivalent (WTE) consultants in post, however, three of these were locum doctors on one or two year contracts with the trust
- The department had three WTE vacancies in the middle grade cover against an establishment of eight WTE. The trust and undertaken a recruitment campaign which had proved successful with two new doctors expected to start in July / August.
- There was a minimum of a middle grade doctor (a trust doctor equivalent to ST4 specialist registrar year 3) or above in the department 24 hours a day, seven days a week. However staff told us this was challenging due a shortage of consultants and middle grade doctors to add into the rotas.
- The consultant rota was planned three months ahead to allow for study and annual leave. For middle grade doctors an eight week rota was produced. This forward planning allowed gaps in the rota to be identified and filled by locum staff.
- Where locum staff were used, an induction checklist was completed before the start of their first shift. This checklist covered orientation to the department, local procedures for emergencies, any specialist training on medical devices and handover procedures. This was signed by the locum doctor and the nurse manager.
- Out of hours cover within the department (8pm to 8am) was provided by a middle grade doctor and a junior doctor. Consultants were required to be on call from home from 11pm. During the week there was an additional middle grade doctor from 5pm to 1am (at weekends, this cover was provided midday to midnight)
- Consultants worked variable shift patterns to ensure the department was covered appropriately. The 2014 General Medical Council trainee survey showed that there had been significant medical workload and staffing pressures in the emergency department. The trust had responded to this by implementing a comprehensive plan to resolve the concerns, including the appointment of new staff (one consultant and four middle grade staff). Additional measures were put in place by the appointment of a new clinical lead for the emergency department.
- Sickness levels within the emergency and urgent care directorate were reported at around 4% for the whole of 2014-15 year.
- Staff turnover within the emergency and urgent care directorate was reported at 19.9% in February 2015. This had gradually increased from a rate of 14.3% in April 2014.

Major incident awareness and training

- There was a major incident plan which had been reviewed and was up-to-date.
- Two of the emergency nurse practitioners were designated trainers for chemical incidents and infectious diseases such as Ebola. 100% of nursing staff had received training to deal these types of major incidents and a chemical exercise had been successfully completed in April 2015.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Although there were policies and procedures in the department which reflected national guidance, performance in national audits and patient outcomes were variable. There was little evidence that outcomes from audits were reviewed to identify areas for improvement and action plans had not been developed.

The levels of medical staffing in the department had an impact on the ability to ensure that patients always received treatment from competent staff, seven day working and on the multidisciplinary team.

Staff were found to have a clear understanding of consent, the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. Staff were seen to be gaining consent in an appropriate manner.

Evidence-based care and treatment

- Clinical guidelines were available to all staff via the trust's intranet system. Each of the guidelines complied with the National Institute of Health and Clinical Excellent (NICE) and the College of Emergency Medicine's Clinical Standards for Emergency Departments.
- There was particular concern regarding the treatment of sepsis. This is a life threatening condition that can result from a serious infection. An initial audit had taken place in 2013 and the results were not as good as other emergency departments. We were told that extra training had been given to staff since then. Despite this additional attention, during our unannounced inspection, we observed four patients displaying signs of sepsis being treated in a way that did not comply with national guidance. For instance, clinical assessment did not take place immediately, they did not receive high flow oxygen and intravenous antibiotics were not given within one hour. Few staff displayed any sense of urgency in treating these patients.

Pain relief

- Although the department scored well in audits regarding pain relief, not all patients reported that they received pain relief in a timely manner.
- The emergency department performed well in the College of Emergency Medicine (CEM) 2013-14 audit for renal colic. It showed that the trust performed similar to other trusts in the UK, but scored well in several areas such as patients receiving pain killers within 20 minutes of arrival to the department. The trust scored poorly for testing a patient's urine as part of appropriate investigations on admission.
- The CEM 2013-14 audit for fractured neck of femur showed the trust performed similar to other trusts in the UK and scored well for re-evaluating the patient's pain within an hour and ensuring patients received x-rays within an hour.
- In the CQC A&E survey, 2014, the department scored 7.2 out of 10 when patients were asked if staff did everything they could to control their pain.
- The CEM 2013-14 audit for fractured neck of femur showed the trust performed similar to other trusts in the UK and scored well for re-evaluating the patient's pain.
- Several patients that we spoke to during our inspection told us that they did have to wait longer than they would have expected for pain relief. However, for one patient, this waiting extended to two hours before they were given pain killers.

Nutrition and hydration

- We noted in patients' records that staff rarely recorded that food and drink had been offered to patients who had been in the department for more than two hours. For those with longer stays, we observed excellent communication between staff and patient's with regards to nutrition and hydration. Staff regularly appeared to offer patients drinks where appropriate.
- In the CQC A&E survey, 2014, the department scored 6.9 out of 10 when patients were asked if they were able to get suitable food or drinks when they were in the A&E department.
- Staff told us that whilst there were no set mealtimes in the A&E department, they were able to serve patients breakfast. In additional they were able to obtain snack boxes and hot meals when necessary. We saw this in evidence during our inspection.
- Where a patient's fluid intake needed to be recorded, we saw evidence that this was documented appropriately by staff on fluid monitoring charts.

Patient outcomes

- The trust participated in national College of Emergency Medicine (CEM) audits so they could benchmark their practice and performance against best practice and against other trusts.
- There was poor performance reported in the CEM 2013-14 audit of consultant sign off where only 11% of patients within three specific groups (Adults with non-traumatic chest pain, febrile children less than one year old, patients making an unscheduled returned to ED with the same condition within 72 hours of discharge) were signed off by a consultant compared to the CEM standard of 100%. We saw that this had reduced from the 2011 audit. Of the patients in these three groups 50% were seen by a registrar for sign off.

Urgent and emergency services

- In the CEM 2013-14 audit of vital signs in majors, the trust scored well in most areas such as recording vital signs (pulse, blood pressure, respiratory rate, temperature) achieving 96% plus. However, they only scored 52% for recording the Glasgow Coma Scale. (The Glasgow Coma Scale provides a practical method for assessment of impairment of conscious level in response to defined stimuli.)
- The CEM 2013-14 audit for severe sepsis and septic shock showed that although improvements had been seen in the numbers of patients receiving oxygen therapy in the department and that patients received antibiotics within the department, the speed of administering antibiotics was poor and had reduced since the 2011audit. Fewer than 10% of patients received antibiotics within the department within one hour of admission. This is known as the "golden hour" because the delivery of antibiotics within this time, increases the chance of a positive outcome.
- The CEM 2013-14 audit for renal colic showed that the trust performed similar to other trusts in the UK, but scored well in several areas such as patients receiving pain killers within 20 minutes of arrival to the department but scored poorly for testing a patient's urine as part of appropriate investigations on admission.
- The CEM 2013-14 audit for fractured neck of femur showed the trust performed similar to other trusts in the UK and scored well for re-evaluating the patient's pain within an hour and ensuring patients received x-rays within an hour.
- An audit of knowledge had been completed relating to the management of anaphylaxis in 2015 and prior to our inspection. This showed that 100% of emergency department consultants, middle and junior grade doctors were up to date with their advanced life support and all recognised the correct medicines, dosage and route required in anaphylaxis. Staff within the emergency department had excellent knowledge of the correct treatment of anaphylaxis although more training was required for staff in other areas within the trust.
- Although the trust had undertaken these audits there was no evidence to show that these had been used to improve performance within the department. There was no documentary evidence of review of this performance within the trust to identify areas of improvement and no plans of action following the audits. The new clinical lead for the emergency department told us they were aware of this issue and that a priority for them was to develop plans for improvement. None were available at the time of our inspection.

Competent staff

- We saw evidence that new staff underwent a two week induction period during which time they were supernumerary. Competencies were checked and the supernumerary period could be extended as necessary. The staff we spoke with all confirmed they had received a trust-wide induction and a departmental induction, both of which were appropriate and prepared them for their role.
- Appraisal rates for the emergency and urgent care directorate in February 2015 were 85.6% and in the emergency department were 77% for medical staff and 92% for nursing staff. This was worse than the trust target of 90%.
- There were concerns about the level of consultant staffing on the ability to provide a consultant-led service during the day and in the evenings over a seven day period. There were also issues with low numbers of middle grade medical staff. The College of Emergency Medicine visit to the trust in September 2014 found that there was no evidence of any education, training or longer term development opportunities for middle grade doctors at the hospital. This meant there was a risk of junior doctors having to undertake procedures which they did not feel confident or competent to undertake due to the reduced numbers of senior medical staff in the department.
- Although there was a high regard to the professionalism of nursing staff within the department, nurse practitioners were seen to work largely without medical supervision and development opportunities for nursing staff were limited. The College of Emergency Medicine found that although nurses were welcome to attend SHO (senior house officer – a level of junior doctor) training, the levels of activity in the department meant that nurses were rarely able to attend.

- The level of appraisals undertaken within the emergency and urgent care directorate was 85.7% in February 2015 which was slightly above the trust compliance level of 85%. This had decreased since April 2014.

Multidisciplinary working

- Multidisciplinary working required improvement. The findings of the College of Emergency Medicine review of the department in September 2014 showed that better collaboration between medical, nursing and nurse practitioner teams could create a more synergistic environment. The review also showed improvements could be made to the flow of patients through the department, communication between staff, the medical rotas and the medical leadership within the emergency department. An action plan had been produced by the department following the review. During our inspection we observed that progress had been made to achieving completion of the action plan. For example, a new clinical lead was appointment to oversee the department.
- There was evidence that there were some good working links with some other teams within the hospital, notably the paediatric teams. However, improvements were required in the communication and working with anaesthetic colleagues regarding paediatric resuscitation events in the emergency department and also with medical teams to facilitate admissions of patients to the hospital.
- The department had good links with other agencies such as the Substance Advice Service and North Somerset Youth Offending team. These were especially evident for adolescents and young people with overdose, self-harm and substance abuse issues.
- There was an admission prevention team run by North Somerset Community Partnership Trust. A member of this team were based on site within the hospital and acted as a liaison to help manage timely discharges and prevent inappropriate hospital admissions.
- The British Red Cross had been commissioned to provide assisted discharge services by North Somerset CCG. Clinical staff could refer patients from the emergency department who were medically fit for discharge and who fell under the British Red Cross criteria. They then arranged to transport patients home and offered a period of resettlement in which practical support was offered such as shopping, making a light meal and making drinks.

Seven-day services

- Although there was seven-day working in the department, there was fragility in the sustainability of a high quality service. There was not consultant presence within the department on a 24 hour a day seven day a week basis, although consultants were available to attend on an on call basis.
- Radiology services were available seven days a week.
- Mental health liaison was available seven days a week. However, specialist support for patients presenting with drug or alcohol misuse was not available at weekends. As a result of this, we saw incident reports which identified patients sometimes waited for extended periods of time in the department for a mental health assessment and subsequent admission to an appropriate location.

Access to information

- There was a bespoke IT system which was real time and allowed tracking of patients through the department. The system also allowed for statistical analysis and reporting of activity. However, we found this to be inaccurate and recently identified software malfunctions had only just brought this to light.
- A discharge summary was sent to general practitioners when the patients were discharged from the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent. We heard doctors and nurses explaining things to patients simply, checking their understanding and asking permission to undertake examinations or perform tests.
- Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff that we spoke with were clear about their responsibilities in relation to obtaining consent from people, including those who lacked capacity to provide informed consent to treatment.

Urgent and emergency services

Are urgent and emergency services caring?

Good

Services delivered in a caring and compassionate way, with patients and those close to them involved in their care and treatment. Privacy and dignity was in most cases maintained, although this was not always the case when patients were queuing in the corridor. Emotional support was provided to patients, relatives and staff alike.

Compassionate care

- We observed care delivered with kindness and compassion. We saw staff discussing care with patients in a polite, courteous and compassionate way. We observed two staff members provide care to a child attending the department. We saw them go to the child's level to talk to them as well as discussing care with their parent. In the CQC A&E survey, 2014, the trust scored 'about the same' as other trusts when patients were asked if they were acknowledged by staff and whether staff talked in front of them as if they weren't there.
- Patients' privacy and dignity was mostly respected. The CQC A&E survey, 2014, reported the trust scored 8.8 out of 10, which was 'about the same' when patients were asked if they had enough privacy in the department. Within the majors and minors areas, we observed staff close curtains behind them when carrying out procedures. However, there was no means of providing privacy to patients who were waiting for handover from ambulance crews to department staff.
- The department captured patient feedback using the friends and family test. In line with other trusts, response rates were low. However, the department was generally above trust target for responses received each month. Data provided by the trust showed the department would be recommended by 94% of respondents (out of an average 81 patients who completed the survey each month.)
- Without exception, all patients we spoke to during the inspection told us how friendly and caring staff were.

Understanding and involvement of patients and those close to them

- We saw evidence that patients and those close to them were involved as partners in their care. In the CQC A&E survey, 2014, the trust scored 'about the same' as other trusts when patients were asked about involvement and understanding, with the department scoring 8.1 out of 10 when patients were asked if they were involved as much as they wanted to be in decisions about their care and treatment.
- We spoke with a number of relatives who had accompanied family members to the emergency department. They told us they had been kept well informed of their family member's condition and what was happening at all times. We observed staff explaining procedures to the relative of an older person in an easy to understand way, checking out that they understood the procedure before it was undertaken.
- Self-presenting patients were kept informed about waiting times via a board outside of the entrance and an electronic board in the waiting area. However, despite the department being relatively quiet at times, we noted the time on the board outside the department was not updated, but remained as four hours for waits to be treated, whilst the electronic board was updated appropriately. We asked staff about the board outside the department entrance and were told it was never changed.
- We observed receptionists give people an estimate of their waiting time upon booking in at reception. When emergencies came in which had an impact on the waiting time, staff explained this to patients in the waiting area.

Emotional support

- There was no specific bereavement support for relatives or staff within the department. However, a chaplaincy service was available if required, and if not available personally was supported by a number of volunteers.
- Staff told us they undertook debriefing following traumatic events and could be referred to occupational health for emotional support. In addition, staff could self-refer without the need for manager approval and referral.

Urgent and emergency services

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

Requires improvement

Patients did not always receive timely care and treatment. The emergency department was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival. Patients regularly queued in the corridor because there were insufficient cubicles in the department. This impacted on patient safety, comfort, privacy and dignity.

There were recovery plans in place in order to improve patient flow. These worked well during the day. However, out of hours staff did not recognise the risk posed to patients waiting in the corridor. Actions taken to improve performance included the introduction of assisted discharge teams, increased partnership working with the local authorities and commissioners. A 'chaser nurse' had been introduced to 'chase' diagnostic tests which patients were waiting for to enable them to be transferred or discharged within the four hour target.

All expected admissions to the hospital were channelled through emergency department and this increased the pressure on the department.

Service planning and delivery to meet the needs of local people

- There was not a strategic plan for the department for the 2015-16 year because of the ongoing transaction process. The strategic plan for 2015 was focused around the need to improve medical staffing levels and the use of non-medical practitioners including emergency nurse practitioners to support the delivery of care and treatment in the department. There was also a focus on improving flow through the department and into other areas of the hospital. It also included working with external partners and commissioners in delivering care.
- ED facilities and premises were largely appropriate for the services that were delivered. The department was accessible. There was parking available close to the department and quick and easy access to the ambulance entrance. The main waiting area was adequate and staff told us at most times it was large enough to accommodate patients and visitors.
- The trust was working with health and social care partners to ensure there was a system-wide approach to managing demand and the impact that fluctuating and increasing demand had on the emergency department.
- The department only accepted children who arrived via ambulance during the day. Out of hours, ambulances automatically diverted all children to Bristol Royal Hospital for Children. If a child was in a cardiac arrest they may be brought to the department and stabilised before transfer to Bristol. Children who self-presented were seen in the normal way, but seen as a priority.

Meeting people's individual needs

- The service took account of individual needs of different patient groups. The department was accessible for people with limited mobility and people who used a wheelchair. There were wheelchairs available in the department and staff could access wheelchairs and trollies which could accommodate bariatric patients.
- Dementia screening was undertaken for all patients where necessary. This made sure early referrals were made where appropriate. All patients over 75 years of age had a dementia screen undertaken.
- There were vending machines in the waiting area so that patients and visitors could access food and drink. Drinking water was available and televisions were also present for people to watch. Toilets were suitable for adults and children and nappy changing facilities were available in the children's area. There was also a designated area for breastfeeding mothers. There was a separate waiting area for children. It was suitably furnished, decorated and equipped with toys.
- There was a mental health liaison team which supported the emergency department. They aimed to respond to all crisis and urgent referrals for mental health advice or assessment and provided assessment according to the urgency of the referral. A Child and Adolescent Mental Health team were also available for help, advice and assessment.
- Staff within the emergency department also had access to specialist drug and alcohol services to help patients who needed additional support. Staff also had access to specialist paediatric advice from Bristol Royal Hospital for Children.

- Staff recognised the importance of supporting bereaved relatives. Deceased patients were moved to a side room where family members could spend time with them.
- For those patients whose first language was not English, interpreting facilities were available. We asked staff about these and they were able to tell us the process of getting an interpreter should the patient require one. Staff also explained that patients sometimes brought in other relatives who were able to interpret for them in the short term until a qualified interpreter was available. Staff said that they refused to allow children to interpret for their parents in line with national best practice.
- The reception desk was designed in such a way as to give privacy to people booking in. Two people could be booked in simultaneously as the desk was fitted with a privacy wall between them.

Access and flow

- People did not always receive care and treatment in a timely way. The trust was consistently failing to meet key national performance standards for emergency departments including the standard which requires that 95% patients are seen, treated and either discharged or admitted to the hospital within four hours of arrival. Performance between July 2014 and February 2015 varied between 93.7% and 88.2%. Performance from 1 April 2015 to the time of our announced inspection in May 2015 was 84%. Daily performance as well as average performance was also reported and showed a wide variation. For example on 7 April 2015 performance was as low as 69.2%. Performance in the month prior to our inspection had been consistently around 92%.
- We saw that within times of high demand patients did not receive timely assessment care and treatment. However, when the department was not overcrowded, patients were treated in a timely manner. During our announced inspection, we did not see ambulances waiting to hand over patients, but during our unannounced inspection, during a time where there were a higher number of people attending the department; we saw that there were delayed handovers.
- In December 2014 patients waited on average two hours and 52 minutes from the time they arrived in the department to departure. For patients needing admission to the hospital, they waited on average three hours and 52 minutes.
- The trust was failing to meet the targets regarding unplanned re-attendances at the department within seven days of their original attendance. The trust target was 1-5%; however, the department averaged 7.7%.
- Patients arriving by ambulance as a priority were taken immediately to the resuscitation area. Ambulance crews phoned through in advance in order that appropriate teams could be alerted and prepared for the arrival of the patient. However, during times of surge on our unannounced inspection, we noted ambulances were kept waiting for sometimes in excess of an hour. Performance data for April 2014 to February 2015 showed that up to 1.9% of ambulances were kept waiting for longer than 60 minutes. The trust identified as an area for improvement in the performance assurance framework in March 2015. The number of ambulances delayed by less than 60 minutes was between 0.2% and 1.5% between April 2014 and February 2015. There was no clear improvement seen in these rates over that period of time and performance remained variable.
- We observed on the three mornings we attended the site meeting, there were over 30 patients that were classed as 'green to go'. This meant they were medically fit for discharge, but were waiting for facilities and/or services in the community. This had an impact on the department where at times patients remained awaiting transfer to a suitable ward or department after a decision to admit had been made.
- All patients who required admission to the hospital were referred through the emergency department. The staff told us they felt this contributed to the difficulty experienced with patient flow through the department and onto the wards.
- The rate of emergency admissions to hospital within 30 days of discharge required further improvement. There had been a gradual reduction in the rate between April 2014 and February 2015 from 12.3% to 5.1%.
- There were clear escalation procedures in place within the trust for times of surge and influx of patients into the emergency department. This involved both internal and external escalation to executives via the patient flow manager and clinical site manager, in and out of normal working hours. Staff told us that when the hospital went into black escalation, the executive on call attended the department, if necessary, additional staff were brought in and additional beds were opened up on occasion.

- The escalation policy described and 'RAG rated' the escalation, ranging from green (low risk) to black (very high risk). The escalation level was triggered by bed capacity or emergency department capacity or both and was reviewed regularly.
- The escalation plan included actions that staff needed to take when patients had been waiting in the emergency department for 2.5 hours, three hours and then again at 3.5 hours. Escalation cards were available for the emergency department coordinators, matrons, consultant staff and managerial staff.
- Site meetings took place at specific points during the weekday starting at 8:30am. These meetings looked at the capacity across the whole hospital, expected and emergency admissions, discharges and other pressures such as staffing. A range of staff attended these meetings, including consultants, managers and the Director of Operations. Actions were decided at these meetings and documented. At the end of the meetings, a daily report was produced. These reports were then circulated and included emergency department performance, bed management, hospital status and action plans.
- Patient flow meetings occurred at least three times a day during the week. These were attended by the nurse in charge of emergency department, the site management team and where possible, the consultant staff. Staff told us that apart from the morning, it was difficult to get consultants or medical staff to attend. At the first meeting of the day, actions were agreed as necessary and depending on the needs of the hospital. These actions were then updated at the subsequent meetings throughout the day. Staff told us they felt if the doctors were present at all the meetings the discharge of patients to improve patient flow might be expedited.
- At weekends, the on-call team monitored the bed state across the hospital, including patients waiting for discharge, those waiting in the emergency department and the total number of expected discharges
- The department had introduced a 'chaser nurse' to help to improve the performance against the four hours target and to take patient referrals from GPs in order to ensure that patients were appropriately referred. This had reduced the number of calls received from the GPs and had improved the efficiency with regard to admission avoidance to the department.
- A recovery plan was in place to deliver the four hour target in the short and medium term. The plan had actions for all wards and departments within the trust. The actions implemented by the emergency department included a rapid assessment process for patients, an enhanced consultant rota and early decision making to reduce inappropriate admissions.
- The department was undertaking a pilot project to ensure ill patients who arrived were seen promptly and urgent treatment initiated. This was led by a team, known as the Early Assessment and Stabilisation Team (EAST). The team's remit was also to ensure patients waiting an hour in the department had a timely review. This pilot project was designed to reduce the clinical risk of patients waiting in the corridor and to help the flow of patients through the emergency department. The staff told us that they felt the project was working well, although they acknowledged that it was a new project. We did not see this team in operation during our inspection or at our unannounced inspection. We were therefore unable to judge its effectiveness.

Learning from complaints and concerns

- From May 2014 to May 2015 the emergency department received 51 complaints. The majority (30) of these complaints related to the clinical care patients received. Eight complaints related to lack of communication and seven related to the attitude of staff. Other themes included discharge arrangements (four), privacy and dignity (one) and medication (one). During the same time period, the Patient Advice and Liaison Service (PALS) dealt with 148 cases relating to the emergency department. Complaints about the emergency department represented 25% of all the complaints received in the trust. However, only 0.09% of all the patients seen within the department felt the need to make a complaint.
- All complaints were recorded, together with the outcome of the investigation and any lessons learned.
- Leaflets explaining how to raise a complaint were on display throughout the department. Staff were familiar with the complaints procedure. The staff that we spoke with were confident that they would deal with complaints as they arose and where they could not be resolved, they would direct people to the Patient Advice and Liaison Service (PALS).
- We spoke with the PALS team who told us that the biggest issues raised with them as complaints were the

care patients received and waiting times. They told us that they considered staff in the emergency department very proactive in dealing with concerns either direct from patients or when raised via the PALS team.

Are urgent and emergency services well-led?

Requires improvement

The service lacked a clear strategy and vision for the 2015-16 year because of the ongoing transaction process. Although a new clinical lead was in place in the emergency department, the identification of areas for improvement and subsequent actions to drive the improvements was lacking.

The workforce was passionate about patient care and committed to the delivery of safe and high quality care and treatment. Staff told us they enjoyed working within emergency department and for the trust. Staff also told us they felt valued and supported by the emergency department and divisional management.

We saw examples of strong nursing leadership and without exception, staff we spoke with were very complimentary about the nursing leadership. However whilst the nurses were well organised, we observed during the unannounced inspection that there were not always aware of the risks within the department. It was acknowledged that until approximately three months prior to our inspection, the medical leadership had been weak, although it was felt to be improving.

Vision and strategy for this service

- In the context of a trust which was subject to a transaction process, it was unsurprising that the long term vision for the service was unclear.
- We were given a copy of the emergency department strategic plan for 2014/2015. This plan included developments for the department for medical staffing, reviewing the role of the emergency nurse practitioners, leadership and performance against targets. However, there had been limited improvements in performance and quality seen as a result of this strategic plan.

Governance, risk management and quality measurement

- Business and governance meetings were held monthly. Minutes of these meetings showed a range of issues were discussed, in particular the emergency department recovery plan and review of patient flow through the department. Action points were noted. There was also a daily quality and leadership meeting within the department which reviewed performance, activity and issues in the previous 24 hours. Immediate actions and learning were identified in these meetings for dissemination. However, it was not clear to see if actions delivered improvements from these minutes.
- The identification of risks within the department required improvement. The emergency department risk register contained 10 items which were mainly historical. These included risks relating to: medical staffing levels; a high turnover of nursing staff in January 2015; sick children arriving in the department rather than going directly to Bristol Royal Hospital for Children; an increase in incidents in the emergency department in November 2012 and risks associated with delays in patients receiving mental health assessments. There were no entries which related to patient access and flow through the department or to the safety and quality of care and treatment patients received in the department in times of high patient attendances. Although senior clinical and nursing staff were aware of the risks on the risk register there was not cohesive leadership of the risk management process.
- Although the department had undertaken national audits, there was little or no evidence seen of actions identified or taken as a result to drive improvement in the department. Equally although the consultant body requested a review from the Royal College of Emergency Medicine, which occurred in September 2014, following which a number of recommendations were made, including: appointing a new medical lead for the emergency department; introducing the pilot project EAST (early assessment and stabilisation team) team; utilizing dedicated portable phones for the clinical leads on each shift. Not all of these were seen to have been completed. For example, the EAST project was not 24 hours a day, and was not in place during our unannounced inspection. The dedicated portable phones were in use during our inspection, but we observed one consultant leave the phone to ring unanswered.
- Recent GP complaints had highlighted an issue with blank GP discharge letters being sent out from the

department. The manager we spoke to about this was aware of the issue and of what caused the blank letters, however, did not seem to have any knowledge of how big the problem actually was. We saw that measures have been put in place and additional training provided to staff on the electronic system, but the problem persisted.

- An emergency preparedness resilience and response plan was in place and reported on regularly at the trust board. This showed the work undertaken to make sure the trust was compliant with the statutory duties under the Civil Contingencies Act, 2004. It showed the trust was prepared for emergencies such as a heatwave and Ebola.
- There were good relationships with external healthcare partners, including the clinical commissioning group (CCG), the local community trust and the ambulance service.

Leadership of service

- Staff told us the trust management team was visible and approachable. The director of operations and director of nursing frequently attended the department to provide assistance when there were capacity issues. One member of staff told us that it was like a big family and they felt able to approach any of the managers, including the chief executive if they had a problem.
- We met with the clinical (medical and nursing) leads together with one of the management team. The consultants made us aware that there had been lapses in the medical leadership in the past and that this had been resolved three months prior to our inspection with the introduction of a new clinical lead. The consultants also told us that they felt the department had been led by the nursing management and had done an excellent job of keeping the department together. The staff we spoke to during this inspection also confirmed both the poor medical leadership and the strength of nursing leadership. As well as a new clinical lead consultants now received dedicated management time had also been included in their job plan which previously had not been available to the clinical leads.
- Staff told us that historically the medical leadership within the department had been poor. Staff also told us that this was shown the lack of response to audits, poor information assessment and treatment times, response to CEM audits and low appraisals rates for doctors. We understand that there had been four medical leads for the department in the two years prior to our inspection.
- The reception staff and domestic told us that they felt very well supported by the nursing team within the emergency department. Although the reception staff did not feel as supported by their own managers.
- The matron told us that she was very proud of her team and felt very supported by both the divisional management and the trust executive teams. The feedback we had regarding the matron's leadership was excellent.
- The trust holds an award ceremony each year to celebrate success within the organisation. We were told that the emergency department team were nominated for an award in the category of team spirit and the matron had been nominated for her leadership. Both had been successfully shortlisted at the time of our inspection.

Culture within the service

- There was a patient focused culture within the department but not all issues relating to poor quality patient care were identified and acted upon. However, there had been a high turnover of nursing staff in the early part of 2015 and an unsustainable medical rota.
- Staff in the emergency department told us they felt respected, supported and valued by their immediate managers.

Public and staff engagement

- The emergency department used the friends and family test to capture patient feedback.
- Regular meetings were held with staff regarding the transaction process of the trust and staff within the emergency department had attended and were aware of what was happening. Minutes of emergency department team meetings were displayed in the staff room for all staff to read as appropriate.
- The staff we spoke to told us how much they loved working within the department and that morale was very good.
- Staff told us that they were encouraged to raise concerns and they felt they were listened to.

Innovation, improvement and sustainability

Urgent and emergency services

- There seemed to be uncertainty with regards to innovation and sustainability because of the transaction process.

Medical care (including older people's care)

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

Information about the service

Medical care was delivered by the emergency care division (the division) which was responsible for all unscheduled care. Services included acute medicine, high care, short stay, stroke, gastroenterology, cardiology, care of the elderly, rehabilitation, endocrinology and respiratory medicine. For the purposes of this report, high care is reported under critical care.

The trust admitted 16,973 medical patients in 2013/14. There were six medical wards: Harptree ward (22 beds cardiology, short stay medicine and high care), Berrow ward (28 beds gastroenterology and respiratory medicine), Stroke unit (20 beds stroke medicine), Uphill ward (24 beds rehabilitation) and Kewstoke ward (28 beds care of the elderly) and a 27-bedded short stay medical assessment unit (MAU). There was also a 20-bedded 'escalation ward', Cheddar ward, which was opened at times of increased demand. This ward was not open at the time of our visit.

There was a discharge planning team and a discharge lounge based in the Churchill Unit.

The trust provided a range of cancer services including breast, colorectal, lung, skin, gynaecology, palliative care and urology. There was a chemotherapy unit which provided day case treatment and could accommodate up to nine patients.

There was a medical day care unit (MDCU) which provided transfusion or infusion treatment on a planned or semi-planned basis. There was also a day case endoscopy service.

There was an ambulatory emergency care unit (AEC) located adjacent to the emergency department (ED) which operated between 9am and 7pm on Monday to Friday and between 10am and 5pm at weekends and could accommodate up to eight patients on chairs. The ambulatory emergency care unit provided urgent assessment and treatment for patients referred by their GP or by the emergency department, who were not acutely unwell, were clinically stable but required assessment or treatment in order to prevent admission.

We visited the hospital over two and a half weekdays, and conducted a further unannounced visit on a Saturday. We spent time in the following areas: Berrow, Uphill, Kewstoke, Draycott and Harptree wards, medical day care unit, MAU, endoscopy, chemotherapy unit, and the discharge lounge. We spoke with approximately 50 patients and three relatives. We spoke with staff, including consultants, junior doctors, nurses, therapists, support staff and managers. We observed care and treatment and looked at care records. We received information from our listening event in January 2015 and from people who contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

Medical care (including older people's care)

Summary of findings

There were insufficient numbers of suitably qualified and experienced staff employed consistently to ensure that patients were protected from the risk of avoidable harm. Staff shortages across medical, nursing and allied health professional groups posed a risk to patients' safety. An acute shortage of consultant physicians impacted on their accessibility and the level of support they were able to provide to junior medical staff. Junior medical staff experienced high levels of stress and work overload. They were not always well supported in relation to their workload and ongoing training and development. They were frequently asked to perform tasks outside of their level of competence or without adequate supervision.

Risks in relation to medical staffing had not been effectively mitigated. Medical leadership was weak. Junior doctors felt unsupported but there was a lack of insight and empathy for the widespread concerns they expressed and this issue was not identified as a risk on the division's risk register. We were also concerned about a culture in which some junior medical staff felt unable to speak up for fear of recrimination.

Lack of workload capacity impacted on doctors' ability to participate in audit activity and there was limited evidence of learning from audit and incidents. A shortage of therapy staff meant that patients' treatments were sometimes delayed. Staff told us this sometimes increased patients' length of stay, particularly at weekends. A shortage of pharmacy staff caused inefficiency in the discharge process and patients' medicines were not consistently checked to ensure that they were correct during their stay.

Patients did not always receive care and treatment in the right place at the right time. Patients were not always cared for on the most appropriate wards and some patients experienced numerous ward moves, sometimes at night. Patients' discharges were often delayed, sometimes because their treatment was delayed and sometimes due to difficulties in arranging appropriate packages of care in the community. The management team was taking steps to reduce delays and improve patient flow. There was a competent patient flow team which worked well with the rest of the hospital and external health and social care partners and maintained an overview of bed availability and patient flow.

We observed nursing, therapy and support staff to be responsive and attentive. Patients appeared comfortable and well cared for, with plenty to eat and drink and they were encouraged and supported in their recovery. However, patients with complex needs did not always receive the level of care they required. Although reducing, the incidence of falls and hospital acquired pressure ulcers remained too high because appropriate care pathways were not consistently followed. The ambulatory emergency care unit and the medical day case unit were not located in appropriate premises so that people's privacy and dignity were protected.

Patient feedback about medical wards and departments was overwhelmingly positive. Patients told us staff were caring, compassionate and supportive and we saw many examples of this during our visits.

We saw excellent multidisciplinary working on medical wards. Staff across all disciplines worked cohesively to provide effective and seamless care for patients. Regular multidisciplinary board rounds were structured and focused on a plan of care and discharge for individual patients.

There was a strong and visible nursing leadership and nursing staff felt well supported. Senior nurses understood, and were focused on quality and on risk. There were detailed action plans in place to mitigate risks to patients, for example by reducing the incidence of falls and pressure ulcers, although further work was required to ensure that improved practice was embedded and sustained.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

People were not protected from avoidable harm. There were insufficient numbers of suitably qualified and experienced staff employed consistently to ensure that patients were protected from avoidable harm.

There was an acute shortage of consultant physicians and this impacted on their accessibility and the level of support that they were able to provide to junior doctors. There was widespread concern expressed by junior doctors about their workload and the lack of senior medical staff support. This meant that they were frequently expected to perform tasks for which they felt ill prepared or competent to perform. Some junior medical staff were afraid of or discouraged from raising concerns. This was because they rarely received constructive feedback when they reported concerns and some doctors had been the subject of recrimination for doing so.

Appropriate nurse staffing levels were not consistently maintained in the medical day care unit.

A shortage of pharmacy staff meant that patients' medicines were not consistently checked during their inpatient stay.

Compliance with mandatory training was variable and did not meet the trust's target compliance rate of 90%.

Premises were mostly fit for purpose; however, we had concerns about the ambulatory emergency care unit which was inappropriately laid out and poorly equipped. Patients could not be adequately observed or monitored and there was a risk that patients whose condition deteriorated may not be adequately supported.

The hospital had experienced a difficult winter, with numerous outbreaks of Norovirus. However, we found medical wards and departments to be visibly clean and staff observed appropriate infection control precautions.

Senior nurses were focused on reducing risks to patients through investigation, staff education and training. However, improved practice was not yet fully embedded and the incidence of falls, pressure ulcers and medication errors was still too high.

Incidents

- In the 2014 staff survey the trust scored worse than the England average for the percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month.
- The division did not have a good track record on safety. There were 37 serious incidents reported between February 2014 and January 2015, of which 16 related to pressure ulcers (grade three), seven related to grade four pressure ulcers and five related to slips, trips and falls. There were three serious incidents in February 2015 of which two were in the emergency department and one occurred on Harptree ward and involved a patient who fell and sustained a subdural haematoma. Two serious incidents were reported in March 2015, both of which were grade three pressure ulcers, one on the stroke unit and one on Uphill ward.
- There was a high incidence of pressure ulcers, although a decreasing trend was seen between December 2013 and December 2014. Five hospital acquired pressure ulcers were reported in February 2015 and nine in March 2015.
- The trust had identified three top causes of pressure ulcers: failure to acquire pressure relieving equipment in a timely manner, not assessing patients at risk within two hours and poor documentation on re-positioning charts. The division was very focussed on driving improvement in this area and by educating staff and increasing their awareness of the risks and how to manage them. The Tissue Viability Nurse regularly attended 'Teaching Thursday' sessions. Round table meetings after investigations of pressure ulcers were carried out to share learning with the teams and a pressure ulcer pathway was currently being developed. Further improvement was being led through an improvement programme, with an identified group of front line staff meeting regularly to agree actions and next steps. We were told by the divisional management team that the incidence and severity of pressure ulcers was reducing.
- On Uphill ward we looked at records for patients who had been identified as being at risk of developing pressure ulcers. Risk assessments had been conducted and a regime of regular re-positioning had been put in place. However, we found three examples where this

regime had not been consistently adhered to. We asked the ward sister whether they regularly audited records. They told us that weekly documentation audits were undertaken, in addition to spot checks by the sister and junior sister. They acknowledged that performance in this area still had room for improvement.

- There was a high prevalence of falls. A total of 218 falls were reported trust-wide in December 2014 and January 2015, with medical wards reporting the highest number. It was noted in the integrated performance report presented to the board in March 2015 that there were 18 falls reported on the stroke unit in December and January 2015 compared with six in October/ November 2014. During this period the unit had six additional beds. The sister on the stroke unit described the measures that had been put in place to reduce the number of falls but acknowledged that staff education was ongoing and good practice was not yet fully embedded. They told us that risk assessments were completed well but management plans were not always followed. They described practice as reactive, as opposed to proactive.
- The trust was piloting a post-fall assessment on Kewstoke ward. This was completed by a senior nurse as soon as possible after a fall. The assessment included an interview with the patient and staff and an assessment of the environmental factors. Information had been analysed for emerging trends, a falls reduction and prevention group had been established and had developed an action plan to reduce the number of falls incrementally, aiming to achieve a reduction of 80% in 12 months.
- A falls bundle (a series of steps to assess and reduce the risk of falls) had been adapted from guidance from the National Institute for Health and Care Excellence (NICE). NICE guidelines require that all patients over the age of 65 or who are aged 50 to 64 and assessed by a clinician to be at high risk of falls, should have a falls risk assessment completed within 72 hours of admission. We saw evidence that risk assessments were being completed appropriately and some measures had been put in place to mitigate the risk of falls. Measures included the use of crash mats, monitors, positioning of patients close to the nurses' station and hourly checks (intentional rounding). A falls flow chart had been introduced which included a series of prompts for staff to consider according to the severity of risk identified. However, we found few examples of detailed care plans aimed at reducing the risk of falls and risk assessments were not consistently regularly reviewed.
- On Kewstoke ward there had been seven falls in April 2015, five of which had been unwitnessed. The sister told us that some of these patients should have had adjustable beds. Learning had been taken from these incidents and there was more focus being given to ensuring staff presence in bays. They told us the incidence of falls was reducing, with more attention being given being given to positioning and observation of patients. Staff told us that where necessary, continuous one to one supervision of patients identified as being at high risk of falls could be provided.
- The incidence of catheter acquired urinary tract infections (CAUTI) was monitored. . It was reported in the harm free care report (November 2014) that there had been no hospital-attributable CAUTIs reported on the day of the safety thermometer for the previous six months. It was reported that work was underway to address a rising trend in catheter insertions (28%) in September 2014. Work was being led by the lead nurse for urology.
- The incidence of venous thromboelisms (VTEs) was monitored. From October to December 2014 there were no new hospital acquired VTEs. It was reported in the Harm Free Care Report presented to the board in March 2015 that the VTE committee met monthly to monitor compliance with VTE risk assessment and VTE prophylaxis (treatment to prevent VTE). All hospital acquired thromboses were investigated using root cause analysis. This analysis had not identified major deficiencies in either VTE/bleeding risk assessment or the administration of appropriate prophylaxis. Results were being collated quarterly and presented to the divisional governance meetings.
- Staff understood their responsibilities to raise concerns but not all staff did so. Most nursing staff we spoke with told us they were encouraged to report incidents and did so. However, some junior medical staff told us that they were not encouraged to report incidents. One junior doctor told us they had been instructed by a consultant not to report their concerns through the incident reporting procedure and another junior doctor told us they had been subjected to snide comments

from a consultant after they had reported their concerns. In the 2014 staff survey the trust scored below the England average in relation to the percentage of staff that would feel secure raising concerns about unsafe clinical practice. Consultants told us they encouraged junior doctors to report incidents. However, incident reporting by doctors was low, suggesting a possible reluctance of junior doctors to report concerns.

- A number of doctors told us that when they did report incidents, they either did not receive any feedback or the feedback they received was not useful or constructive and did not assure them that their concerns had been taken seriously. One junior doctor told us they had reported 10 incidents relating to workload and supervision. They told us they had not received a response to most of them and those responses they did receive did not provide a resolution. In the 2014 staff survey the trust score was in the bottom 20% nationally in relation to the fairness and effectiveness of incident reporting procedures.
- We were told by the divisional management team that Mortality and Morbidity (M&M) meetings were held monthly. However, these meetings were not minuted and it was not clear how many staff were able to attend these meetings or how learning was disseminated. Junior doctors told us that M&M meetings did not take place in care of the elderly or in respiratory medicine. This meant that there was not a consistent approach to ensure that learning and improved practice resulted from reviews of clinical complications or unexpected clinical outcomes.

Duty of Candour

- The trust had a system in place to ensure that patients were informed when something went wrong, given an apology and informed of any actions taken as a result. This is known as the duty of candour. In the Harm Free Care Report presented to the board in March 2015 it was reported that from the date that the duty of candour regulation came into force in November 2014 until 31 December 2014 a total of nine incidents had been classified as moderate or severe and therefore the duty of candour may apply. Eight of these incidents occurred within the medical division and five of them had been subject to duty of candour disclosure. We asked nursing and medical staff about their understanding of duty of candour. Most nursing staff were able to describe their responsibilities. However, few junior medical staff demonstrated a clear understanding of this requirement.

Safety thermometer

- The trust board received a harm free care report at each meeting, which included data collected using the NHS safety thermometer. This is a national measurement tool used to record patient harms. Data was collected on a single day each month and recorded the presence or absence of four harms:

- Pressure ulcers
- Falls
- Urinary tract infections in patients with a catheter (CAUTIs)
- Venous thromboelisms (assessment and correct treatment to prevent this condition).

- In January 2015 harm free care was reported as follows:

- Berrow ward 96.3%
- Kewstoke ward 71.4%
- Stroke unit 88%
- MAU 100%
- Harptree ward 96.3%
- Uphill ward 83.3%

- Safety thermometer performance was displayed at the entrance to each ward.

Cleanliness, infection control and hygiene

- There were seven outbreaks of Norovirus in December 2014 and one in January 2015. It was reported to the board in March 2015 that analysis of these outbreaks had demonstrated that the trust was operating within the national Norovirus prevention guidelines. However, a number of areas for improvement were identified: quality of documentation, analysis of airflow on wards, and closure of whole ward as opposed to bays. A further five cases of Norovirus were reported in March 2015.
- There were six cases of Clostridium difficile reported in the division between January and March 2015. Two cases occurred on Kewstoke ward, one on Uphill ward, two on Berrow ward and one on Cheddar ward. During

this period the trust installed macerators and removed bedpan washers, allowing waste to be disposed of instantly, and negating the risk of substandard cleaning with re-usable products.

- There were no reported cases of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia between January and March 2015.
- The division reported two cases of methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia between January and March 2015, both of which occurred on Berrow ward. It was reported to the board in March 2015 that a rapid improvement plan was being implemented to urgently address concerns around cannula care, standard infection control precautions and isolation practice. It was reported that a programme of ward based training in aseptic non-touch technique with competency assessment was due to be launched.
- We observed wards and departments were clean, tidy and free from offensive odours. We saw regular cleaning taking place. Staff disposed of waste appropriately, used appropriate protective equipment and complied with the 'bare below the elbow' policy. There were side rooms on each ward where infectious patients could be isolated and barrier nursed to prevent the spread of infection. However, we noted on Uphill and Berrow wards there was damaged and peeling plaster on the walls. This meant that these walls were difficult to keep clean.
- Cleaning audits were undertaken monthly. In the last quarter of 2014/15 Kewstoke ward and MAU achieved over 90% compliance and were rated 'green'. Berrow and Cheddar wards were rated 'amber' and Harptree ward and the stroke unit were rated 'red', with year-to-date average scores at 88% and 77% respectively. In the divisional infection prevention and control assurance committee report (quarter 4: 2014/15) it was reported that the stroke unit had consistently failed national standards of cleanliness. The associate director of nursing had asked for a review of standards on this unit.
- We observed staff frequently washed their hands. There were appropriately sited hand wash basins and hand gel dispensers to encourage regular hand sanitisation. Hand hygiene audit results in March 2015 were variable. Harptree and Kewstoke wards achieved 100% compliance, the stroke unit and Cheddar ward scored 98%, Berrow ward 97%, Uphill ward scored 88.6% and MAU scored 86%
- The divisional infection prevention and control report for quarter 4 (2014/15) noted that "further work is needed to monitor hand hygiene compliance."
- Training in infection control was a concern, with only 85.2% of staff having completed mandatory infection control training in March 2015. Medical staff, management and pathology staff performed the worst.

Environment and equipment

- Premises were mostly appropriately designed, laid out and equipped to keep people safe. However, the ambulatory emergency care unit was poorly laid out and equipped. The patients' waiting area could not be easily observed by staff. There was no heart monitor or piped oxygen and the nearest resuscitation equipment was in the minors area of the adjacent emergency department. Consulting rooms were cramped and would not allow easy access to a deteriorating patient, should they need urgent medical assistance. There were no call bells to summon assistance.
- Wards were well lit, floors were non-slip and toilets and showers were large enough to allow people to be assisted with personal care and could accommodate equipment, such as lifting aids. There was a call bell system so that patients could summon assistance from their bed and from bathrooms and toilets. On Uphill ward we noticed that there was not always clear access to the fire exits. One thoroughfare was blocked for some time by wheeled equipment such as the notes trolley, a linen skip and an over-bed table. The other fire exit door had observation equipment positioned in front of it.
- Wards were appropriately equipped. We checked a range of equipment, including lifting aids and resuscitation equipment. All was clean and well maintained. Resuscitation trollies were appropriately stocked and there was evidence of regular checks.

Medicines

- We checked the storage of medicines and found they were stored appropriately and securely. Appropriate checks were undertaken daily, including those for fridge temperatures and controlled drugs.

- There were concerns about missed doses of patients' medication. A new prescription chart had been introduced and some staff felt this had resulted in more missed doses. On the MAU we were shown a missed doses flow chart which, it was reported, had resulted in a reduction in this type of incidents. Three errors had been reported in April 2015. We looked at patients' prescription and administration records. Most patients received their medicines as prescribed by their doctor, although we saw five records where a dose of medicine was missed or given late because it was not available on the ward. This meant there was a risk that patients' medicines may be less effective or an increased risk of side effects.
- There were 31 medication incidents reported in the division in February 2015 and 42 in March 2015. A medicines management report to the divisional governance committee in February 2015 reported that nurses had cited constant interruptions as a cause of incidents. It was reported that a safety alert was circulated trust-wide requesting that all staff should not disturb nurses undertaking ward rounds. We observed staff wore 'do not disturb' tabards when undertaking medicines rounds but on Uphill ward the nurse was frequently approached by colleagues. There were no signs displayed on wards to discourage visitors from disturbing staff. It was also reported that "sloppy practice is common in both prescribing and administration incidents." It was reported that a quality improvement initiative was underway on Uphill ward for prescribing and for missed doses on Harptree ward.
- The risk associated with medication errors was recorded on the divisional risk register (amber risk) and included incorrect calculation of infusion rates, inaccurate prescribing of insulin and inaccurate processes for discharging patients on anti-coagulation agents. It was reported that although incidents remained high, the number of incidents causing harm was reducing. A number of actions had been put in place to mitigate risks, for example, nursing staff had undertaken medicine calculations assessments and an anti-coagulation pathway had been introduced.
- The divisional risk register also highlighted a 'red' rated risk associated with pharmacy workforce capacity to support medicines reconciliation and timely TTOs (to take out medicines). Senior nursing staff on Harptree ward told us that pharmacy support was limited and in particular, medicines reconciliation was not consistently undertaken. In a recent audit only three out of 27 patients' medicines had been checked. They told us "we rely on doctors to check drug charts."
- Medicines reconciliation is the process by which pharmacists check that they have the correct information about patients' medicines to make sure they continue to be given correctly during their hospital stay. Data provided by the pharmacy department showed that in March 2015 medicines had been reconciled for 37% of inpatient admissions. This meant there was a risk that patients may not receive their regular medicines correctly during their hospital stay. There was an action plan in place to improve this.

Records

- Patients' records were mostly clear, legible and up-to-date, with some exceptions.
- On the stroke unit we looked at the nursing records for five patients. Documents were well ordered and easy to follow. Assessments and reviews were up-to-date.
- On Uphill ward we saw variable performance in relation to record keeping. Nursing care was documented in folders kept at the end of patients' beds. Notes were kept in a folder with dividers to make them easy to follow; however documents were not always properly filed and we found several loose sheets of paper. This meant that records could be lost or overlooked because they were not in the right place. Some records had not been consistently completed, for example, records of patients being re-positioned at regular defined intervals and checks on cannula sites were not always consistently recorded. We could not be assured therefore that the necessary intervention and checks had taken place. Risk assessments were generally well completed but not always reviewed within an appropriate timescale. For example, we found one record for a patient who had been identified as being at high risk of falls but their falls risk assessment had not been updated for two weeks.
- Monthly documentation audits were undertaken on each ward.

Safeguarding

Medical care (including older people's care)

- There were effective systems in place to ensure that people were protected from abuse. As of September 2014, 89.7% of staff in the emergency care division had received recent training in safeguarding adults. Nursing staff we spoke with demonstrated a good understanding of the risk of abuse and of their responsibility to report concerns.

Mandatory training

- Staff did not consistently undertake regular mandatory training in safe systems, processes and practices to keep people safe. In March 2015 compliance with mandatory training for the emergency care division as a whole was 82.5%, which was below the trust's target level of 90%. Adult basic life support, fire safety and safeguarding children were the areas which required improvement. It was reported in the Divisional Quality and Governance Assurance report for February/March 2015 that "due to high numbers of agency staff it is difficult to achieve compliance with mandatory training". The divisional risk register highlighted non-compliance with mandatory training as a 'red' rated risk. It was noted that the division was working with the human resources department to ensure staff were aware of their responsibilities and the repercussions of not undertaking mandatory training. Nursing staff confirmed to us that they received frequent reminders to complete their mandatory training.
- Compliance with mandatory training for nursing staff in March 2015 was as follows:
- Berrow ward 94.5%
- Kewstoke ward 79.4%
- Stroke unit 89.3%
- MAU 90.9%
- Harptree ward 80.4%
- Uphill ward 77.3%
- Cheddar ward 91.6%
- Compliance with mandatory training for medical staff was as follows:
- Care of the elderly 86.7%
- Foundation year 2 doctors medicine 100%
- Cardiology 80%
- General medicine 66.4%
- Compliance with mandatory training for other groups of staff was as follows:
- Allied health professionals 94.2%
- Divisional management (administration) 40%
- Clinical management 100%
- Nurse specialists 73%.

Assessing and responding to patient risk

- The trust aimed to ensure that urgent or unplanned admissions were seen and assessed by a relevant consultant within 12 hours of admission or within 14 hours of time of arrival at hospital and assessed by a suitably qualified medical practitioner within 30 minutes (London Quality Standards). However, an audit undertaken in 2014 highlighted that only 74% of patients were seen by a consultant within 14 hours of arrival and the average time was over nine hours. It was recommended that consultant presence needed to be increased and changing the timings of consultant ward rounds should be considered to improve this. We asked the trust to provide us with updated information about this. They told us that this standard was not routinely measured and could not provide information to show how they were performing in this area.
- There was a physician of the day identified each day. They were responsible for coordinating the 'take' (urgent and unplanned admissions) out of hours.
- A survey of post-take ward rounds conducted in March 2015 found that 55% of respondents thought that sometimes important post-take ward round jobs were not completed and 30% reported this occurred frequently. Comments from doctors who completed the survey included "Patients seem to fall through the net when they attend on Friday and then are not seen over the weekend", "I have found on occasion that a registrar and consultant have done the post-take ward round and no weekend plan has been put in place", "Patients seen on post take ward round are often neglected. There is no clear guidance and no clear handover for these patients… I have to say that generally the feeling amongst juniors is that the current system is rather dangerous for patients."
- The division used a 'rounding tool' (a safety checklist) at ward rounds to reduce omissions and improve patient safety. We saw this in use.

Medical care (including older people's care)

- Acute admissions were assessed promptly by nurses following admission using the National Early Warning System (NEWS). Risk assessments were also undertaken for Venous Thromboelism (VTE), and falls in accordance with NICE guidance.
- Each patient had a 'patient at a glance' board at the head of their bed which alerted all staff to individual patient risks such as whether they were at risk of falls.
- Risks were regularly discussed and reviewed at daily board meetings and safety briefings on each ward.

Nursing staffing

- The divisional risk register (March 2015) highlighted nurse workforce vacancies as an 'amber' risk.

In March 2015 the vacancy rate for the division was 8% for registered nurses and 4.6% for healthcare assistants. On Kewstoke ward there were 2.8 whole time equivalent (WTE) vacancies (17%) for registered nurses. On Berrow ward one third of the nursing establishment was covered by agency staff, many of whom worked on the ward regularly.

- Staff on Berrow ward and MAU reported that night staff were regularly "poached" from their wards to supplement staffing on other medical wards. They told us they submitted incident reports every time this occurred.
- There were high levels of sickness across the division. In March 2015 the division-wide sickness rate was 5.48%.
- Bank and agency staff were regularly employed to cover shortfalls in staffing. The chief executive told us that the hospital was "heavily reliant on agency nurses" and there were concerns about temporary staff failing to follow trust processes and policies. There were also concerns about continuity of care due to "ever changing staff". A rolling recruitment campaign was ongoing, including overseas recruitment.
- Nursing staff we spoke with reported no concerns about staffing levels on the wards. They confirmed that bank and agency staff were frequently used to cover short notice absences but on the whole, staff were happy with the quality of these temporary staff. A bank nurse we spoke with told us they were required to complete the same level of training as their substantive colleagues and this was monitored by the bank coordinator.
- There were detailed and structured nurse handovers and safety briefings so that incoming staff were familiar with their patients' needs and any risks.
- There were daily meetings to review staffing to ensure that all areas were appropriately covered. Staff told us that additional staffing could be arranged if they were concerned about patients who were confused and may pose a risk to themselves. This was the case on Kewstoke ward on the day of our visit. When visited MAU during our unannounced visit there were two patients who the staff were concerned about due to their cognitive impairment and challenging behaviour. The ward sister had requested additional staff so that one to one care could be provided. They were managing to supervise these patients by ensuring that there was always a staff member present in the bay. However they were concerned that this level of supervision could not be maintained at night. When we spoke with the site manager at 4pm they told us they were trying to obtain additional staff but had not yet found any. Their shift report did not document that there were any nurse staffing issues on MAU or that any additional staff had been ordered.
- We undertook observations on Kewstoke and Berrow wards and noted that there were always staff present in ward bays, who were attentive to their patients' needs. These wards felt calm and we rarely heard buzzers being used to summon staff. When they were used, staff attended promptly.
- The division's risk register (March 2015) highlighted safety concerns in the medical day care unit due to staff vacancies and the long term absence of one staff member. It was noted that a member of emergency department staff had been identified to provide continuity, with a second staff member sourced from the bank. It was reported that the booking system was to be reviewed to ensure time slots, thereby reducing the number of patients in the unit at any one time.
- We were told by staff that the medical day care unit was regularly under-staffed. We were advised at our listening event by a patient who regularly attended the unit that it was sometimes under-staffed. They told us "it is not unusual for the nurse in charge to be on her own to deal with up to five patients, whose treatment requires checking by another qualified person (she has to phone and find another qualified person)."

Medical care (including older people's care)

- The standard operating procedure for the medical day care unit stated that the unit should be staffed by two registered nurses. It stated "Where it is not operationally possible to provide two trained nursing staff on any given day, medical day care unit will be covered by one trained nurse and one nursing auxiliary. Coordination will be required between medical day care unit and ambulatory emergency care unit/emergency department to ensure that breaks are covered and to facilitate drugs counter-signing requirements." Staff in ambulatory emergency care unit confirmed they were frequently called to assist in medical day care unit. Concerns were expressed about the remoteness of the department and the vulnerability of staff working on their own, should a patient suddenly deteriorate. This posed a risk to patient safety.
- During our visit the medical day care unit was staffed by two registered nurses. The trust told us that there had been three occasions during the three months prior to our inspection when there was only one registered nurse staffing the unit for the whole day but they were not able to provide assurance that the unit was consistently appropriately staffed.
- The ambulatory emergency care unit was not consistently fully staffed. When we visited the department during our unannounced inspection there was one registered nurse working on their own. They told they were supposed to be assisted by a nursing assistant but this staff member had not arrived. They told us they had not complained because they knew that the emergency department was very busy (the ambulatory emergency care unit was staffed from the emergency department staffing establishment). We asked them if this was a frequent occurrence at weekends and they told us "it is a lucky dip". We asked them how they would deal with an emergency situation, for example if a patient's condition deteriorated. They told us they would run to the adjacent emergency department and shout "help!" While we were in the department the nurse had to leave the department briefly to take blood specimens to the pod. There was only one patient in the department and she checked with them that they were happy for her to leave the department. They told us they would not be able to do this if they were concerned about any of their patients. They would have to ask for assistance from the emergency department, as they did when they needed a second signature for medicines administration or to take a break.
- The trust confirmed that there was one occasion in March 2015 and two occasions in May 2015 when a nurse worked single-handed in the ambulatory emergency care department at the weekend.

Medical staffing

- Medical staffing levels and appropriate skill mix were not always provided to ensure that that people received safe treatment at all times.
- The proportion of senior medical staff was lower than the England average.
- The division's risk register (31 March 2015) recorded a very high ('red') risk due to "insufficient medical workforce to deliver care across the division." It was recorded that there was an inability to recruit suitably qualified and experienced consultant physicians (acute medicine, respiratory medicine and gastroenterology). There was a funded establishment of 13 whole time equivalent (WTE) consultants (excluding cardiology, which was fully staffed). There were 4.2 WTE vacancies with one WTE being covered by a long term locum. Only 6.8 WTE consultants were actively employed and only five WTE maintained the on call rota which was supposed to be maintained by 11 WTE. The director of medical education told us the physicians worked extremely hard but were under huge pressure.
- It was widely acknowledged by consultants that with a 40% deficit in their numbers they were under immense pressure. The shortfall meant that consultants were unable to undertake ward rounds every day or at weekends. We were told by the division's clinical director that that most wards had two consultant-led ward rounds per week. However, junior medical staff and nursing staff told us that this was not always the case. On one ward a staff member told us that one of the consultants only ever visited the ward when their colleague was on leave.
- A doctor on one ward described senior medical cover as "fragile when anyone is away". They told us that during periods of consultant absences, assessments and discharges were delayed.

Medical care (including older people's care)

- The divisional risk register (March 2015) highlighted that there was a shortfall in rheumatology capacity due to the absence of the rheumatology consultant. This meant there was a risk of impacting on referral to treatment times. It was recorded that there was no locum cover in place.
- Concerns were expressed to us by both junior medical staff and nursing staff that lack of access to consultant staff impacted on junior doctors' workloads and the tasks they were expected to perform. A nurse told us "we have a skeleton medical staff; it is incredibly stressful for junior doctors." Another nurse told us that junior doctors were left on their own too much and lacked appropriate supervision. They told us that nurses supported junior doctors as much as they could.
- A junior doctor told us that "nursing staff have taken the role of the specialist registrar (SpR) to help junior doctors". They told us they had been asked to cover another ward and specialty to cover a shortfall in the rota and did not feel competent or supported.
- A junior doctor reported that often medical staff handovers were junior doctor to junior doctor and were completely unsupervised.
- The Director of Medical Education confirmed that the deanery had received a number of complaints from junior doctors. They said they felt the complaints were "fully justified".
- At the junior doctors' forum meeting in March 2015 a junior doctor reported having to carry two bleeps when their colleague called in sick at short notice. It was also reported that locum cover was not always provided for gaps in the rota, even when notice had been given that there was a gap. A doctor told us that a locum had been employed in surgery but they had refused to cover medical patients on the second floor (normally covered by surgery). This meant that the junior doctor on call had to cover wards on the first and second floors. It was reported that junior doctors had contacted the British Medical Association for support because they believed their rotas were not compliant with working time regulations. Junior doctors told us that there was significant disparity between the hours that they were rostered to work and the hours that they actually worked. It was reported that one consultant had refused to sign off a junior doctor's hours unless the record was falsified.
- We invited junior doctors to attend a focus group during our visit. Twenty-nine doctors attended, the majority of whom worked in medicine. Following the focus group a further interview was requested with us to feedback conversations which had taken place in the doctors' mess.
- Eleven doctors told us that medical staffing levels were unsafe. They told us that because of a lack of senior medical cover, they were expected to undertake tasks which they were not trained or competent to undertake. For example, a junior doctor had been asked to undertake sedation when they had not received training in advanced airway management or advanced life support. They reported that they had been unable to obtain support from more senior and appropriately qualified colleagues. They had reported this situation as an incident but neither they nor we received any assurance that steps had been taken to mitigate this risk.
- Several junior doctors told us that they were pressurised to work extra hours on call to cover gaps in the rota and they were tired. "
- A junior doctor told us that consultant reviews of patients were "sketchy" and it was difficult to get patients reviewed. This meant that they were forced to make decisions that they felt uncomfortable with. Another junior doctor told us that ward rounds did not take place as planned due to the rota, rest days and annual leave. They said it was not unusual for one ward round per week to be undertaken by a foundation year 1 doctor.
- We spoke with five consultants. They acknowledged junior doctors' concerns about workload and told us they had recently set up a working group to look at ways in which working patterns could be improved.
- Consultant cover in MAU was appropriate, with two consultants providing day time cover (including responsibility for expected medical patients in the emergency department). They performed a daily morning ward round. A post-take ward round was

performed by the on call consultant on weekday evenings. Out of hours cover was provided by consultants on call who performed a morning and late afternoon ward round.

- In the ambulatory emergency care unit medical cover was provided by a specialty doctor from 10am to 6pm, assisted by an F2 (foundation year 2) doctor or a physician's associate on an alternate week basis. Senior medical cover was provided by an acute care consultant on a rota basis. After 6pm medical cover was provided by the medical registrar on call. At weekends medical cover was provided by the high care medical registrar from 1pm to 5pm, supported by a consultant on call.

Major incident awareness and training

- There was an escalation policy which provided clear guidance on responsibilities actions when there extreme demand pressures. During the winter additional funding had allowed the provision of additional resources and facilities to increase capacity. It was acknowledged, however, that there were other seasonal fluctuations in demand with the influx of holiday visitors to the town. The management team and patient flow team took account of this and planned accordingly. Staff we spoke with were aware of arrangements for dealing with extreme surges in activity; however, they could not tell us when they had last practised arrangements for a major incident. There was a major incident plan but no evidence was provided to demonstrate that staff were familiar with or trained to implement it.

Are medical care services effective?

Requires improvement

There was limited evidence that the division measured patient outcomes and provided care and treatment in accordance with evidence-based guidance and good practice. Concerns were raised by junior doctors that there was a lack of treatment protocols and guidance and that where protocols did exist, they were not consistently followed. There was limited participation in national clinical audits and little evidence of dissemination and learning from audit. Performance against national standards in relation to stroke care, although improving, was below the national average.

We saw excellent multidisciplinary team working and a focused and cohesive approach to care planning and discharge. The trust's average length of stay was better overall than the England average, although worse in some specialties.

The trust had scored well in the 2014 staff survey in relation to the provision of training. Feedback we received from nursing staff was consistent with this. However junior medical staff told us that access to training, supervision and support was poor. This was supported by the trust's Director of Medical Education and the General Medical Council Survey (2014).

Evidence-based care and treatment

- There was some evidence that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and good practice. However, there was limited evidence to show that the trust consistently complied with guidance such as NICE guidelines.

- The Medical Professional Standards for the Management of Inpatients Policy outlined the consultant physicians' responsibility to ensure that patients were reviewed daily. The policy stipulated that board rounds should take place morning and afternoon and should be led by a consultant or specialist registrar. Staff told us that board rounds took place regularly as required, although consultant and specialist registrar presence was not consistent, for example on the stroke unit. The divisional management team told us that consultant-led ward rounds took place twice a week on medical wards but concerns were expressed by junior doctors that their consultant-led ward rounds were "irregular" and sometimes junior doctors conducted ward rounds on their own. One junior doctor told us their consultant attended only one ward round per week and they were difficult to get hold of if they needed input at any other time. Another junior doctor reported they only saw their consultant four times in the space of 20 days. Serious concerns were expressed about senior medical cover on Kewstoke ward where it was reported that a junior doctor usually led the ward round and the consultant "occasionally attended". Access to consultants on MAU was reported to be good.

- The Medical Professional Standards for the Management of Inpatients Policy (April 2014) stated that

'model ward' principles were being rolled out across the medical division. A rounding tool was used to document a range of quality indicators at each ward round and this form was kept in patients' medical records. Indicators included diagnosis, treatment plan, discharge criteria, risk assessments/screening, resuscitation decision, presence and reason for cannula or catheter, review of medicines chart and reason for staying in hospital. We saw this document in use during our visit.

- On Uphill ward, the team was in the process of developing and implementing a new rehabilitation pathway. External consultants had assisted the team to develop new processes which would enhance the rehabilitation culture. A new care planning document had just been introduced which was designed to be completed every day by members of the multidisciplinary team. Every three days the Barthel outcome measure (a tool used to measure performance in activities of daily living) was used to review patients' progress. A new referral tool had been developed to ensure that referrals to the ward were appropriate. Adaptations were being made to the ward to provide opportunities for patients to engage in normal daily activities, such as cooking and dining and socialising with other patients. However, an occupational therapist told us that with existing staffing levels, rehabilitation was limited outside of the hours of 8am and 4.30pm and the quality of therapy intervention the team was able to offer was limited.
- Minutes of the divisional governance meeting in August 2014 reported NICE compliance as being "a weakness across the trust, as well as national audits". It was reported in the divisional quality and governance assurance report for February and March 2015 that a gap analysis was to be completed for all relevant NICE guidelines.
- A junior doctor told us that there was limited guidance available on the treatment of medical conditions. At the junior doctors' forum meeting in April 2015 it was reported: "protocols are hard to find and the ones that are on there (the intranet) need updating and some are missing altogether." In response to this, we were told, the junior doctors were encouraged to search for protocols produced by other trusts and to use these for information. On the stroke unit there were clear, up-to-date guidelines on stroke management available on the intranet. A referral form for patients with TIA (transient ischaemic attack or 'mini stroke') had also been recently reviewed and included a clear flow chart.
- A junior doctor told us that clinical guidelines were not adhered to. For example, chest x-rays were not always performed post-pneumonia and there was no ultrasound guidance of chest drains.
- There was limited evidence of local audit activity. The clinical director acknowledged that workload impacted on this and there was little evidence of dissemination of learning following audit. Monthly audits had begun to be presented at divisional governance meetings but consultant attendance at these meetings was variable. Audits included two recent quality improvement programmes: an audit of the management of community acquired pneumonia (March 2015) and an audit of the management of acute kidney injury in accordance with NICE guidelines. The latter audit was undertaken by a team of doctors, including junior doctors and a student doctor. It was reported that a number of actions arose from the audit, including teaching, the introduction of a sticker to be affixed to patients' medical records and a poster with prompts to diagnose and manage acute kidney injury.
- In 2010 the endoscopy unit was inspected by the Joint Advisory Group on gastrointestinal endoscopy and received the official certificate of competency (a national measure of quality and safety against rigorous standards). The service was due to be re-assessed in 2015.
- The chemotherapy day unit had met national cancer peer review standards, which had included annual nurse assessments. Patients were pre-assessed two to three days before treatment. There were written treatment protocols which were printed for each patient.

Pain relief

- Pain management was a quality indicator audited on each ward every month. In October 2014 wards scored the following:

Berrow ward 80%

Harptree ward 75%

Kewstoke ward 100%

MAU 90%

Stroke unit 70%

Uphill ward 70%

- Most of the patients we spoke with told us that pain relief was provided promptly when they needed it. Pain relief was discussed with individual patients during matrons' daily ward visits.
- On Harptree ward a patient had been prescribed a pain relieving patch to be applied at 8am every 72 hours. On two occasions the supply had run out and the patient had to wait until 12pm until a new supply was delivered. The delay caused them discomfort and anxiety on both occasions.

Nutrition and hydration

- Patients had nutritional assessments on admission. Staff used a recognised nutritional assessment tool and where indicated, patients' nutritional and fluid intake was monitored. We saw evidence of this in patients' records. We observed that inpatients had easy access to drinking water at all times.
- There was a team of ten dieticians supporting inpatient wards from Monday to Friday.

Patient outcomes

- The trust participated in the 2014 cancer services peer review. Concerns raised included: lack of interventional radiology input (upper GI), causing delays in patient treatment, lack of oncologist cover for all of the MDT meetings and failure to achieve quorate MDT meetings for the treatment of lung cancer. Concerns were developed into an action plan which was monitored by the cancer management group and cancer strategy steering group. We were provided with the most recent version of this action plan, dated 18 May 2015 and noted some progress; however, there were a number of actions where the review dates and deadlines had passed. The status of the above three concerns was recorded as 'red' (action not started) or 'amber' (in progress). This meant that patients were not benefiting from the knowledge and expertise of a full multidisciplinary team when decisions were made about diagnosis and care and some patients were experiencing delays in their treatment.
- The trust performed poorly in the Sentinel Stroke National Audit Programme (SSNAP). Trusts are scored from 'A' to 'E', with 'E' representing the worst score. Between October and December 2014 the trusts scored 'D'. This represented an improvement on the previous quarter when the score achieved was 'E'. Improvement was needed in relation to therapy input, where staff shortage impeded progress. We were also told that there was a lack of community-based stroke facilities in North Somerset which affected performance against the discharge performance indicator.

However, in December 2014 and January 2015 the trust exceeded the target which requires that 80% of stroke patients spend 90% of their inpatient stay in a specialised stroke unit.It was reported to the board in March 2015 that the patient flow team had been instructed to keep a 'hot bed' for both sexes available at all times to ensure that all stroke patients could be promptly transferred from the emergency department (ED) to the unit to start their care and treatment. The sister on the stroke unit told us that this was challenging but mostly achieved by keeping a side room free, which could be used for patients of either sex. The hot bed was available during our visits.

- The trust performed worse than the England average for two of the three applicable Myocardial Ischaemia National Audit Project (MINAP) indicators (2013-14). However, referral rates for angioplasty for non-STEMI patients were above (better than) the national average.
- The standardised relative risk of re-admission for non-elective admissions was higher (worse) than the England average overall, although lower (better) in gastroenterology. For elective cases the risk of re-admission was lower (better) than the England average in haematology and oncology. The trust monitored emergency re-admissions within 14 and 30 days. It was reported to the board in March 2015 that the trust had achieved the lowest re-admission rate in 12 months over the last quarter (November 2014 to January 2015), with rates consistently below 6%. It was noted that the division was undertaking regular audits of re-admissions to provide assurance that patients were not being re-admitted as a result of the trust's treatment and care or inappropriate discharge. The most recent audit showed that the majority of patients had been appropriately discharged.

Medical care (including older people's care)

- The trust performed significantly worse than the England averages for all but one of the indicators in the Heart Failure Audit 2012/13, although a consultant cardiologist doubted the accuracy of the data.
- The trust performed better than the England median for most of the indicators in the National Diabetes Inpatient Audit September 2013.

Competent staff

- Most nursing staff told us they had received appropriate training, learning and development relevant to their role. This was consistent with results from the 2014 staff survey where the trust scored higher than the national average.
- There were clinical nurse specialists in stroke care and respiratory medicine who provided advice, support and training to staff trust-wide.
- Physicians' assistants were employed to support medical and nursing staff and were trained to undertake a range of investigations and procedures, such as venepuncture, femoral nerve blocks and arterial blood sampling. Physicians' assistants reported that they were well supported and supervised by medical staff.
- Feedback from junior medical staff however, was less favourable. The national General Medical Council (GMC) survey (2014) identified concerns in training experience, teaching, supervision, workload and overall satisfaction in all grades of trainee doctors in medicine. This was consistent with much of the feedback we received from junior doctors:
- Many junior doctors told us that access to teaching was limited and unstructured. There was ad-hoc teaching during ward rounds and some formal teaching took place at Thursday teaching sessions but the standard was described as variable.
- There was a 'grand round' on Wednesdays but this had been cancelled for the two weeks prior to our inspection and some staff told us they could not attend due to their workload.
- There were no mortality and morbidity reviews on some wards so that learning could be taken from deaths and unexpected clinical outcomes. The trust told us they used a 'global trigger' audit tool to identify triggers and potential causes of death and unexpected outcomes.
- Some junior medical staff told us they were not encouraged to take part in audit. The divisional clinical director acknowledged that some locum consultants did not participate in teaching or audit activity.
- A junior doctor told us they had missed mandatory training due to their workload.
- Teaching on the stroke unit was described by junior doctors as "good" but they reported a lack of engagement by consultants. We observed a consultant-led ward round on this unit where informal teaching took place. We were told that regular teaching also took place on MAU.
- A doctor told us it had been "impossible for three months to arrange consultant teaching" for an exam in Practical Assessment of Clinical Examination Skills (PACES), which was part of the MRCP qualification.
- Consultants told us that they thought junior medical staff teaching was good.
- In the 2014 staff survey the trust scored worse than the national average for support from immediate managers. Most nursing staff told us they were well supported and received regular mentoring and supervision.
- Junior medical staff expressed concerns about lack of support and supervision from consultants.
- On one ward a junior doctor told us that ward rounds with consultants "can be intimidating" and expressed frustration that ward rounds were rushed and consultants did not take patient histories' relying on junior doctors to bring issues to the fore. Another junior doctor told us that they often conducted ward rounds alone and that one particular was not accessible or supportive. A third trainee doctor told us that consultants only saw their own patients. They had to seek support from the medical register on call to review sick patients. Cardiology support within the hospital from consultant and middle grade staff was not always easily available.
- A junior doctor told us that when they worked one particular medical specialty they were put under pressure to provide a specialist opinion for an emergency patient. There were no senior medical staff available to respond and they were put under pressure to respond. They told us "You get this pressure everywhere across the medical floor."
- One junior doctor told us that they were regularly asked to conduct solo ward rounds two to three days in a row.

They were expected to make management decisions and make assessments about suitability for discharge without adequate senior medical support. They had reported their concerns on more than one occasion but had received no response.

- A junior doctor told us they had been asked to step up to the role of specialist registrar with no resident specialist registrar or consultant support. They had reported their concerns and it had not happened since.
- The trust-wide appraisal rate was 88.1% in January 2015.

Multidisciplinary working

- Staff and teams worked well together to deliver effective care and treatment. In the 2014 staff survey the trust scored higher than the national average for 'effective team working'.
- The trust's Medical Professional Standards for the Management of Inpatients Policy (April 2014) reflected the principles and best practice set out in Ward rounds in medicine: Principles for best practice, jointly published by the Royal College of Physicians and Royal College of Nursing (October 2012). This emphasises the importance of multidisciplinary professionals actively participating and interacting in ward rounds.
- There were twice daily multidisciplinary (MDT) meetings held on each ward between Monday and Friday. We observed MDT meetings on the stroke unit, MAU and Uphill ward, attended by a range of staff, including junior doctors, nurses and therapists. On MAU a member of the discharge planning team also attended. Meetings were structured, focussed and effective, with a clear plan recorded for each patient. There were discussions about patients with complex needs and the need to seek specialist support from other services, such as dietetics and the mental health liaison team.
- On the stroke unit the housekeeper and cleaners were long-standing employees and were regarded as integral members of the team.
- All medical wards had access to therapy services. However, the divisional risk register highlighted lack of therapy staff capacity as a 'red' rated risk. It was recorded: "as a result of increased demand (both numbers of patients and demands on therapy time) and lack of staff, particularly in physiotherapy, speech and language therapy, occupational therapy and dietetics, there is a risk that patient treatment will be compromised and the trust will not meet targets e.g., SSNAP." Staff on the stroke unit and Uphill ward confirmed that patients sometimes experienced delays in their treatment because of staff shortage in this area. On Uphill ward staff told us that there was excellent support provided by therapy staff but the team did not have the capacity to cover for staff absences or weekend working and this delayed and compromised the quality of patients' rehabilitation programmes.
- We noted there was no access to psychology support. The clinical nurse specialist for stroke care told us patients who had experienced a life changing illness or injury would benefit from this support.
- On MAU there was regular review of patients by sub-specialties such as respiratory medicine, cardiology and oncology; however this service was not available at weekends.
- On Uphill ward a rehabilitation project was underway which was focussed on a multidisciplinary approach to care. Nurses, physiotherapists and occupational therapists worked as one team, with a range of shared minimum competencies and over-lapping roles. There were plans to appoint an activities coordinator to the team.

Seven-day services

- Consultant cover out of hours was provided on call. There was no cardiology consultant cover at weekends and during bank holidays. If requested by junior medical staff patients on non-emergency wards would be seen by the on call (general medicine) consultant.
- Therapy services were not routinely available out of hours, although there was a physiotherapist available on call.
- Pharmacy services were available on Saturday mornings but closed on Sundays, although an on call pharmacist could be called in an emergency.
- The endoscopy service operated between Monday and Friday but emergency endoscopy was performed outside of these hours in theatre. There was an endoscopy nurse on call to support.

Medical care (including older people's care)

- The discharge lounge was open between Monday and Friday only. On the day of our unannounced visit (Saturday) a nurse expressed concern that they had come under pressure to free up a bed and the patient being discharged had to wait in the ward day room for transport. They were concerned that the patient could not be observed there.

Access to information

- Patients' records were easily accessible for all members of the MDT and staff reported no problems with access to information when patients moved between teams.
- Care summaries were sent to GPs to ensure continuity of care within the community, although it was reported that this communication was not always as prompt as it should be.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of their responsibilities in relation to consent, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).
- As of September 2014, 71.8% of staff in the emergency care division had received training in the Mental Capacity Act 2005.
- Where people lacked capacity staff made best interests decisions in accordance with legislation. Advice could be sought from the trust's DoLS team.

Are medical care services caring?

Good

Feedback from patients and relatives was overwhelmingly positive. Nursing staff in particular were praised for their friendly, compassionate and caring approach. Staff were on first name terms with their patients, where appropriate, and had taken the time to understand their needs and preferences. Patients and their relatives were involved as partners in their care. Staff took time to ensure that patients and those close to them understood their condition and their treatment. Patients were treated as individuals and their dignity was respected.

This feedback was consistent with information in patient surveys and what patients and their relatives told us during our inspection. We observed very positive staff interaction with patients in all of the areas we visited.

Compassionate care

- We saw staff interact with patients in a friendly, considerate and supportive manner. All staff, including housekeepers and cleaners, were familiar with the patients on their wards and chatted to them as they went about their work.
- On Kewstoke ward patients told us: "The nurses are fabulous", "Everyone is friendly" and "They look after me really well". We saw a patient being discharged and many of the ward staff came to say goodbye. During the tea round we observed the housekeeper chatting to patients in a friendly manner.
- On the stroke unit comments from patients and relatives included: "Wonderful place, nurses so caring and kind", "everything great; couldn't have my (relative) in a better place" and "The staff are wonderful, kind, funny; they chat to you and treat you as an individual."
- On Uphill ward patients told us: "I have been very well looked after"; "I think the ward is very good; the staff are always cheerful" and "the staff are very nice; I can't fault them."
- The trust used the friends and family test (FFT) to capture patient feedback and this showed mostly high levels of satisfaction. The friends and family test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family. Exit cards were also given to patients on discharge asking them "how was your nursing care?" Friends and family test feedback in January 2015 showed that the percentage of patients who would recommend the service was as follows: Berrow ward 98%, Cheddar ward 90%, Kewstoke ward 57%, Stroke unit 100%, MAU 96% and Uphill ward 92%.
- In the 2014 cancer patient experience survey (for inpatients and day case patients with a primary diagnosis of cancer discharged between September and November 2013) 89% of respondents rated their care as 'excellent' or 'very good'. The trust scored in the top 20% nationally in 10 questions, in the middle range in 48 questions and in the bottom 20% for 12 questions.

Medical care (including older people's care)

The high performing areas included: information provided about financial support and free prescriptions, staff providing a complete explanation of what would be done, patients given enough privacy when discussing their condition/treatment or being examined/treated. The low performing areas included: staff providing information about support groups, provision of information and explanation about tests; side effects explained in an understandable way, patients given the name of a clinical nurse specialist in charge of their care and patients given the right amount of information about their condition and treatment. There was an action plan to address areas of concern. The trust had improved the provision of patient information and was conducting a series of more focused surveys with patients to identify further areas for improvement.

- We saw staff taking care to observe patients' privacy and dignity. Curtains were drawn when examinations and personal care took place. Confidentiality was also promoted; staff took care to discuss patients away from the ward areas.

Understanding and involvement of patients and those close to them

- Patients told us they were kept informed about their condition and their treatment. However, a family whose relative was on the stroke unit told us that doctors were rarely available to speak with.
- On Berrow ward we observed a doctor engaging with patients during a ward round. They knelt down to speak with a patient and explained their treatment plan using clear, simple language that the patient could understand. All patients were asked if they had any questions.
- Families were involved as partners in care. We heard staff discuss plans to liaise with families about future care packages. Multidisciplinary team meetings were arranged with families at a time to suit them.

Emotional support

- Patients and those close to them were provided with support to help them cope emotionally with their care, treatment or condition.
- At the MDT meeting on Uphill ward we witnessed a discussion about the need to provide emotional support to a patient's relative. Staff also discussed how they could facilitate a patient to attend a relative's funeral.
- People were enabled to have contact with those close to them. A patient on the stroke unit told us that they missed their dog. The nursing staff had arranged for the dog to be brought in and took the patient off the ward to spend time with them.
- On Kewstoke ward we observed staff transferring a call from a relative to a mobile phone and taking it to the patient.
- Emotional support was provided on the stroke unit by a volunteer who visited the ward regularly and spent time chatting to patients who needed company and support.

Are medical care services responsive?

Requires improvement

Services were not always delivered to meet people's needs. Although premises were largely fit for purpose, there were concerns about accommodation in the medical day care unit and the ambulatory emergency care Unit. Both of these areas were cramped and patients' comfort, privacy and dignity were compromised.

Bed occupancy at Weston General Hospital was high. Bed capacity and patient flow was a constant challenge. Patients did not always receive care and treatment on the most appropriate ward and some patients were moved several times during their inpatient stay, sometimes at night. Patients were not always discharged in a timely manner, partly due to staffing issues resulting in delayed treatment and partly due to difficulties arranging suitable care packages in the community.

The divisional management team was very focused on patient flow and was taking steps to improve efficiency and reduce delays and length of stay.

The service took account of patients' individual needs, particularly the complex needs of older people who represented a large proportion of the inpatient population.

Medical care (including older people's care)

We observed that nursing staff on wards were attentive and responsive. Patients were given assistance when they needed it, whether this was assistance with personal care, mobility or support to eat and drink.

Service planning and delivery to meet the needs of local people

- Facilities and premises were not always appropriate for the services delivered. There was a medical day care unit which provided treatment for patients who required transfusions or infusions on a planned or semi-planned basis, and who would otherwise deteriorate and present at the emergency department as an emergency. The unit operated five or six days per week between 9am and 6pm. The division's risk register (March 2015) highlighted the risk to patient privacy due to the environment in the medical day care unit. A patient we spoke with at our listening event in January 2015 told us that the environment was cramped, with patients sitting 600mm apart, and drip stands and tables in the available space. They also complained that the chairs, although they could be reclined, were uncomfortable for patients who underwent lengthy treatments. They were concerned about patient privacy, infection control risks and the risk of staff and visitors tripping over equipment. They also told us that there was no room to accommodate patients' relatives/friends. Staff acknowledged that the environment was not appropriate and that lack of space impacted on patients' comfort, personal space and confidentiality. The risk register recorded that there were plans to relocate the medical day care unit so that it was co-located with the discharge lounge, which was a larger space.
- There was an ambulatory emergency care unit which provided assessment and treatment for patients who attended the emergency department but who were not sufficiently acutely unwell to require treatment there, and were unlikely to require admission. This unit was open between 9am and 7pm on Monday to Friday and between 10am and 5pm at weekends.. Patients remaining in the department after it closed would either be admitted to an inpatient ward or would be cared for by emergency department staff while they waited for final medical review or results of investigations.
- Patients attending the ambulatory emergency care unit were accommodated in an unsuitable environment. Patients were seated in a cramped waiting area, sometimes for long periods of time. There were eight waiting room chairs and when the area was full, people had very little personal space. Staff told us that the waiting room very often overflowed into the adjacent emergency department waiting room or the outpatients department. There was some limited reading material provided but there was no television. There were vending machines in the adjacent emergency department and staff offered patients drinks and snacks.
- Although consultations, tests and treatments took place in private consultation rooms, these were also sometimes used for patients who needed to lie down. In order to ensure they could be observed by staff, the doors were left open and patients were in full view of people (other patients, staff and visitors) using the corridor, which was a thoroughfare to other departments.
- We saw from records that some patients stayed in the ambulatory emergency care unit department for long periods of time and we did not consider that this was a suitable environment to wait for anything but a short period of time. On 13 May 2015 a 76-year-old patient stayed in the department for seven hours and a 78-year-old stayed for nine hours. On 15 May 2015 an 80-year-old patient stayed in the department for seven and half hours and on 20 May an 84-year-old patient stayed in the department for four and a half hours.
- The division's clinical director told us that they were proud of the ambulatory emergency care service. One of the performance indicators used to measure success was the proportion of patients who were admitted to a bed in the hospital from the ambulatory emergency care unit. If the department is used effectively and appropriately, this should be a small proportion of patients. The clinical director told us that approximately 10% of patients who attended ambulatory emergency care unit were subsequently admitted as inpatients. However, we were told that this was an estimate as the number of patients admitted from the ambulatory emergency care unit was not routinely audited. A 'snapshot' audit was undertaken in response to our request. This showed that from a sample of 500 patients seen in AEC between 15 March and 1 May 2015, 4% were subsequently admitted.

- We saw that a number of inappropriate referrals to the ambulatory emergency care unit had taken place during May 2015. On 12 May it was documented in the ambulatory emergency care unit diary for two patients that the reason for their referral was "breach avoidance". This was again documented on 14 May for one patient. This suggested that patients had been referred to the unit for reasons that were not based on their clinical need and to avoid breaching the waiting time in the emergency department.
- Car parking was raised as a concern by a number of visitors to the hospital. One visiting relative told us it had taken them 35 minutes to find a parking space.

Access and flow

- Patients did not always receive access to care and treatment in a timely way. Patients were not always admitted to the most appropriate ward because of issues of bed capacity and patient flow. Discharges were sometimes delayed, causing blockages which impacted on this and on emergency department waiting times.
- There was a policy, Medical Professional Standards for the Management of Inpatients, which set out standards "to ensure that patients were cared for by the right team, in the right place for the right amount of time."
- There was a patient flow team who coordinated flow within the hospital and worked well with the rest of the hospital.
- The trust monitored performance daily and monthly against delayed transfers of care. A delayed transfer of care is defined as when a patient is ready for transfer from acute care but is still occupying a bed. Monthly performance against a threshold of 3.5% was variable. An improving trend was noted in December 2014 when performance was 0.8%, although this worsened in January 2015, with performance at 3%. February and March 2015 saw another improvement with performance between 1 and 2%. It was reported to the trust board in March 2015 that "there is still considerable work to do with partners and the use of the 'green to go' list (a list of patients who are ready for discharge)." It was noted that agencies and other care providers were invited in regularly to assess patients, particularly those who may have complex needs, with a view to discharging them as soon as possible. Daily 'green to go' meetings were held, with all North Somerset organisations represented. Daily teleconference calls with senior representatives from across the health community, reviewed performance indicators.
- During our visit we were told that approximately half of patients on Kewstoke ward were ready for discharge but this had been delayed because care packages had been delayed. Two patients on the stroke unit expressed frustration that they were ready for discharge but this had been delayed.
- The average length of stay in medical services overall was shorter (better) than the England average. However, length of stay varied across different specialties: For elective admissions it was higher than the England average in general medicine and respiratory medicine and for non-elective admissions it was higher than the England average in the rehabilitation service and in gastroenterology. The average length of stay was consistently below the trust's target (three days) between April and November 2014 but increased to three days in December 2014 and January 2015 due to the higher acuity of patients. The trust also monitored percentage of patients with a length of stay over 10 days and had achieved a steady reduction year on year as a result of the programme of work to improve patients' pathways and a focus on the 'green to go' list. The introduction of the ward rounding tool was also thought to have had a positive impact on length of stay.
- The division had taken steps to ensure that the discharge process was as efficient as possible and that preventable delays did not occur. The Medical Professional Standards for the Management of Inpatients Policy set out these steps.
- The policy stated that all patients should have an expected date of discharge (EDD) identified and recorded within 24 hours of admission. This date was to be reviewed as part of the board round process and any changes would be made on the predicted date of discharge (PDD). We saw evidence that discharge dates were planned and documented in all of the patients' records we reviewed and these dates were regularly reviewed by the multidisciplinary team and displayed on each ward's MDT white board.
- The policy stated that TTOs (to take out medicines given to patients when they are discharged) should be

completed at least 24 hours before discharge. For same-day discharges the TTOs and discharge summaries should be completed by midday. Staff on some wards and in the discharge lounge reported that delayed TTOs were an ongoing problem which delayed patients' discharge. There was ongoing education of junior doctors to ensure that TTOs were anticipated and organised as soon as possible and not left until the day of discharge.

- The policy stated that at least 50% of patients being discharged should leave the ward before midday, either directly home or to the discharge lounge. The discharge lounge operated from 9am to 6pm Monday to Friday and was staffed by two nursing assistants. However we found that it was not being used effectively. Nursing staff on Uphill ward told us the discharge lounge was not used regularly or frequently. This was because they did not consider it to be a safe or appropriate area for patients who were cognitively impaired or patients with limited mobility. We fed this back to the discharge planning team who told us that two patient trollies were now available in the discharge lounge. This meant that patients who needed to lie down, such as patients who needed to be transported by ambulance on a stretcher, could do so. When we visited the discharge lounge, we saw there were two cubicles but only one was equipped with a trolley. The nursing assistant who was staffing the area told us that this trolley had only arrived that week. They were not aware of a second trolley and felt that with the current staffing levels, they would not be able to safely care for patients because there was no direct line of sight from the waiting room and their work station. The cubicles were not equipped with call bells. On the day of our visit there was only one nursing assistant on duty in the area. They confirmed that this had been the case on a number of occasions recently and that this would limit the number of patients that could be accepted in the area. They told us that when there was only one member of staff on duty they could not leave the department to collect patients TTOs or collect snack boxes so they had to find staff from another department to run these errands.
- Regular multidisciplinary board rounds (reported earlier this report under the section entitled "are medical services effective?") ensured that there was a constant focus on patient flow. Meetings were attended by a member of the discharge planning team so that they had an overview of inpatient activity across the hospital and could identify any blockages.
- The patient flow team told us that fewer discharges took place at weekends, although the trust was taking steps to improve this. The hospital out of hours' team, staffed by senior nurses, monitored and coordinated patient flow, liaising closely with the emergency department to oversee admissions and with wards to ensure that all possible discharges could be facilitated. There was a junior doctor (Foundation year 2) on duty who was responsible for reviewing and facilitating where appropriate, planned discharges i.e. those that had been anticipated on a Friday. During our unannounced visit the hospital was under significant pressure to find beds, while patients waited too long in the emergency department. On the MAU this situation had not been helped because the consultant morning round had not taken place until late morning and the pharmacy had closed at 12.30pm, making it difficult to facilitate a safe discharge for patients with appropriate medicines to take home.
- At times of pressure on medical beds, patients were accommodated on non-medical wards. These were known as medical outliers. The patient flow team told us they made every effort to ensure patients were accommodated in the most appropriate ward but outliers were an ongoing and daily problem. The Medical Professional Standards for the Management of Inpatients Policy set out standards for the management of these patients. There was a dedicated team identified as responsible for patient review and advice for medical outliers on each ward during weekdays, with responsibility transferring to the medical take/on call medical team out of hours.
- Between April 2014 and April 2015, 4.5% of medical inpatients spent time on surgical wards. On the day of our unannounced visit, we were told that there were six medical outliers in the hospital. Four were accommodated on surgical wards and two on the stroke unit.

Medical care (including older people's care)

- At the junior doctors' forum meeting held in April 2015, junior doctors reported concerns that patients were being moved to wards which were not suitable for them and they were not consulted about the appropriateness of the move.
- During January 2015 the trust experienced periods of reduced flow and declared 'black escalation'. For two weeks during the month, 14 maternity beds were made available to medical admissions. This was in addition to 20 additional beds on the escalation ward (Cheddar ward) and six additional beds on the stroke unit. Substantive nursing staff were deployed to run Cheddar ward and their roles were backfilled by bank and agency staff. Nursing staff told us they felt this had a detrimental effect on patient care. On the stroke unit, staff expressed concerns that additional patients had been "squashed" into the existing ward and felt that they received sub-optimal nursing care.
- During our visit staff told us that Cheddar ward was closed; however, escalation beds continued to be used during April and May 2015. Medical and surgical patients were accommodated on an additional bay which had been opened on Hutton Ward (a surgical ward). This had been staffed by existing ward staff, supplemented by bank and agency staff.
- The number of bed moves during a patient's stay and the number of bed moves at night was monitored by the patient flow team on a patient by patient and a day by day basis, although these performance indicators were not routinely reported on because information was not collated. The trust told us that between January and March 2015 the average number of bed moves per patient stay was 1.6. During this period 119 patients were moved at night. Some bed moves were clinically appropriate but the trust did not report on the number of bed moves which were undertaken for non-clinical reasons. A patient on Harptree ward told us they had moved twice in the space of a few days. We spoke with a patient in the discharge lounge who had also been moved twice during their inpatient stay. The last move had taken place at 10pm when she reported she had been "half asleep".
- There was an admission prevent team (APT) run by North Somerset Community Partnership which provided a facilitated discharge service. We did not meet the team and the trust was unable to provide any detailed information about this service, except to say that the aim of the team was to reduce the likelihood of hospital admissions by directing patients to primary care alternatives.
- Performance against referral to treatment time (RTT) for patients who were admitted to hospital was consistently better than the England average. This standard requires that 90% of admitted patients start consultant-led treatment within 18 weeks of referral. Between November 2014 and May 2015 the trust achieved between 90% and 96% compliance with this target.
- No concerns were raised with us with regard to waiting times for diagnostic investigations.
- Access to therapy staff was not routinely monitored; however, staff told us that a shortage of therapy staff meant that some patients' treatment was delayed. The responsiveness of therapy services was audited from time to time but there had been no recent audits.
- The most recent audits carried out between May and September 2014 showed that physiotherapy and occupational therapy staff saw 100% of patients within 24 hours of referral.
- In the dietetics department an audit carried out in September 2014 showed that 89% of patients were seen within the required timescales as required by agreed priorities (priorities 1-3 require a response within one day, two days and as soon as possible respectively).
- In the speech and language therapy (SALT) department the most recent audit was carried out between February and September 2013. This showed that 55% of patients referred to the service were seen on the same day and 45% the following day. 100% of patients referred to the department with dysphagia (swallowing difficulties) were seen within the national standard timescale (two working days) set by the Royal College of Speech and Language Therapy.
- Rapid access services were provided in the ambulatory emergency care unit. This was an admission avoidance initiative. The service saw patients referred by their GP or the emergency department. The trust had recently extended the service to accept patients directly from the ambulance service.

- There were TIA (transient ischaemic attack or 'mini stroke') clinics held each weekday; at weekends patients were seen at North Bristol NHS Trust. There was access to CT scans every day but ultrasound was only available twice a week.
- Staff in the chemotherapy day unit told us that a shortage of pharmacists meant that there were sometimes delays of up to an hour in obtaining chemotherapy medicines. This affected the efficient running of the treatment sessions and patients experienced unnecessary waits.

Meeting people's individual needs

- We saw that staff took account the different needs of patients, although there was still work to be done to improve the experience for patients living with dementia. The average age of patients at Weston General Hospital was 79 years and a significant proportion of patients had some form of cognitive impairment, memory loss or were living with dementia.
- We received an anonymous complaint from a relative of a patient who was treated at the hospital during the summer and autumn of 2014. The patient, who had dementia, could not communicate or feed themselves. Their relative told us that they saw other patients ignored by staff and not assisted to eat because they could not communicate their wishes. They felt that staff showed a lack of understanding, awareness and training in relation to patients with dementia. This appeared to be an isolated complaint however and we did not see any evidence to suggest that this was a typical experience.
- The trust repeatedly failed the national target set by commissioners (Commissioning for Quality and Innovation) in relation to the identification and care of patients with dementia and other forms of cognitive impairment. The most recent report for quarter 3, 2014/15 highlighted ongoing shortfalls in performance, although some improvement had been achieved. A trust-wide audit of dementia care for inpatients was undertaken in November 2014. The audit highlighted that only 43% of patients had a cognitive care plan in place. Only 24% of patients were identified on their name board with a 'forget me not' sticker (to raise awareness of dementia to other professionals) and none of the patients who took part had a 'This is me' or 'all about me' booklet completed. Lack of staff training in dementia was also a concern, with only 46% and 50% of staff on Uphill ward and Kewstoke ward respectively having undertaken training in dementia care.
- We asked the trust for an update on progress since this audit but they were unable to provide this. However we saw a number of positive steps had been taken to improve the hospital experience for people with complex needs, including those living with dementia or other forms of cognitive impairment.
- On the stroke unit and on Kewstoke ward we saw patients with a cognitive impairment and communication difficulties had a 'This is me' profile completed in their records. This described how they could communicate, their hobbies and those people close to them. This ensured that staff caring for them could provide appropriate and individualised care.
- We observed that all patients had drinks within their reach and records showed that regular drinks were offered and people were assisted to drink where necessary. Volunteers were employed to assist people to eat and drink at mealtimes.
- On Uphill ward we observed the start of a lunch time service. All available staff were on hand to assist with serving meals. Red trays were used to alert staff to those patients who required assistance to eat and drink. The staff member serving meals was aware of each patient's individual preferences, such as portion sizes and individual needs such as the need for adapted cutlery or plate guards.
- The trust told us that on Berrow ward visually impaired patients and patients with hearing difficulties were identified to all staff at the start of each shift at the safety briefing. This was also documented on the electronic handover and then at the bedsides of those concerned with magnetic signs so that all members of the multidisciplinary team were aware and could communicate effectively. There was a link nurse who was a resource for staff and also took responsibility for checking that hearing aids were functioning. Once a week a volunteer from the local council visited the ward and provided support and advice for visually impaired patients. There was a pictorial communication book and adapted equipment to aid dexterity where eyesight was compromised.

Medical care (including older people's care)

- On the stroke unit we observed a 'quiet hour' after lunch when lights were dimmed and patients were able to rest.
- Kewstoke ward was described as the 'dementia friendly' ward and the environment had been adapted, taking into account the needs of people living with dementia. There was a 'forget me not café' where patients could socialise and enjoy a cup of tea in a safe and 'non-ward' environment. Other wards had taken steps to meet the needs of people with dementia. There were large face clocks, displaying the time day and date, to help people orientate themselves.
- All of the staff we spoke with told us they had undertaken training to care for people with dementia. There were dementia 'champions' identified on each ward who provided advice and support to their colleagues.
- Patients told us they received plenty to eat and drink and that meals were of a good quality. People's dietary needs were taken into consideration; some patients told us they had been offered alternatives when they did not like any of the menu choices. Drinks and snacks were available throughout the day and night.
- The national inpatient survey highlighted that there was room for improvement in relation to the information that patients received when they went home. Patients reported that they did not feel they had adequate information about what medicines they were taking and why, what treatment they had when they were in hospital and who they should contact if they felt unwell.
- New patients attending the chemotherapy day unit were invited to talks given by senior nurses, where they received information about their treatment. All patients were given information to take home with them following their treatment, with contact telephone numbers to use if they had any questions or concerns.

Learning from complaints and concerns

- Most of the patients we spoke with told us they knew how to complain and felt able to do so. However, one patient we spoke with in the ambulatory emergency care unit, who was unhappy with the time they had to wait, said they did not know how to complain.
- People who complained about the trust between April and July 2014 were asked by the trust to provide feedback on their experience of the complaints process. Twenty-seven out of 34 respondents said that it was easy to complain and 31 out of 34 respondents said that their complaint was acknowledged and they were informed about the trust's complaints process. However, the survey highlighted that improvement was needed to ensure that complainants were kept informed of progress and any delays in the process.
- Complaints were investigated at ward or department level and learning was shared with staff at staff meetings. Lessons were also shared across the division and were discussed at divisional governance meetings.

Are medical care services well-led?

Inadequate

The divisional management team faced significant challenges. The hospital was seeing increasing numbers of patients with an increasing acuity and age profile. This caused problems with capacity and patient flow, exacerbated by an acute shortage of consultant physicians. The divisional management team were very focussed on improving patient flow. However, they had not won the hearts and minds of all of the staff within the division and there were some significant issues to address in relation to medical staff workload, supervision and morale.

Medical leadership was seen as weak. Consultants worked very hard but they were under great pressure due to the number of vacancies. Some consultants were not visible, accessible or supportive and they showed a lack of insight into, and empathy with the pressures felt by junior medical staff. There was a very palpable feeing of discontent amongst junior medical staff who reported high levels of stress and work overload and a lack of confidence in medical leaders to either recognise or resolve their concerns. The culture in relation to medical staff was not one of fairness and openness and did not encourage challenge. Several examples of bullying behaviour were reported to us. There was little innovation or service development and minimal evidence of learning or reflective practice.

In contrast, nursing leadership was strong and focused. Senior nurses were respected and liked; nurses felt inspired and empowered through their leadership.

Medical care (including older people's care)

Vision and strategy for this service

- In the context of a trust which was subject to a transaction process, it was unsurprising that the long term vision for the trust was unclear. Within the emergency division however, the management team were very clear that their top priority was to improve patient flow in the hospital. Staff understood this but there was less clarity around how the challenges associated with capacity and patient flow were to be addressed. Many staff expressed concern about what they perceived to be constant pressure to discharge patients in order to relieve pressure in the emergency department. Managers expressed frustration that some staff failed to 'see the bigger picture' or understand the necessity to balance risks associated with early discharge with the risks associated with patients waiting in the emergency department corridor. The clinical director told us "I have not been able to convey my message adequately".
- The trust had a published set of values. Some staff struggled to articulate what these values were but all of the staff we spoke with shared as their top priority their desire to deliver safe and high quality care to patients. Many staff expressed pride in the level of care that was provided in spite of capacity and patient flow challenges.

Governance, risk management and quality measurement

- Monthly divisional governance meetings were held where a range of quality and safety performance data was reviewed and discussed. This included incidents and trends, complaints and audits.
- There was a ward audit dashboard which monitored monthly performance ward by ward against a range of quality indicators, including safety thermometer, records and cleaning audits and friends and family responses.
- Matrons conducted daily visits to the wards and spoke with patients about their experience. Feedback was largely positive but any negative feedback was immediately fed back to the ward staff and acted on immediately.
- Patient feedback was used to inform improvements. Wards displayed "you said, we did" messages. On Berrow ward it was reported that patient booklets had been produced in response to feedback from patients that they didn't know who was who on the ward.
- The division maintained a risk register which was regularly reviewed and progress in mitigating and eradicating risks was monitored at governance meetings.
- The risk register largely mirrored the concerns expressed to us by staff. However, there was one notable omission and this related to the widespread concerns expressed by junior medical staff about workload pressure and lack of support and supervision.

Leadership of service

- We asked a range of staff in the division if they felt supported, valued and respected. There was a marked difference in the feedback we received about nursing leadership and medical leadership. Nursing leadership was felt by the overwhelming majority of staff to be strong. Ward sisters, matrons, the division's head of nursing and the trust's director of nursing were seen as strong, visible, accessible and supportive; they were liked and respected. One nurse told us "They have given nurses their voice back".
- Student nurses told us they were well supported and enjoyed working at the hospital.
- In stark contrast, many junior doctors and some nurses expressed concerns about the quality of medical leadership. This was partially due to consultants' capacity and accessibility, associated with the shortage of consultants. However, we also heard comments about lack of senior input at ward rounds and consultants who were described by one doctor as "not involved or interested".
- One junior doctor told us that nurse leadership was very strong and "compensated for the lack of medical leadership". A senior clinician in the hospital acknowledged that consultant physicians were very busy and worked very hard but told us "Some physicians are not very junior doctor friendly."
- Junior doctors reported pressure to discharge patients without sufficient senior medical support. One junior doctor told us that they had been put under pressure by

a consultant to discharge a patient and they did not feel comfortable with this course of action. They told us when they challenged this, they were shouted at by their consultant. They told us "junior doctors are often in tears."

- We discussed junior doctors' concerns with the divisional management team. Issues regarding junior doctors' working patterns and their rotas were acknowledged and there was a piece of work in progress to address concerns. There was less recognition of concerns about lack of senior support and supervision. Although the clinical director acknowledged that locum consultants "don't do so much of the training and support", they and the general manager separately referred to the issues around lack of support and supervision as "junior doctors' perceptions". This showed both a lack of insight into and lack of empathy for the widespread and deep rooted concerns voiced to us.
- There was a junior doctors' forum which met monthly. The forum was chaired by the director of medical education and was attended by members of the executive management team. Issues raised by junior doctors included rotas and their inability to book leave because rotas were not published sufficiently in advance. They raised concerns about conducting ward rounds without senior support, being pressurised to discharge patients and being asked to perform tasks they were not trained to do. We saw no evidence that the trust was taking steps to address these concerns.
- Consultants told us they felt well supported by the division's clinical director and by the trust board.
- Many staff told us the chief executive was accessible and approachable. The trust's medical director was not regarded as visible or accessible and many staff could not name this individual.

Culture within the service

- In the 2014 staff survey the trust's score in relation to staff motivation at work was worse than average. This may have been partially attributable to staffing and workload issues.
- It was acknowledged by the chief executive that the transaction process had had an unsettling effect on staff because there was uncertainty about their future employment.
- There was a real sense of team work within the hospital and many staff told us they enjoyed working in the hospital because it was a friendly place to work. Senior nursing staff had a developed their own peer support network and met regularly to discuss concerns and find joint solutions.
- We did not find evidence of a culture in which all staff felt comfortable to raise concerns. A number of staff were anxious about speaking with us in case they might be identified in our report and penalised for this by their seniors. We were told about some examples of bullying behaviour amongst consultants. We were concerned that some consultants showed insufficient interest in the safety and wellbeing of their junior staff.

Public and staff engagement

- Patients' views were captured and used to improve the quality of care. The trust used the friends and family test and exit cards to measure patient experience. Matrons also visited wards and spoke with patients and listened to their feedback. Wards displayed "you said, we did" messages.
- In the 2014 staff survey the trust's score in relation to the level of staff engagement was in the lowest 20% when compared with trusts of a similar type.
- Although some staff were anxious about their future employment, many told us that the trust management team had made efforts to ensure they were kept informed. Some senior staff had been invited to participate in planning for future service provision.

Innovation, improvement and sustainability

- The trust's tissue viability specialist was awarded Pressure Care Nurse of the Year in March 2015 by the British Journal of Nursing. This was in recognition of an innovative campaign using gingerbread men to raise awareness of the risk of pressure ulcers. Gingerbread men were used during regular 'trolley dashes' to wards to demonstrate to doctors and nurses the areas of pressure ulcer risk by drawing on the biscuits with icing.

Medical care (including older people's care)

- On the stroke unit we saw pictorial warning notices on single bedroom doors, advising staff and visitors that rooms were being used to isolate infectious patients an what infection control precautions should be taken before entering.

Surgery

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

Information about the service

Weston Area Health NHS Trust provided a range of surgery services at Weston General Hospital (WGH). The hospital had a main theatre unit with four operating theatres, and a self-contained 15-bed day surgery unit with two operating theatres. Surgery provided included general, urology, orthopaedic, breast, colorectal, and upper gastro-intestinal. Surgery was provided as both elective (planned) and in an emergency. The hospital also provided some interventional radiology: a process of using minimally invasive image-guided procedures to diagnose and treat diseases.

At the time of our inspection the main theatre unit was undergoing planned refurbishment. The first of the four theatres had been sealed off from the main unit while work began on the updating of the area. Each of the other three theatres would then follow for refurbishment individually once the first had been completed and handed back to the department.

The hospital had two main surgery wards located opposite the main theatre unit: Steepholm, a 22-bed ward (for patients having planned or elective operations/ procedures) and Hutton, a 27-bed ward (for patients having emergency operations/procedures). The smaller Waterside ward, with 12 beds, was also used for surgery patients, both NHS and privately funded. Within surgery services, the hospital had a patient pre-operative assessment unit and an eight-bed surgery assessment unit (SAU) for patients coming either through the emergency department or admitted via their GP. The SAU was combined with the Clinical Decisions Unit (CDU) which supported medical patients coming through the emergency department or via their GP.

On this inspection, we visited the surgery services on Wednesday 20, Thursday 21, Friday 22 May 2015 and made an unannounced visit on Saturday 30 May 2015. We visited the three surgery wards, main theatres, the pre-assessment unit, the day surgery unit, and SAU (for which some data in this report is for the combined SAU/CDU). We spoke with staff, including the main and day-case theatre managers, the head of nursing, the departmental general manager, operating department practitioners, matrons, ward sisters, consultants, senior doctors, junior doctors and nurses. We also talked with healthcare assistants, pharmacy staff, housekeeping staff, a dietician and physiotherapist. We met with patients and their relatives and friends. We observed care and looked at records and data.

Weston General Hospital carried out around 11,000 operations between April 2013 and March 2014. Of these 54% were carried out as day case procedures, 12% as inpatient elective (planned) cases, and 34% as inpatient emergency cases.

Surgery

Summary of findings

We have judged the surgery services at Weston General Hospital as requiring improvement overall. Within this service there were, however, some areas judged as inadequate and others judged as good.

Patient safety requires improvement. There were some elements within safety judged inadequate and others were good. Improvement is needed in audit and use of the surgical safety checklist in main theatres; competency tests for theatre staff; the removal of used surgical instruments; medical cover out-of-hours; errors in prescriptions; patient record confidentiality; and staff mandatory training. There was a high use of agency and bank staff, and this, the trust determined, had led to a rise in avoidable patient harm. Cleanliness and infection control in most areas was good and patient records were well maintained. Risks of deteriorating patients were responded to appropriately and there was good support for patients from the allied health professionals.

Effectiveness of surgery services requires improvement to demonstrate patient care was delivered in accordance with best practice. The policies used in the main theatres were not using the latest guidance of the royal colleges and some policies, such as infection control, and use of the surgical site checklist did not exist. Audit work needed to demonstrate the effectiveness of care with actions taken and lessons learned improving care. Patient length of stay was affected by delays in being able to discharge patients. Patients were well supported with nutrition, hydration and pain, but there was no specialist acute pain team. Staff had the skills, knowledge and experience to deliver effective care and treatment through training and appraisals and revalidation of their competence, although there was limited professional development of nursing staff. Staff teams worked well to deliver effective patient care. People's consent was being sought in line with legislation and guidance.

The caring by staff was good. Feedback from people, including patients and their families, had been mostly positive. Patients said staff were kind, treated them with dignity and respect, and demonstrated compassion. Patients, their family or friends were involved with decision making. People were able to ask questions and raise anxieties and concerns.

The responsiveness of surgery services was good. There was good provision of the number of operating facilities and emergency surgery scheduling to meet the needs of the local population for both main and day-case operations. The hospital was meeting referral to treatment times in March 2015 for surgery patients, and had been for most of the last six months. The hospital met the needs of patients and their families and visitors well in relation to attention to equalities and diversities. A high bed-occupancy contributed to making last-minute changes or emergency admissions hard to manage. Bed pressures meant frequent delays in discharging patients.

The leadership and governance of surgery services requires improvement. The governance framework did not ensure quality performance and risk were well understood. It was unclear how review of audits, incidents, complaints and other key information was used to learn and make changes to practice. The theatre IT system did not provide staff with the tools to look at surgery outcomes and a wide-range of governance data. The operating theatres were not running efficiently and were under-utilised with insufficient planning to avoid last-minute changes or emergency admissions hard to manage. There was mostly a good level of support for staff, but frequent staff changes in main theatres had been difficult for a staff team who worked in a high-pressure environment. There was, however, a strong and committed and experienced group of core staff. Staff were dedicated to their patients and one another and we were impressed with their loyalty and attitude. There were a number of excellent nurses recruited from overseas who had impressed patients and other staff alike.

Surgery

Are surgery services safe?

Requires improvement

We have judged the safety of surgery services as requiring improvement. There were some elements within surgery judged inadequate and some others were good. The safety culture within day-case unit was good, and there were good elements within the wards, although some areas needed improvement. There were some elements of inadequate practice within the main theatres, although a lot of practice was good. Incidents were being reported but there was insufficient focus from the medical team as to how they were being used to identify trends and make changes to practice. Mortality and morbidity were reviewed but the accountability for some of the actions was not specifically allocated to a member of the surgery team, or revisited to look for improvements.

There were failings in the attendance at the debrief session and the auditing of the World Health Organisation surgical safety checklist in main theatres. There had been a recent increase in avoidable patient harm on the surgery wards which the trust had apportioned to the high use of agency staff. The wards were open with their publication of this data and how they were making improvements, but there was no action plan discussed at risk meetings to learn lessons and drive improvements. Care for people with pressure ulcers was specifically receiving an improved focus to reduce them and improve their treatment. Nursing staff were assessed for their competency for using equipment, but there were concerns about how this was being conducted in main theatres. Since the recent refurbishment had started, some used surgical instruments from part of the main theatre were not being removed with additional infection control at the start of their journey to be sterilised. Most mandatory update training was not meeting trust targets, particularly for doctors.

Medicines were mostly well managed, stored and administered safety, but discrepancies in writing prescriptions had been increasing. There were good levels of nursing staff on the surgery wards, but a high use had been made of agency and bank staff on both wards and the main theatre to cover unfilled shifts. There was a highly flexible and dedicated team of doctors, but cover at the weekends and out of hours did not always follow the trust's operational policy. Trainee doctors, who were not yet at the stage in their training required by trust policy, were often on duty without appropriate senior support. There was, however, a low use of locum consultants and locum specialist registrar doctors in most surgery services.

The theatre areas and wards were visibly clean and well organised. Infection control protocols were followed by staff in all areas. This had resulted in low rates of hospital acquired infections and surgical site infections. There was mostly a good range of safe and well maintained equipment, although there was a shortage of some items. All consumable equipment was safely stored and well maintained. The majority of patient records were completed well, and particularly the nursing notes. The storage of patient notes, however, meant they were sometimes not secure. There was a clear and well followed process for responding to acutely ill patients and experienced and skilled staff supporting the ward staff with patients who were deteriorating.

Incidents

- The trust had reported two Never Events in surgery services in the last 12 months. One of these related to maternity and gynaecology services and is discussed in this section of our report. These Never Events were both wrong-site surgery, but were not linked in their characteristics. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. The root-cause analysis report into the event in surgery contained clear details of the event. All parties had been interviewed and able to contribute. There were some criticisms accepted within the report of the equipment and information available to some of the surgery team. Requirements for changes to the system managing this equipment and information were within the recommendations. Our areas for concern within the report were where 'notable practices' (those areas staff felt were done specifically well) were reported. These were not notable, but standard practice. Also, although the requirement upon NHS trusts to explain and apologise to a patient was not yet in force on the date of the incident (Duty of Candour) the trust made no formal response to the patient as, according to the report, the patient had not formally complained.

Surgery

- There was an event in surgery in October 2014 that the trust had not reported as a Never Event. When reading the root-cause analysis report for the Never Event mentioned in the paragraph above, we saw a comment about this being "the second time this had happened." The investigation report into this 'second' incident described different circumstances, but the event was nevertheless 'wrong site surgery'. We requested the trust look into this urgently and review with their NHS clinical commissioning group.
- All staff we met were open and honest about reporting incidents. The majority of staff we spoke with in theatre and wards said there were no barriers to reporting incidents. They were able to describe what events they would report and gave examples of recent reports made. These included evidence of pressure ulcers, the failure of collection of surgical instruments, and problems with dates and times of medicines given to patients. The trust, overall, was slightly above (higher than) the NHS England average for reporting incidents. This could be taken as an indicator of good report of incidents by staff.
- Incidents were discussed at divisional departmental meetings, but there was no evidence from these meetings, specifically for medical issues, of any learning or changes to practice. The departmental meetings for the surgery division discussed incidents only in relation to how many were still open for review. The minutes the divisional department meeting in December 2014 stated "100 incidents remain open for the division. Please can all managers go into their [management system] and close off these incidents. If you need to reassign in order to do this please do". There was no discussion about emerging trends in types of incidents reported; how feedback had been presented to staff; the quality or progress of any action plans; lessons learned; or practice changed. In the Surgical Directorate Board meeting minutes dated 24 April 2015 there was a discussion about the backlog in open incidents and process of managing the reporting system. There was no discussion about the incidents themselves, development of any trends, actions taken or outstanding, and improvements (or otherwise) from changed practice. We could not see them discussed as an agenda item in either the January or February 2015 meeting. The surgery division produced a Planned Care Division Quality and Governance Assurance report. There was some information on trends emerging, but this was not specifically incidents, and there was no evidence of actions agreed or progress. As a response to a rise in medication incidents, there was, however, a monthly medicines' newsletter started in March 2015.
- There was a good review of incidents by ward staff. There were root-cause analysis reports for significant incidents, with outcomes and actions. Most staff felt incidents were addressed well on the wards and, although the process was not always as formal as it could be, actions were taken and learning shared among the teams.
- Actions and learning from incidents was not always shared among staff in a formal process. Staff we met in theatres and wards said incidents were discussed at weekly or monthly departmental meetings. In main theatres, any serious incidents were discussed at the daily meeting and staff were emailed with the relevant reports. Other incidents were placed on the noticeboard in the coffee room for staff to read. There was, however, little evidence to show how incidents were formally fed back to staff, producing changes to practice where identified, and improvements always being looked for from incident management.
- Actions from serious incidents were agreed, but some of the causal factors were not included. We reviewed a report from an incident in theatre in February 2015. This involved an injury to a patient in theatre from equipment being used at the time. In the root-cause analysis report, there was evidence of a possible link with an action of one of the medical wards from where the patient was sent to theatre. There was no action agreed to address the possible causal factor which, the report stated, would not have occurred had the patient been admitted from a surgery ward. There was also no evidence to show whether the organisation had taken note of a recommendation from the Association of Perioperative Practitioners (2014) to use different equipment to that being used, and whether it had decided, for acceptable reasons, to not follow these recommendations. If, as the report stated, this guidance had become apparent following the incident, there was no action to address how recommendations of this nature would be incorporated into practice in future. There were also contradictions within the report. It was stated in one section of the report how it was "unclear"

whether a cream used in the case (which involved a burn to a patient) was a factor when in another section of the report the cream was "identified to be flammable."

- Patient mortality and morbidity (M&M) was reviewed by the medical team, although there was no evidence to show how agreed actions were delivering improvement. There was not complete accountability of staff for all actions agreed. We reviewed two sets of minutes provided from meetings in October and December 2014. The December minutes reported discussions of two cases, both of which were considered to meet classification of care A: good practice, from the National Confidential Enquiry into Patient Outcome and Death classification of care. There was therefore no action plan required. In the more detailed October minutes, four cases were discussed. Three of these cases were classified as 'room for improvement'. Action plans were developed alongside each area identified for improvement. Some were assigned to specific staff, whereas others did not show who was accountable for delivering the action. There was no evidence of how actions agreed upon were followed up and no 'action plan follow-up' as a standing agenda item. We requested the November 2014 minutes to check for any updates to the October actions, but these were not provided. Two weeks after requesting them we were told "the meeting occurred but due to a change in personnel, it was not minuted."

Duty of Candour

- Duty of Candour had been introduced, but a serious incident root-cause analysis report (RCA) did not demonstrate practice had been yet understood and embedded by all staff. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consequently, organisations were required to inform and to apologise to all relevant parties to specific patient safety incidents. In the report for the serious incident in February 2015, the comment about the discussion with the patient/relative read: "In line with the Duty of Candour policy with patients and relatives it has been shared that harm was committed prior to the patient's death which was unrelated. [Doctor's name] has discussed this with the patient." In a further internal report was a comment relating to all serious incidents and Duty of Candour that read: "Duty of Candour applied to all apart from the patient with [the incident in question] who passed away during surgery and not related to the incident. Conscious decision not to apply [Duty of Candour]." The organisation does not have a right to derogate from the duty to apply this regulation to serious incidents. The two reports gave a contradictory response about whether the duty was followed.

World Health Organisation Surgical Safety Checklist

- The audit of the World Health Organisation (WHO) Surgical Safety Checklist was carried out, but in the main theatre unit this was found to be inadequate. The WHO checklist is an internationally recognised system of checks designed to prevent avoidable harm during surgery procedures. The hospital had declared high levels of compliance when auditing the form used to document the checklist. However, there was no agreed or approved policy or protocol within either theatre unit for carrying out the audit. So, for example, there was no agreed number of forms to audit over any specific period. The staff in the main theatres were auditing only one record each day from what could be as many as 30 operations carried out. The most recent audit return for May 2015 only included the first five days of the month. Staff had not audited any procedures after 5 May 2015 when we reviewed the records on 21 May 2015. There were three failures in one of the indicators monitored (medical practitioner signature) on 3, 4, and 5 May 2015. There was no evidence to show this had been picked up, and as no further records had been audited, no evidence of this being addressed and resolved with the staff concerned.
- The audit procedures in main theatre did not demonstrate consistent improvement. Although lacking credibility, the audit results presented for the WHO checklist for main theatres showed the most variation in compliance when compared with other areas using them, and no particular sustained improvement in results following drops in compliance.
- The audit of the WHO checklist in the day case theatre unit was performed well. All records were checked each

day and there was a high level of compliance which had shown improvements over time. When a drop in performance was shown, this was immediately followed by a marked improvement.

- We observed good practice with staff's adherence to those parts we observed of the WHO checklist protocol in the main theatre. All staff involved were present and included. There were no distractions. We observed practice and felt it appeared 'natural' (that was not being performed for our benefit) and well embedded in practice. One area of concern, from discussions with a number of staff in different roles, was around the debrief activity. The debrief session was a discussion of either the operation or the list and an opportunity to learn from what went well and what did not go well. The attendance at the debrief was not reported upon in the checklist audit, but the latest data on the performance board in the main theatre showed full attendance from staff only 78% of the time. Minutes for the theatre team showed this had improved since November 2014 when it had reached as low as 30%. A senior member of the theatre team said it was still only between 60 and 70%. Governance minutes commented upon the debrief attendance being an area for concern, but no actions or accountability for improving it.
- The clinical guidelines for main theatres did not contain reference to the WHO checklist.

Safety thermometer

- As required, the hospital reported data on avoidable patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (including only the two more serious categories: grade three and four) and patient falls with harm. The hospital trust had shown a marked decrease (improvement) over time in both of these indicators over the last three years. However, hospital-acquired pressure ulcers had increased in March 2015 with three reported for the hospital, and one of these relating to a patient on a surgery ward.
- The surgery inpatient areas had a recent increase in avoidable patient harm when measured across a whole month (as opposed to one given day in a month as per the safety thermometer data above). In March 2015, there had been an increase in falls, hospital-acquired pressure ulcers, urinary tract infections, and an incidence of venous thromboembolism (VTE or blood clots) which had, up until then, been zero since November 2014 to February 2015. One of the pressure ulcers had been on the surgical assessment unit and grade three, which was just below the worst category of harm (grade four). In January 2015 there had been a pressure ulcer on Waterside ward being graded as category four (the most serious). The governance report had noted how this correlated "against the use of temporary staff to cover significant sickness and redeployment [of staff] to winter-funded beds." There was no action plan with improvements identified to address these issues.
- There had been an improvement in pressure ulcer management in the surgical assessment unit (SAU). Following identification of the increase in incidences of pressure ulcers, one of the sisters had introduced a 'pressure ulcer box'. This comprised all the policies, procedures and equipment relating to identifying, caring for and reporting of pressure ulcers.
- There was public display of the results of avoidable patient harm data on the wards. The wards were open about their patient care data, and displayed when they had last treated a patient with a hospital-acquired pressure ulcer or a patient had a fall with harm.

Cleanliness, infection control and hygiene

- At the time of our inspection the theatre areas were visibly clean. This was despite some of the environment, particularly the main theatre recovery room, not having been updated for many years. The recovery room in the main theatre had not been decorated for at least 15 years according to staff, who could recall when it was last done. There was some chipped plaster and paint and a wallpaper patterned border circulating the tops of the walls. There was a paper fresco on one end wall for paediatric patients, which were no longer operated on at the hospital. As the wallpaper border was lifting away from the walls in some areas, it presented an infection control risk to patients in the theatre recovery room. The flooring was also scarred and damaged in places from mostly age-related deterioration. Despite this and the need to store some equipment from a theatre which was closed for refurbishment, the recovery room was

visibly clean and tidy. It was not part of the current refurbishment plan, but currently in the plans for 2016. The day-case theatre unit was a visibly clean environment in all areas. The unit was of a high standard and arranged and organised to make cleaning efficient.

- At the time of our inspection the ward areas were visibly clean. This included patient bed spaces, corridors, staff areas and equipment used both regularly and occasionally. They were clean, well-organised, and tidy. Patient bed spaces were visibly clean in both the easy and hard to reach areas such as beneath beds and on top of high equipment. Bed linen was in good condition, visibly clean and free from stains or damage to the material. A patient we met during an afternoon on Steepholm ward told us how they had seen a member of the housekeeping team clean the toilet "at least three times today that I have seen, and it could be more than that. [They are] really thorough." Another patient on the same ward told us "the place is spotless."
- Infection control protocols were followed in theatre. We observed full adherence to the surgical scrub technique when in the main operating theatre. Sterility was observed and maintained during setting up and instrumentation. Handling of used sharp instruments was performed safely. There were standards for certain aspects of infection control in theatres, but the hospital trust did not have a specific policy for operating theatre infection prevention and control and not particularly within the theatre refurbishment period.
- The hospital trust had scored highly in cleanliness in the PLACE (patient-led assessments of the care environment) in the 2013 and 2014 surveys and higher than the NHS England average.
- There was a low rate of infection in the surgery division. In the 12 months to March 2015, there had been six incidences of Clostridium difficile, but none in the first three months of 2015. There had been one case of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia (presence of bacteria in the blood) in the year, but none in the first three months of 2015. There had been two incidences of methicillin sensitive Staphylococcus aureus (MSSA) in the year with one in the first three months of 2015. There had been a relatively high incidence of MSSA in the hospital in the year from April 2014 to March 2015 (11 reported against a target of three) and this had been noted in the surgery directorate board minutes of April 2015. An action to train a member of staff to deliver specific training to nurses and medical staff had been agreed and we were told this was underway.
- There was regular audit of cleanliness in the surgery areas with mostly good results. This was reported through the Planned Care Division Infection Prevention and Control report produced quarterly for the infection control committee. In the matron audit (conducted by ward sisters) results needed to be 95% or above to be rated as meeting trust targets. For the year to March 2015 results showed Hutton, Waterside and Steepholm wards had met or exceeded the target. Steepholm was at 89%, but had improved over the year.

The shortcomings on Steepholm ward were highlighted in the report to the matron concerned for action to be taken.

There were audits undertaken by the housekeeping staff for other areas of the surgery division.These audits looked at the areas in relation to where the responsibility for the cleaning fell.For the year to March 2015 results showed the cleaning team were meeting the target, but nursing and estates' department were some way below the 95% target.The shortcomings in the elements of the nursing cleaning were highlighted in the report, and to the matron concerned, for action to be taken.There were no comments in relation to how the estates' department was to address the shortcomings.

- Hand hygiene rules were followed and audits showed good results. We observed doctors and nursing staff following policy by washing their hands between patient interactions, using anti-bacterial gel and wearing disposable gloves and aprons at bedside and elsewhere when required. All staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow) when they were working on wards or in surgical scrubs when in the operating theatres. Patients we asked said they had seen staff washing their hands and wearing gloves and aprons. A patient on Waterside ward commented on how staff gave them hand wipes to clean their own hands before eating their meals, which they had appreciated. Results for hand hygiene audits on the wards in the period over six weeks from 9 February to 16 March 2015 were all at 98% and the surgical assessment unit was 99%.

- Infection control was a standing agenda item at surgery department meetings, although with a limited discussion generally around hospital-acquired infections. Other data was presented through the Planned Care Division Quality and Governance Assurance reports. This data extended to surgical site infections, catheter and urinary tract infections, hand-hygiene audit results (added recently). Cleaning audit results against national standards were reported upon in the governance report for January to March 2015.
- Clinical waste was well managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. None of the waste bins or containers we saw on the wards or within the theatre units were unacceptably full. Nursing staff said they were emptied regularly.

Surgical site infection rates

- The surgical site infection (SSI) rates for neck of femur operations at the hospital were in line with national averages. In the Public Health England (PHE) SSI report for repairs to neck of femur, the percentage of readmissions in four different periods of three months each since July 2012 and up to December 2014 for patients with SSIs was 1.6%, which was the same as the five-year national average from Jan 2010 to December 2014.
- The surgical site infection (SSI) rates for large bowel surgery operations at the hospital were better than national averages, although for only a small number of patients, and were showing a decline in recent months. In the Public Health England (PHE) SSI report for large bowel surgery, the percentage of readmissions in four different periods of three months each since October 2013 and up to September 2014 for patients with SSIs was 10.9% which was below the five-year national average from Jan 2010 to December 2014 of 12.5%. There was an increase in SSIs in large bowel surgery in 2014. The PHE report stated the infections were predominantly from high risk patients, who had longer operations, but there was no specific age group affected more than another.

Environment and equipment

- Resuscitation equipment on each ward and in the units was checked daily, with records in place showing completion. Although the trolleys had a handle to keep the drawers closed, this did not fully secure the units to prevent tampering with the contained drugs or other equipment between checks or demonstrate the equipment had been opened and may have been used.
- Nursing staff were assessed for their competency on using equipment, but there were concerns about the rigour of the assessment for staff on the main theatres. On those competency assessments we looked at, staff had been reviewed by one of their peers and this had been reciprocated. The assessments were, therefore, not done by a member of staff who had been approved or was recognised as a competency assessor for a specific piece or equipment or area. This had been identified also by the new matron for theatres and was to be addressed.
- During the theatre refurbishment period, some used surgical instruments were not being removed from the main theatre with additional infection prevention and control measures. In the main theatres, the used (dirty) instruments were being brought through the main corridor, as the 'dirty' corridor was currently out of action during the refurbishment (to allow contractors to access the working area without encroaching into theatre). At the same time there were some clean instrument sets stored in the main corridor ready for use. The used instruments for two of the three theatres were being taken past the clean wrapped instrument sets stored in an open side corridor awaiting use. In the refurbishment plans, the instrument flow had been risk assessed by theatre staff. Consequently, all dirty instruments were being sealed, 'double-bagged', and transported in closed trolleys to prevent any risk of contamination. However, this was only when they had passed clean wrapped instrument sets and gone into a room at the far end of the theatre area. This plan was put in place to prevent cross infection when instruments moved through other areas of the hospital before being removed for sterilisation. In the day-case theatres, used instruments were brought through the single corridor in single sealed bags and open trolleys. We saw they were being brought past sets of clean wrapped instruments stored on shelves in a side corridor. We asked the senior sister for the day-case unit about the storage arrangements and it was identified this process of removal was sub-optimal practice. When we returned to

the day-case unit two hours later there had been a rapid response. Clean instrument wrapped sets had been moved and storage established in a room behind closed doors.

- Reusable theatre sterile instruments were processed, wrapped, and returned safely. Used instruments were sent off site to be sterilised and wrapped by a third-party through a contractual agreement. They were collected twice each day. While the theatre refurbishment was in process, the bulk of the instrument sets for the main theatre were being stored in another part of the hospital. They were sent up to the theatre each day according to the theatre list for the following day and held awaiting use.
- There was a varied quality of the different environments in the surgery services. The wards and theatres had wide corridors which enabled equipment and patients to be moved safety. On the wards, the patient bed spaces had limited space between them, but were well-equipped and safe. Wards had side rooms used for patients who needed to be nursed in isolation from other patients and visitors. The day-case theatre unit was a safe and well-organised environment for the patients and staff. The pre-operative assessment centre was equipped with four rooms for patient assessment and consent. This unit was looking worn and had not been updated for a number of years. The arrangement of patients meeting staff in rooms was good for confidentiality, but meant patients had to enter and leave rooms while they waited for the various staff they needed to see.
- There was a limited amount of some equipment in the main theatres, but good provision of others. Equipment was safely maintained and repaired quickly if and when required. The anaesthetic machines were being replaced in accordance with a capital replacement programme. There were four operating theatre tables (one had recently been out of action for repairs). There were six operating theatres and provision of trolleys for performing some surgery. However, if the tables were moved between the day-case unit and the main theatre, they were taken through the main hospital corridor. This meant tables had to be decontaminated before use. This had been entered to the risk register but a business case to purchase a new table had not been accepted. Otherwise, theatres had a trolley suitable for operating on bariatric patients and pillows designed for the optimal positioning of the patient's head during surgery. There were insufficient drip stands in the main theatre recovery room. When we inspected the room there were two stands for the five beds. Staff were using angle-poise lamps from which to hang intravenous infusion bags. Senior staff told us there had been an issue with equipment being borrowed from theatre and not returned. Any staff from other areas of the hospital were now required to sign out any equipment they were borrowing and made responsible for its return. Staff said this had helped to reduce the incidence of missing equipment, but equipment still went missing at nights and on weekends.
- In the areas we checked, all consumables and equipment were within their expiry date. The nursing sisters we talked with in one of the wards and on the day-case theatre unit said the stores and trolleys were regularly checked by one of the nursing team. They checked for evidence of damage to packaging (these were then disposed of) and for items approaching or past their expiry date. Staff said they endeavoured to use equipment first when it was approaching the use-by date. We observed consumables and equipment in the departments were kept to a minimum of those things used often in order to reduce waste and the risk of expired equipment.
- There was an issue with security of both theatre units. The day-case theatre entrance doors were open to enable patients to gain access on arrival and enter either the waiting area or the reception. However, we were able to walk directly into clinical areas and could have accessed the operating theatres and recovery room, as these areas were not secured from the main corridor. The main theatre unit front entrance door was locked with security card access for staff. However, once opened, the doors took a significantly long time to close. We were therefore able to enter the unit unchallenged and could have accessed the operating theatres. This was the case on one occasion when there was no member of staff in the corridor outside or visible within the unit, indicating how long it was taking for the doors to close.

Medicines

- All medicines were supplied and stored securely on the wards, theatres and SAU. Medicines' refrigerators were available with temperatures recorded daily to show

these medicines had been stored at a safe temperature. Medicines were in locked cupboards with appropriate staff being responsible for the keys. There were arrangements for the supply of regular medicines. An inpatient pharmacy service supplied stock drugs to all wards and departments and dispensed discharge medicines for patients to take home.

- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. The pharmacy had produced a standard operating procedure for controlled drugs to help ensure these medicines were looked after safely and any problems would be identified. Incidents involving controlled drugs were investigated. The chief pharmacist told us they made quarterly reports, as required, to the Controlled Drug Local Intelligence Network on behalf of the trust's Accountable Officer.
- Most patients received their medications safely as prescribed by their doctor. Most of the patients we met told us they believed they took or were given their medicines at the correct times. We reviewed 15 patients' prescription and administration records on the surgery wards and the majority were completed accurately. However, two patients prescribed two eye drops had several gaps in their records where it was not clear whether the eye drops had been applied. Another patient had been prescribed a medicine once daily, but was being given this twice daily as there was a contradiction within the prescription. We immediately brought this to the attention of the ward sister who started to investigate.
- As required, patient allergies were recorded on the prescription and administration records. We checked this with 15 patients' prescription and administration records on the surgery wards.
- The trust had a policy and procedure for the self-administration of medicines for patients. However, there was a patient without the required risk-assessment for this in their notes. The patient told us they were looking after their own medicines and were pleased to be able to do this.
- A clinical pharmacy service was provided to all surgery wards. This was mainly focused on medicines' reconciliation, the clinical checking and supply of newly prescribed medicines, and the clinical check of discharge prescriptions. Medicines' reconciliation involved hospital staff checking they had the correct information about patients' medicines. This was to ensure patients continued to be given them correctly during their hospital stay. Information provided by the pharmacy showed improvements were being made with the number of patients whose medicines were reconciled within 24 hours of them being in the hospital. This result did, however, have some way to go. The most recent data for March 2015 showed they were able to reconcile medicines for 37% of total inpatient admissions (so across all wards). This had increased from 13% in November 2014. The aim was to reach a figure of 80% reconciled within 24 hours. A report for the Executive Management Group included an action plan to improve this.
- The number of discrepancies in prescriptions identified by the pharmacy team was increasing. Staff told us they were not always able to resolve these quickly. Sometimes this was delayed until the patient was being discharged from hospital. This had increased the risk of patients not receiving their regular medicines correctly during their hospital stay. The chief pharmacist told us they concentrated their activity in checking patients' medicines on their admission to hospital and their discharge because they had been identified as the most risky times. There was therefore a risk of mistakes made with prescribing during a patient's stay not being identified by pharmacy staff. For example, we saw one patient was a prescribed a medicine for blood pressure once daily on admission to hospital. No change had been made in the prescribed directions but records showed an additional time for administration had been indicated. It was therefore given twice daily instead of once. There was no indication of the reason for this change or whether the patient was having their medicine correctly.
- Results for getting medicines to patients to take home were generally good, although there were sometimes delays. Staff on some wards and one patient who was waiting for their medicines to take home told us there was sometimes a delay for patients and discharges had been delayed. This was partly because the discharge medicines were not requested until the day of discharge. Delays in writing the prescription and delivery systems in place meant medicines were often

delivered to the wards around mid-afternoon when nurses were also giving out medicines to patients. This made it more difficult for staff to find time to explain to patients about their medicines. Some patients were able to move to the discharge lounge to wait for their medicines to take home. Staff said some patients who lived locally would go home and come back to the ward later in the day to collect their medicines. The pharmacists were around the hospital on wards until 11am. This meant staff could not request medicines to take home or for use on the ward before that time unless their pharmacist was able to come to the ward and arrange it for them. This sometimes caused delay in patients receiving their medicines on the ward or delayed their leaving the hospital. In response to concerns over delays, the pharmacy had introduced a tracking system which allowed staff to monitor what was happening to a prescription and to be able to collect it when it was ready. The pharmacy collected data about their performance with take-home medicines, which showed that 92% of requests were completed within three hours.

Records

- Patient notes were clear and could be followed through the records. Nursing care plans, risk assessments, and observations were up-to-date and interactions well documented. We reviewed a set of notes of an orthopaedic patient on Waterside ward and found good completion of patient risk assessments including mobility and falls. The notes included all admission, discharge, and daily ward round information. There were completed clear and legible medication charts, theatre notes and anaesthetic records. There were good notes from the physiotherapist and occupational therapist who had reviewed and supported the patient. We reviewed seven sets of notes on Steepholm ward (four nursing folders and three medical folders) and eight sets on Hutton ward (four nursing folders and four medical folders). We found all to be up-to-date, legible and clear. There were well documented risk assessments and early warning score documents. Turn chart completion (for pressure ulcer management) and malnutrition/hydration risk scores were done well. The fluid charts were added up so the balance of input and output was being addressed. There was evidence in the records of action being taken to address any issues raised by any of these risk assessments and care plans.
- The majority of patient notes in their ring binders were in good condition, but some we reviewed on Steepholm and Hutton wards had loose pages which fell out when the files were picked up. This was due to the holes at the edge of the document having broken through the paper. There was therefore a risk of the document being lost or possibly replaced in the wrong file.
- Patient paper notes were often supervised, but not always to ensure their confidentiality and security. The records were held in specific areas of the ward which were close to the nurses' station and reception area. Both doctors and nurses were frequently using the records and they were therefore often attended. However, the records on the wards were held in notes' trolleys, but these were open, not able to be locked, and, as we observed over a 30 minute period, were sometimes left unsupervised. Any electronic notes were kept confidential and at no time did we see patient confidential information left visible or unaccompanied on any screens or boards.
- Patient notes from operating theatres were updated to show the track and traceability of surgical trays, medicines and equipment used. Records had labels applied in the patients' theatre notes for relevant items.
- There was mostly a good record of assessment of patients pre- and post-operatively. The hospital had a pre-operative assessment unit and theatre receiving unit where patients were assessed for risks and to provide consent. The surgical team had recognised there was a poor documentation of the risks involved with anaesthesia on the patients' anaesthetic plans. This was being addressed and had been highlighted at a governance meeting. The observation charts were saw on the main and day-case theatres were well completed, legible and contained those indicators for patient health we would expect to see being carefully monitored.

Safeguarding

- In surgery services, most non-medical staff (all staff excluding doctors) were up-to-date with their training to recognise and respond in order to safeguard a vulnerable person. Medical staff were not meeting trust targets. The training provided was required to be updated every three years. The training compliance as

at March 2015 showed most non-medical staff had updated their adult and children training. Just over 70% of the medical staff had completed this training against a trust target of 90%.

- There were policies, systems and processes for reporting and recording abuse. The safeguarding adults at risk policy had been updated in February 2015 and was set for review in 2018. The policy highlighted the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The six principles of the new Care Act were described at the start of the policy. The policy listed definitions and types of abuse and who might be at risk. It was linked with the provisions of the Mental Capacity Act (2005) in relation to deciding if a person was vulnerable due to their lack of the mental capacity to make their own decisions. Staff were correctly directed to assume people had capacity to make their own decisions unless professionally assessed otherwise. The policy stated people were to be given all practicable help before anyone treated them as not being able to make their own decisions. The policies (including the policy for child safeguarding) clearly described the responsibilities of staff in reporting concerns for both adults and children, whom, as required, were subject to different procedures. There were checklists and flowcharts for staff to follow to ensure relevant information was captured and the appropriate people informed.
- Staff were clear about reporting safeguarding. Most staff we asked were able to name the senior nurses and doctors who were responsible for safeguarding. Other staff knew where to access this information on the hospital database, along with any other information they might want in order to raise a safeguarding alert. Temporary (agency) staff told us they would take up any concerns with the person in charge in their unit and ensure concerns were addressed. One agency nurse said they were also able to report any concerns to their agency which also had procedures and responsibilities to safeguard people.

Mandatory training

- Staff were trained and updated in a wide range of statutory and mandatory subjects at various intervals, but no areas were meeting trust target levels for updating training. Staff were responsible for their own training being completed, and their annual review would not be signed-off by their line manager if update training had not been completed. The training included a wide range of topics such as dementia awareness at different levels relating to the staff job role, Deprivation of Liberty and the Mental Capacity Act, life support, and health and safety topics. Compliance with the mandatory training requirements at the end of March 2015 against a trust target of 90% showed non-medical staff (all staff excluding doctors) on the wards and theatres at between 74% and 79%. There were only 45% of medical staff having undertaken their training updates and therefore not meeting trust targets by a significant factor.

Assessing and responding to patient risk

- The hospital had a policy in place for monitoring acutely ill patients. It had implemented and was using the 2012 National Early Warning Score (NEWS) system for the monitoring of adult patients on wards. This used a system of raising alerts through numerical scoring of patient observations. The system was used on wards and also in recovery rooms. As the NEWS of patients in recovery were placed in the patient notes, these were entered in red ink. This was to differentiate from the ward form NEWS and indicated it was for the patient in their recovery only. We saw the NEWS forms completed and in use appropriately in the patient records we reviewed on the three surgery wards.
- Patients were assessed pre-operatively. The nursing team in the pre-op assessment centre (POAC) and theatre receiving unit were responsible for the assessment. If they had any concerns or had identified specific risks, they referred the patient to the anaesthetic team for a review, as anaesthetists held sessions in the POAC.
- Patients were assessed for various risks, such as falls, malnutrition and safety. There were, however, some patients who were not being repositioned in bed to relieve pressure not as often as required by their risk assessment. This was of particular note on Steepholm ward in the mornings between 9am and 11am. We looked at three records for patients who had been assessed as needing to be repositioned every two hours. This was in order to help prevent their skin from deteriorating and for the comfort of the patient from being in the same position in bed for too long. These turns had been carried out at three and four hour

intervals only during the morning period. The nurse in charge accepted this was the case and they were not meeting some targets as staff had a number of competing priorities during the busy mornings.

- We observed one patient who was at risk from falls. They had already had a fall on the ward and did not get full support from staff as required when they started to get up and walk to the toilet. We saw other patients, however, being helped when they needed it. The patient we observed was required, in their risk assessment, to be helped by staff when they wanted to move around to reduce the risk of further falls. Their walking frame was, however, not located close enough to them to enable them to stand with the support of the frame. They managed to reach their frame and slowly made their way to the nearby toilet. We were not aware at that time of their need for support from staff, but could see they were having difficulty walking. The sister confirmed how the patient was supposed to be helped and supported with mobility by staff.

Nursing, healthcare and operating theatre staffing

- The nursing staffing levels across the surgery services were mostly safe in numerical terms, but had been relying heavily upon temporary staff to cover unfilled shifts. This was as a result of staff being off the rota following an on-call session, vacancies, sickness and other leave. The risks of using temporary staff were highlighted in the Planned Care Division Quality and Governance report for February to March 2015. They were seen as a contributing factor to the "increase in falls, hospital-acquired pressure ulcers, medication incidents and suboptimal documentation records." There was a common theme among almost all patients we met (particularly the 15 patients we spoke with on the Saturday visit) who said staff were "rushed off their feet", "running from one person to the next, but still managing to do a good job", "doing a great job, but they could do with an extra pair of hands." We did, however, hear all patient buzzers being answered in a timely manner on all our visits to wards. Turnover rates for staff had also been high.

The data for the nursing staff for March 2015 for the three surgery wards showed bank/agency use in Hutton and Waterside at 23%.This rate had fluctuated over the previous 12 months but had been between 15% and 26% since December 2014.Steepholm ward had 13% of bank/agency staff which had fallen slightly since the beginning of 2015, but risen from April 2014 when the rate was only 3%.

For healthcare assistant staff there was a high usage of agency and bank staff and some high levels of sickness. Waterside ward had used 66% of bank/agency staff in March 2015 due to vacancy rates and regular staff secondment to support escalation beds elsewhere in the hospital.

- There was good supervision and support for nursing staff on the wards from an experienced team of the matron and ward sisters. These staff were expected to be and usually were supernumerary (that is, not counted within the nursing staff numbers) but would assist on the wards giving help, support and advice to their teams when required.
- Nursing staff levels on the day-case unit were at safe levels. There was good supervision and support on the unit from an experienced senior sister and their team. The senior staff were supernumerary, providing managerial and organisational support, but help, support and advice to their team at all times. The data we were provided with showed sickness, agency and bank use for the day-case unit combined with the main theatres and not separately. Staff on the day-case unit and main theatres said although the day-case unit had some use of bank and agency staff, the majority of this usage was in the main theatre complex.
- Nursing and operating department practitioner staffing levels on the main theatres were generally, but not always running at optimum levels. There was a high use of bank and agency staff to cover unfilled shifts. A senior member of staff said there had been some cases taking place without a full optimal complement of staff. Understaffing was recorded in the risk register. There was, however, just one incident logged through the hospital reporting system in a review of incidents reported in December 2014 to March 2015 (although the list was very difficult to interrogate as the hospital did not use standard entries for categorising incidents).

In main theatres the senior nursing positions (band seven and six) were staffed.The theatre manager post (senior sister, band seven) was a supernumerary role, but the sister explained they had been stepping into an unfilled post of

either band seven or band six "several times a week now."The highest level of nursing roles in the main theatres were for band five nurses and operating department practitioners (ODPs).The theatre manager said the planned establishment for band five nurses (that is the number of staff planned to work in the unit) had been designed at safe levels.But there remained unfilled vacancies, staff on maternity leave, and a number of untrained staff being supervised so not yet counted in the numbers.This affected just over 9 of the 24 posts for band five nurses/ODPs in the main theatre.

- There were varied rates of vacancies for the nursing team, with the majority for the Waterside ward and the operating theatres. Data for March 2015 reported 46% of nurse vacancies in the pre-operative assessment unit. However, when we visited the unit, staff we met said there were no problems with staffing the unit with the six-strong full-time team. This was therefore contradictory to the vacancy rate, unless the vacancies shown had since been filled.

Surgery staffing

- There were sufficient doctors in the hospital in the week, but the out-of-hours cover from doctors did not meet the trust's policy or good practice for patient safety. There was an out-of-hours operational policy to determine which doctors and nurses were on duty on evenings, nights and weekends. This required there to be a medical registrar who was clinical lead, and for the surgery wards a surgical specialist registrar (grade not mentioned) and a surgical FY2 (second-year trainee doctor). On the Saturday afternoon of our unannounced visit there was a FY1 (first-year trainee doctor), and a StR1 trainee (specialist registrar year 1 – previously a senior house officer (SHO) year 2). There was a locum registrar who was on duty from 9am to 5pm. Staff told us how at other times there was rarely a surgical general registrar on duty as required. One doctor we met said a doctor of this grade had been on duty for only five weekends in the past six months. We asked the trust to supply a rota to demonstrate how they had staffed the out-of-hours rota, but the information supplied was only for the nursing staff.
- Consultants carried out appropriate ward rounds, although the configuration of wards had resulted in too many ward rounds. The configuration of the wards had changed from the way they were described on the trust website as specific to their surgery area. They were currently being run as a split between elective and emergency patients. This had resulted in there being up to 17 consultant ward rounds each day for staff to manage across the three wards and the surgical assessment unit. The new directorate management team had recognised the inefficiency of this working practice and the wards were to revert back to surgery speciality arrangements (general surgery, and trauma and orthopaedic surgery) to reduce the number of ward rounds, among other efficiencies.
- We did not observe any handover sessions between doctors on this inspection, but all those medical staff we met said they were carried out well. There was a good range of information handed over. The junior doctors we met said they were completed well, and they were able to ask questions and challenge areas.
- There was minimal use of locum consultant surgeons and locum specialist registrar doctors in the surgery team. There was some use of locum trainee doctors in orthopaedic and general surgery. There had been no locum anaesthetists used since October 2014 to March 2015, although there were two vacancies in the department at the time of our inspection. We were told the team were managing the vacancies among themselves at the present time. We were told by the general manager for the surgical directorate and head of nursing how the surgeons were very flexible with their approach and would adapt to fit in with the theatre programme. This was also when this involved a number of short-notice changes.
- There was availability of consultants on call at all times. Consultants were available by telephone or if required or decided to attend, either lived within a 30 minute journey of the hospital or would be resident at the hospital when on-call. There was a hospital out-of-hours operational policy, but this did not cover the duties of those staff on-call to attend when needed.

Major incident awareness and training

- The hospital trust had a major incident plan. Staff knew how to access and distribute the policy and in what circumstances it was relevant. The plan was, for example, immediately to hand in the manager's office on main theatres. The main theatre manager was aware of their department's responsibilities and key roles in

the event of a major incident. The procedures to follow would depend upon the incident, but would have included the immediate cancellation of elective surgery in order to prioritise unscheduled emergency procedures.

Are surgery services effective?

Requires improvement

We have judged the effectiveness of surgery services as requiring improvement. There were some good clinical audits undertaken, but not for some aspects of clinical practice. Within the audits undertaken there was no evidence to show actions had been followed-up and what lessons were learned. The policies used in the main theatres were not using the latest guidance of the royal colleges and some policies, such as infection control, and use of the surgical site checklist did not exist. Patient length of stay was mostly above the England average, due to delays in being able to discharge patients. There was no dedicated pain team in the hospital, although most patients reported good standards of pain relief. The hospital was using an enhanced recovery programme for specific patients, but there was no evidence to show how this had improved patient outcomes.

There was a comprehensive programme of nursing audit. Patients were well supported around nutrition and hydration including pre- and post-operatively. The hospital performed well in the national bowel cancer audit in 2014. Post-surgery readmission rates were generally good. The hospital performed well in the patients' review of the outcomes following hernia and hip/knee replacement surgery. Surgery services had improved their results in hip surgery standards, although still underperforming against the best-practice tariff financial incentive.

Appraisals for staff were mostly meeting trust targets and the General Medical Council revalidation of doctors was well underway. There was some good local training and development, but it had been recognised this needed to improve in some areas, specifically for theatre staff. There was good multidisciplinary working in wards and theatres. There was access to services to meet patient need across all the week and access to patient information such as their records and test results was good. Consent for patients was completed well and staff understood the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- There was a Clinical Guideline for Main Theatres' policy, dated 15 Jan 2012, although this was not based upon the latest guidance of the relevant royal college. There was no index with the 85-page document making it difficult to navigate. The first part of the document described the 'anaesthetic theatre standards 1-34' although the source of the standards was not shown in the policy. However, they appeared to be those published by the Royal College of Anaesthetists. They were, however, not based upon the most current version of those standards. The document went on to include operating theatre standards 1-41 and PACU (post-operative care unit) standards 1-18. There was also no reference of the origin of these standards.
- Often due to delays in discharges, predominantly for patients needing social care packages or continuing healthcare, the length of stay (LOS) for surgical patients within the hospital was mostly above the England average. It is recognised as sub-optimal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted. Most delays were only slightly above the average, but it was significantly higher for non-elective (emergency) orthopaedic surgery at 12.1 days (England average 8.4 days) and non-elective colorectal surgery at 9.8 days (England average 4.5 days). Non-elective general surgery was below the England average at 3.6 days against 4.3 days.
- Patients were assessed for risks of venous thromboembolism prior to surgery in line with the National Institute of Health and Care Excellent guidance. Pneumatic compression boots were used in theatre where required to reduce the risk to patients of venous thromboembolisms (VTE or blood clots). There was evidence in patient records of the use of prophylaxis (proactive prevention) for VTE.
- There were some good clinical audits undertaken, in line with local or national priorities, but no evidence of action plans being followed-up or lessons learned. For example, the hospital had been self-assessed against

the diagnosis and management of sepsis in acute general surgery admissions. There was a reasonable number of patients (39) studied over seven days in October 2013. The audit found good areas of practice, including use of early warning scores, waiting time for diagnostic imaging, and waiting time for theatre. There was also a zero mortality rate and short length of stay. The areas for improvement included time to review by a member of the surgery team and adherence to the Sepsis 6 protocol, which was described by the audit as 'poor'. These recommendations including re-audited to demonstrate if the requisite improvements could be demonstrated. There was no evidence through clinical governance to show the actions had been addressed and re-audited for improvements and changes to practice. The clinical director for the surgery division said, however, some micro-teaching for Sepsis 6 had been introduced and a consultant and two middle-grade doctors were attending a conference on this topic.

- There was a comprehensive programme of nursing audit, but it was not clear how data reported at senior staff meetings was being used. The programme had a diary for each month of the year. This involved a rolling programme of audit covering cleaning, documentation, ward acuity, productive meals, medications, and infection control measures. The audits were reported by ward area as they related to the infection control committee report, and by directorate level when reported in the governance assurance report. Infection control audits showed variable results although most were achieving between 90% and 100%. Where results fell short of 100% and had shown no improvement over time (such as aseptic non-touch technique on Steepholm ward) there was no evidence to show this had been recognised and addressed.
- There were care pathways for many conditions considered to be typical with the local population and procedures undertaken at the hospital. This included patients with head injuries, pancreatitis, hip fractures, and acute abdominal illness.

Pain relief

- There was no dedicated pain team or specific staff at the hospital trained in pain management. A post had recently been advertised for a lead nurse, but there was no doctor specialising in pain management. The Royal College of Anaesthetists Accreditation Standard 1.4.4.3 and 1.4.4.4 stated there should be specialist medical acute pain management advice and intervention available at all times, and a dedicated acute pain specialist nurse service.
- Pain relief on wards was mostly well managed. Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Comments from patients included: "pain relief is spot on", "generally good" and "pain is well controlled." However, one patient told us they had been in pain and requested their prescribed medicine for pain relief, but staff had been busy and forgotten their request, leaving them in pain for some time. Otherwise, most patients we spoke with said they had been asked regularly by staff if they were in any pain. Nursing staff said, and we observed, patients were regularly checked for pain. We observed a student nurse checking each patient in one of the bays to see if they were in any pain or discomfort. A patient who had just been returned from surgery was also specifically asked about pain. Another who told us they were in some post-operative pain, said they had just had some pain relief and it had been given regularly and "was helping once it kicks in." They said staff had offered them an alternative medicine on this occasion which might be slightly stronger, but explained there were some side effects. The patient had declined the offer but said staff were "really on top of the pain issue for me."
- The surgery team had recognised the hospital's compliance with guidelines post-operative pain management in patients with elective joint replacements was "very patchy" (source: Anaesthesia minutes 9 April 2015). There was, however, no mention in the minutes as to how this had affected patients and how it was going to be addressed or improved.

Nutrition and hydration

- Appropriate guidance and protocols were produced and followed to ensure patients had the right levels of hydration and nutrition. The Malnutrition Universal Screening Tool (MUST) was used to monitor patients who were at risk of malnutrition. Patients' hydration levels were monitored for all patients to ensure they were receiving a good fluid balance.
- For patients able to take their own fluids, drinks were available on bedside tables and usually within reach.

One patient, however, told us they had to ask repeatedly when they were in the early stages of post-operative recovery if their water could be placed where they were able to reach it without having to move and cause themselves pain. They said at one point they "gave up asking". This patient said their water would have been in an accessible place had they been more mobile, but their difficulty in moving post-operatively had not been considered.

- Patients were fasted appropriately pre-operatively when admitted as inpatients prior to their surgery. Patients who came for day-case procedures were given appropriate instructions about food and drink intake before their procedure. If a patient was operated on in an emergency situation, their response to the risk of nausea and vomiting was managed in theatre and recovery either with appropriate medicines or close monitoring.
- There was provision for patients who needed extra help to maintain their nutritional intake. There were build-up soups and drinks available along with soft diets for patients who had difficulty with swallowing.

Patient outcomes

- Senior staff told us the hospital had a policy that was adhered to where no patient would be anaesthetised without an available bed being first identified. This did not mean, however, that there were not some patients delayed in theatre recovery until the bed became available.
- The hospital used an enhanced recovery programme for patients having certain surgery procedures including orthopaedic hip and knee joint replacement and colorectal resections. This followed NHS best-practice and was used to provide better outcomes for patients, reduce length of stay, and increase the number of patients who would be seen. Medical and nursing staff said this included the patient being assessed pre-operatively; reductions in the stress of the operation (so operations carried out as much as possible with local anaesthetic, and/or with laparoscopic techniques); and fast mobilisation of patients post-operatively. We asked the hospital if this programme had been audited to show it was effective, but no information was provided.
- The trust performed well in the national bowel cancer audit 2014. There were 85 patients treated in this period. Results of the data included 100% of patients being discussed with a multi-disciplinary team approach; 97% of patients seen by a clinical nurse specialist; and 94% having a CT scan reported. These were all better than the England averages. The patient length of stay was also lower (that is better than) the England average.
- The hospital participated in the first self-assessed National Emergency Laparotomy Audit (NELA) 2014 with varied results of both good practice and areas in which to improve. For example, 73% of patients were seen by a consultant within 12 hours; all but one patient had a pre-operative CT scan. Of these, all but one were reported on by a consultant radiologist; there was a consultant surgeon present for all cases, and a consultant anaesthetist for all but one; and there were no barriers to age. Advanced age did not preclude surgery with three patients over the age of 90 undergoing emergency laparotomy surgeries.

However, the length of time from decision to operate to anaesthetic review was variable. Thirteen patients (43%) had a delay of more than three hours and only eight were seen within 90 minutes. There were also some long delays between decision to operate and time of arrival in theatre with less than half of the patients waiting under four hours. Delays did not appear to correlate with being listed on an emergency theatre day, but there was a small number of patients listed on that day (nine of the cohort). There was a higher mortality rate (20%) in the sample than when compared with the Emergency Laparotomy Network mortality rate from 2012 of 15%).

We asked if a progress report for the action plan had been drawn up following the review, but were told there was no evidence to support this in a formal paper.The findings were presented at the Anaesthesia/General surgeons meeting in April 2015 and previously in February 2015.

- Patient readmission rates after surgery (due to corrective measures needed or infections) were variable, but mostly good. Rates for the hospital showed 50% of procedures carried out had lower rates of readmission than the England average. For the top three performed elective surgery procedures, urology rates were well below the England average, colorectal surgery

just below and orthopaedic just slightly above. For the top three non-elective (unplanned) procedures urology was just below and orthopaedic and general surgery just above the England average.

- The hospital performed well in the Patient Reported Outcome Measures (PROMs). These were patients who reported back to the hospital on their outcome following surgery for groin hernias, hip replacements, and knee replacements. For the three procedures, and as with the England average, almost all patients reported their health had improved when measured against a combination of five key general health-related indicators. More patients who had groin surgery reported their current general health had worsened following surgery (which was the same as the England average), but the majority of hip and knee replacement patients reported their current health had improved. Almost all patients having hip and knee replacements reported improvements in their outcomes when asked specific questions (Oxford scores) about their condition.
- The hospital had improved performance in the Department of Health standards for fractured hip surgery in 2014/15 compared with 2013/14 for two out of three elements of a self-assessment of performance. Although this performance was below the England and South West averages (only 2013 data available to benchmark). In 2014/15, 58% of patients met the best-practice tariff (a financial incentive brought in to improve care to patients with fractured hips). This had improved when compared with 22% of patients in 2013/14. Only 65% of patients had their surgery in 36 hours (compared with 72% in 2013/14) although and 85% of patients were reviewed by a geriatrician in 72 Hours (up from 60% in 2013/14). The hospital reported almost all patients received a pre- and post-operative abbreviated mental test. The post-operative results were significantly improved in 2014/15 over the previous year.

Competent staff

- Appraisals for staff were mostly meeting trust targets. All staff we asked knew who was responsible for their appraisal. Staff in lead roles knew who was in their team and due an appraisal from records available in the electronic staff record system. All non-medical staff (all staff other than doctors) on Hutton ward and the pre-operative assessment unit had received an appraisal. Other wards were approaching 100% compliance with the exception of Waterside ward where nursing staff were at just 60%. Data for medical staff was not provided to us by our core service segregation, but the appraisal rate for all medical staff at the trust was 97%.
- There was a lack of in-house training and development provision in theatre. This was a concern for the head of nursing and the main theatre manager. An in-house training role was in development and a member of the main theatre team had been approached to take this forward. Some training was provided on equipment by the supplier of the product, specifically for new equipment. But training for new staff was being done by available staff rather than a departmental approved trainer.
- Medical staff were evaluated for their competence. The consultants we met said the revalidation programme was well underway. This was a recent initiative of the General Medical Council, where all UK licenced doctors are required to demonstrate they are up to date and fit to practise. This is tested by doctors participating in a robust annual appraisal leading to revalidation by the GMC every five years. Appraisals of medical staff were carried out each year and evidence demonstrated they were up-to-date.
- There had been a limited response to an increase in medicine errors, but no regular competency training in place. There has been no regular competency check that nurses were administering medicines safely but an annual numeracy test had, however, been introduced for all trained nurses. A competency test was being rolled out across the trust. Information from incident reports stated a high proportion of the medicine errors had been made by agency staff. Staff told us that if there were concerns raised then the nurse would be supervised on medicines rounds to make sure they were following safe practice. A monthly newsletter had now been produced about medicines' management and was in circulation from March 2015.
- Due to a lack of reporting capabilities of the in-house theatre data base, there were no comparative outcomes by clinician available for review.

Multidisciplinary working

- There was, in places, cohesive collaborative working from staff contributing to patient care. We observed a

common sense of purpose among staff, although some areas were strongly nurse-led and there was limited input from medical staff. Apart from senior staff 'cabinet' or board meetings, there were some activities where medical and nursing staff did not meet together or share each other's views and experience. In day-to-day working, however, staff proactively supported each other. We observed and were told there was no obstructive hierarchical structure and all staff were valued for their input and roles.

- Patients were receiving physiotherapy to help their recovery. A patient on Steepholm, for example, said they had been told they required some therapy before being discharged. A physiotherapist had visited them and gone through specific information to deal with a chest infection. They had then spent time doing gentle exercises which were of a type the patient could continue after discharge home. An orthopaedic patient on Waterside ward said they had seen a physiotherapist every day and the nursing staff also helped them walk and exercise.
- There was a mental-health liaison team in the hospital for patients with identified needs. There was a specialist mental health nurse available who worked with and could escalate issues to a psychiatrist. They were also able to liaise with the vulnerable adults' team to support patients who might be at risk.
- The national bowel cancer audit 2014 showed 100% compliance with there being a multidisciplinary discussion in the 85 cases reviewed.

Seven-day services

- There were sufficient doctors in the hospital during the daytime of Monday to Friday, but the out-of-hours cover from doctors across the whole seven days did not meet the trust's policy or good practice for patient safety. The doctors on duty out of hours were required to be a medical registrar who was clinical lead, and for the surgery wards a surgical specialist registrar (grade not mentioned) and a surgical FY2 (second-year trainee doctor). Staff we interviewed said there had only been a general surgery registrar for five weeks in the last six months. The most senior general surgery doctor in the hospital was otherwise in this six months an FY2 trainee. We asked the trust to provide evidence of the out-of-hours rota to demonstrate the cover provided against the trust policy, but this was supplied only for nursing staff.
- There was provision for emergency surgery out of hours. There was a team on call out of hours (from 10pm) each day in the week, and a team was based on site or on-call at weekends from 9am to 5pm to undertake any emergency cases.
- Arrangements were in place for the supply of medicines when the pharmacy was shut. A pharmacist was also available on-call out of hours.
- Access to clinical investigation services was available across the whole week. This included X-rays, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, and echocardiograms (ultrasound heart scans).
- There was access to therapy staff out-of-hours through on-call rotas. Otherwise, therapy staff (including physiotherapists, occupational therapists, speech and language therapists and dieticians) were on duty on weekdays. Therapy staff organised plans for patients needing specific therapies to be continued over the weekends or at night.

Access to information

- Access to patients' diagnostic and screening tests was good. The medical teams said results were usually provided quickly and urgent results were given the right priority.
- Patient records were usually available in good time. Staff said records were provided relatively quickly in emergency admissions (all patient records were on paper for patients coming from other wards or new admissions).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we met said they had been asked to provide valid consent. A patient on Steepholm ward said the consent conversation with the consultant had been clear and straightforward. They said they had asked lots of questions and received clear answers. They said they had been told all the risks and benefits of the procedure

and able to discuss what impact the procedure they were having would have on any future treatment. They had signed consent forms and said all this was checked with them again verbally before they were anaesthetised. Another patient we met in the day-case unit made very similar comments about the consent process. They said they had attended the hospital for a pre-operative assessment and their consent had been given at that stage and again on the day they attended for the procedure.

- Consent was done at appropriate times. Consultant orthopaedic surgeons held consenting sessions in the pre-operative assessment centre prior to the patient's procedure. Consent for general surgery was provided by the patient on the day of the surgery. Consent for emergency surgery was also provided by the patient on the day of surgery if they were able to do so. Patients had come to the hospital in an emergency and not able to provide valid consent due to being unconscious or lacking capacity at the time. The surgery was carried out in the patient's best interests and in accordance with the law around life-saving or emergency procedures.
- An audit of consent undertaken in late 2014 showed good results but some areas identified as requiring improvement. The completion compliance with Form 1 (consent for people over 16 and able to give valid consent) was 95%. Completion compliance with Form 4 (adults who were unable to consent) was less consistent at 79%. Comments from the governance report also said there was a risk with being unable to identify the consenting surgeon. There was no evidence in the governance review of whether the compliance rates had improved or deteriorated and no plans to make further improvements.
- Staff had an understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Nursing staff were clear about assessing patients for their ability to make valid informed decisions when these were required. A member of staff on one of wards made specific reference to how a patient's capacity could change and gave an example of a patient with cognitive impairment who could make decisions at some times of the day and not others. Staff were also aware of when a Deprivation of Liberty might need to be considered.

Staff we met said they would liaise with the vulnerable adults team for guidance and support when either there were concerns over a patient's mental capacity of a patient's liberty was at risk.

Are surgery services caring?

Good

We have judged the caring of the surgery services as good. Feedback from people, who had used the service, including patients and their families, had been positive overall. The Friends and Family Test had showed exemplary results. Patients we met in the wards spoke highly of the caring and kind staff. Staff ensured patients experienced compassionate care, and care promoted their dignity and human rights.

There was an outstanding example of caring shown to a patient with a learning disability who was coming into the day-surgery unit for a procedure. This showed a good depth of knowledge and sensitivity for people with different needs.

Patients and their family or friends were involved with their care and included in decision making. They were able to ask questions and raise their anxieties and concerns. There was access to chaplaincy services and support from the mental health team.

Compassionate care

- The Friends and Family test results for the three wards showed exemplary results. In the first quarter of 2015 Hutton ward would be recommended by 83 to 100% of patients. Steepholm would be recommended by 97 to 98% of patients and Waterside by 89 to 98% of patients. The response rates from patients were good. The best response rates of over 60% were on Steepholm ward. No other response rate fell below 34%.
- Most patients we met said they had received compassionate care. One patient on Steepholm ward said: "the nurses have been really kind", and another on the same ward said: "I've been really well looked after. Cannot complain at all." Another patient commented specifically on the member of staff who was looking after the food. They said: "I couldn't have been looked after better by [the member of staff]." The patient

needed a specific diet and said the member of staff had made sure they always had something provided they could eat. They said: "they were so caring to me." Another patient we met in the ambulatory care discharge area who had been on Hutton ward said some of the staff had "looked after me well" but "I had to wait a long time for help" when pressing the buzzer, and "I had to wait two hours this morning to get help." They said: "night staff were sometimes impatient with me" and "some nurses were short with people." The patient was transferred from another ward and we were told: "when they moved me I arrived at a quarter to 11 [pm]. All my things were dumped on the bed. They said they would sort it out in the morning."

- We observed good attention from all staff to patient dignity. Any patients we observed in the operating theatres were fully covered in all preparation and recovery rooms, in the day-case unit, and when back in the ward area. A patient operation we observed demonstrated dignity was maintained at all times, including when repositioning the patient. On wards curtains were drawn around patients and doors or blinds closed in private or side rooms when necessary. One patient we met on Steepholm did comment, however, how a physiotherapist working with a patient had neglected on a number of occasions to pull the curtains when providing therapy. The patient we spoke with had reminded the physiotherapist they were not respecting the patient's dignity. On the Waterside ward the patients (both private and NHS patients) had individual rooms, so this improved the confidentiality of conversations.
- We observed and were told patients living with dementia were treated with kindness and understanding. A frail elderly patient had been admitted to Hutton ward following a fall. We met with a close family member. The patient had been admitted to the ward that day from the surgical assessment unit (SAU), but the relative was impressed with how the staff were already looking for ways to help the patient to eat. They had made some bread and jam cut up into small pieces for the relative to help give the patient. The relative said the staff on the SAU had been "kind and helpful" and accepted the offer from the family to come and help with the patient. The relative was already getting involved with the patient care also on Hutton ward. The Steepholm ward had recently been awarded the Quality Mark for Elder-Friendly Hospital Wards by the Royal College of Psychiatrists. This was an award for wards that aimed to provide a continuous focus on care provided for people over the age of 65. The ward demonstrated, among other things, how it engaged patients, ward staff and hospital management and governors in assessing the quality of care provided
- The trust scored well in privacy and dignity in the PLACE (patient-led assessments of the care environment) surveys in 2013 and 2014. However, the results had dropped from 2013 to 2014 and were now at the same level as the NHS England average.
- We observed good attention from all staff to patient confidentiality. Voices were lowered to endeavour to avoid confidential or private information being overheard as much as possible. Three patients on the wards said, however, they found it was usually difficult to avoid overhearing some conversations between patients and staff when they took place in the adjacent bed-space. Patient beds were relatively close together on the two surgery wards, Hutton and Steepholm, which meant staff supporting the patient, could usually not avoid being overheard. One patient commented upon the patient next to them having some hearing loss. They said staff therefore had no option but to talk loudly with the patient, but they commented that conversations between staff were usually quieter. Another patient said of the confidentiality of conversations: "it's the nature of being in hospital really. I think the staff here are pretty thoughtful and would talk to us and the family somewhere private if they were saying something we would not want kept private. That's if the patient is well enough to move, but most of us here can move I guess."

Understanding and involvement of patients and those close to them

- Patients with additional or extra needs were supported. There was an outstanding example of care to a person with a learning disability provided by the staff on the day-case unit. The unit had an operating department practitioner (ODP) who had the lead role for supporting patients with a learning disability. They had spoken to the manager of the care home where the patient was living. Arrangements had been made for the patient to arrive early to the unit and for there to be no delays in their procedure, as they were known to be anxious. The ODP had arranged for the manager of the care home to

accompany and support the patient during the day and through anaesthesia and recovery. All of this had been written in an email to the staff on the ward, along with medication information and other details about the patient. The ODP had sent a booklet to the care home which was an 'easy read' guide to having an operation to be shared with the patient.

- Friends and relatives of patients were kept informed and involved with decisions when appropriate. Relatives and close friends of patients we met said they were able to ask questions and could telephone the ward when they were anxious or wanted an update. Staff said they felt there was a high level of older patients who had family members living in other parts of the country. Relatives were able to talk to staff by telephone to get updated information, as long as they were able to identify themselves to the satisfaction of the staff. A family we met said one of the surgical registrars had taken time to talk to them privately when they were anxious about their relative. Others said they felt involved and were encouraged to ask questions. One relative told us: "I said to them [the doctor] my memory was not the best and I was getting a bit overwhelmed with it all. They said if I thought of anything when I was at home, I could ring up and ask or write it down to ask when I come in the next day. That was nice for me to know."
- Patients on the day-case unit were given time to ask questions about their procedure and address any anxieties or fears. The nurses demonstrated a level of understanding of their patients whereby although, by the nature of day-case procedures, the operation was less of a risk or complexity, patients could still be anxious. Staff were generous with their time with patients and made sure they understood any aspects of the procedure and how they would proceed through the unit before going home. Families or carers were able to accompany the patient, or were able to remain in the waiting area or use the café facilities in the hospital.

Emotional support

- There was access to a multi-faith chaplaincy for patients and their relatives and carers. The chaplaincy team were available in the daytime from Monday to Saturday, and held a service for patients on the Sunday at 11am. The chaplain visited the wards each Saturday to tell patients about the service and, if they asked to go, made sure they were enabled to attend.
- There was support for patients with cancer from a team of Macmillan nurses based at the hospital. The nurse in charge of Steepholm ward, on one of our visits said this team had met and talked with patients and their relatives. They had a large resource of knowledge and experience to draw up on to provide advice and emotional support.
- There was support from the palliative care team and specialist nurses. Staff told us these nurses had visited the wards and provided support to patients and families. They were also able to contact and obtain support and advice from social services to further support people where this was needed.

Are surgery services responsive?

Good

We have judged the responsiveness of surgery services as good.

There was good provision of the number of operating facilities to meet the needs of the local population for both main and day-case operations. The hospital was meeting referral to treatment times in March 2015 for surgery patients and had been for most of the last six months. Emergency surgery provision was set aside in one theatre in three afternoons a week and then out-of-hours and on weekends. There was no evidence to suggest not providing emergency surgery provision every daytime was putting patients at risk.

Most patients were accommodated in a surgery ward to provide support from staff specialised in post-operative care. The hospital did not have as many ortho-geriatricians as they needed, but the review by these medical staff had improved. Complaints were reviewed, but the focus on them in staff meetings had been about just the target for responding rather than showing evidence of emerging trends and learning from them.

The hospital met the needs of patients and their families and visitors well in relation to attention to equalities and diversities. It was meeting the needs of patients who had religious and cultural preferences.

There was, however, a high bed-occupancy in the hospital making last-minute changes or emergency admissions hard to manage. Due to bed pressures there were frequent delays in discharging patients from the recovery room in main theatres and onto a ward.

Service planning and delivery to meet the needs of local people

- The hospital trust worked with commissioners to plan for and meet the needs of the local population. There were regular meetings and an open relationship between the stakeholders.
- There was good provision of main operating facilities to meet the needs of the local population and visitors in the summer months. There were four main theatres (one of which was the first to be refurbished – completion of all four would be by November 2015). There were two sessions each weekday and a maximum of 30 operations performed. To meet local demand, one theatre was dedicated to trauma cases each afternoon. The main theatres had one theatre set aside on the afternoon of three days each week (Monday, Wednesday and Friday) for unplanned emergency operations (named as CEPOD sessions following the recommendations for emergency theatre time to be set aside by the Confidential Enquiry into Peri-Operative Death). Emergency CEPOD sessions also took place on nights and weekends as required, through the emergency on call-team. We asked the hospital to provide evidence of the utilisation of the CEPOD theatre time and how the allocation, as it was not provided each day of the week, was able to show it met demand. We were provided with a list of operations performed for April 2015, but no analysis or evidence to show the demand had been met in this hospital or whether patients had to be transferred elsewhere. We were able to see, however, the session was used on most days in April 2015 and on the weekends. In the weekdays of April, there was a provision made for 65 operations (5 slots over 13 days) and there were 20 performed in the Monday, Wednesday and Friday CEPOD set-aside sessions. There were a further 15 operations performed out of hours. Four in the evenings or early mornings and ten on the weekends. This, without any other evidence to use, would suggest demand for CEPOD time was easily and safely meeting demand. A variety of complex and non-complex operations were performed.
- At times surgery patients had been accommodated in other wards or areas due to bed pressures, although this had been relatively infrequent for surgery patients. The data provided showed, over the 13 months from April 2014 to April 2015, the majority of patients not on surgery wards were being accommodated on the Waterside ward (53.8%) and this had been as high as 77.6% in April 2015. This was otherwise a private surgery ward, so staff were appropriately trained and experienced to manage these patients. The next highest incidence of patients being accommodated in a non-surgery ward was patients being accommodated on Cheddar ward (10.8%). This was an escalation ward used for winter pressures which had since been closed. Next highest, specifically over the first four months of 2015, were patients accommodated in critical care (13.1%). These were patients who would have needed a critical care bed at some stage of their care, but were now fit for discharge from critical care to a surgery ward but a bed was not available.
- There had not been excessive numbers of medical patients being accommodated on the surgery wards (sometimes called 'outliers'). Between April 2014 and April 2015 4.5% of medical patients days were spent on a non-medical ward.
- There was a good provision of day-case surgery facilities to meet the needs of the local population. There were two operating theatres with their own preparation rooms. The day-case unit had a separate reception area and an adjacent waiting room. The receptionist told us patients would book in at reception and then be seated in the waiting room before being met and taken through to the ward area by a nurse or healthcare assistant. Patients who were vulnerable or had different or additional needs could be accompanied by a carer into the ward and other areas prior to the operating theatre.
- There was a very high number of older people in the local population, but only two consultant ortho-geriatricians at the hospital, supported by some part-time hours from a community older persons' consultant. The trust had identified three consultants was the optimum number needed and had continuously made efforts to recruit to this post for over three years; there was an advert out for this third post at the time of our inspection. Weston General Hospital had the second highest average age of patients in England

(79 years) and the highest number of people living in care homes per head of the local population in the UK. There was, nonetheless, a national shortfall of ortho-geriatricians in the UK, and the trust was not alone with this problem. The fractured neck of femur audit showed, however, of the 321 patients who had surgery in 2014/15, 85% of them were reviewed by a geriatrician. This was slightly below the South West and NHS England average, but was an improvement over the 60% in 2013/14.

- Of late, the hospital had improved and had met all the NHS waiting targets for referral to treatment times for surgery performed. This was partly due to the low number of operations and limited scope carried out. The latest targets (March 2015) as published by NHS England per surgical procedure showed 99% of general surgery patients and urology patients were waiting within 18 weeks (against the NHS operational standard of 92%). There had been variable but relatively good results in the six months of September 2014 to February 2015. General surgery services met the target from November onwards and urology from October onwards. Trauma and orthopaedic surgery (the trust's largest single specialty) had met the target in March 2015 but was just below 92% in all but one of the previous six months.

- As required, the hospital provided single-sex wards and units for patients. The inpatient wards were divided into male and female patient areas. The SAU/CDU had been redesigned to provide segregated areas. There was also a partition that could be moved between the male and female areas in the SAU/CDU which would allow the beds on one side or the other to be increased or decreased to meet a change in demand. The day-case unit had been reconfigured so there were fully separate ward areas for male and female patients (although one area remained marked as 'recovery' and not, as it was, the female ward). The only areas where there was no ability to provide patients with any segregation was in the recovery rooms, which is not unusual in NHS hospitals. There was the ability to screen patients with curtains, but these would often not be used for safety and observational reasons.

- There was provision of TV screens at most patients' bedsides and this was free access. It included free-to-air channels and dedicated film and news channels.

Access and flow

- We were told by senior staff there were frequently delays in patients being discharged from the recovery room in main theatres to a ward bed. Staff said this caused delays to upcoming sessions or cases and was particularly problematic towards the end of the morning and afternoon sessions. With the hospital being, as most NHS hospitals, under bed pressures and with delays to patient discharge from the wards, this was a clear probability. We asked for evidence of the delays for patients leaving main theatre recovery in the last 12 months. This was not forthcoming as staff said the theatre booking IT system was unable to produce any useful reports. The data we were supplied with was an audit of delayed discharges from recovery dated May 2008 to July 2009 and not current. However, the recovery room was the same size and configuration at that time (5 beds) and the main reasons for the delay then were the lack of a ward bed. We ran our own analysis of the data provided for the operations in April 2015. From the time to recovery and time out of the department we were able to see the time spent in the recovery room. The longest were 8:35hrs and 7:46hrs and 20 patients waiting over two hours. There were, however, no reasons provided for the delays, which could have been clinically justified.

- There were no facilities for patients in the recovery room such as access to any drinks or food if patients who were waiting for a bed or had to remain in the recovery room overnight. The April 2015 list showed there was one patient who was operated on in the early afternoon who was admitted to a bed just before midnight. This patient was delayed by six hours and 50 minutes but, again, this might have been clinically justified. There was no evidence of patients remaining overnight in recovery in April 2015.

- There was a high bed-occupancy in the inpatient wards. It has been recognised that occupancy of over 85% has an impact on the quality of patient care delivered. A rate of 85% or below gives staff flexibility to admit people in emergencies, undertake non-directly patient-related tasks, such as audit work, training, and mentoring of new staff. The occupancy on all wards (we are not able to extract the data by just surgery wards so medical have been included) in the quarter of January to March 2015 was 94.5% against the NHS England average of

88.5%. This was within the top 40 of NHS trusts in England out of just over 220 trusts. It was also 5% higher than the average for NHS trusts in the NHS 'local area' of Bristol, North Somerset, Somerset and South Gloucestershire.

- There was a relatively low number of elective operations cancelled, and the rate had steadily fallen in April 2014 to March 2015. There were nine cancelled operations in January to March 2015, compared with 23 in April to June 2014. Only very few of these (two in the year) were not rebooked and carried out within 28 days of the cancellation. Staff worked hard and with considerable flexibility to avoid cancelling surgery.
- Not all patients with a fractured neck of femur had surgery within 48 hours. Guidance from the National Institute of Health and Care Excellence says hip fracture operations should be performed on the day of or day after of admission. Data from the hospital showed 280 patients were admitted with hip fractures in the period 1 April 2014 to 31 March 2015. Of these, 68% had been operated upon within 36 hours and 81% within 48 hours. This had not been taken to the clinical governance meetings in minutes we reviewed and there was no evidence of it being acknowledged or addressed.

Meeting people's individual needs

- There was provision for people coming to the hospital with drug and alcohol dependency, and mental health needs. Staff said the hospital experienced fluctuating incidences of patients admitted with either primary or secondary drug and alcohol long or short-term dependence (that is to say, the dependence was either the reason for the admission or part of the patient's health profile). The hospital was based in a town with a high population of summer visitors and a number of drug and alcohol support services based locally. The staff on the SAU said they had good links with the experienced mental health crisis team who were based on the hospital site (provided by another NHS organisation) and also social services. They said they had a good and usually rapid response from this team when they needed support.
- Wards had notice boards with useful information for patients and visitors. They had a variety of information, but included the names of the nurses who were in charge of the ward that day. On the days we visited they had been updated with the latest information. There were posters about giving comments, compliments or making a complaint, and other information about infection control, healthcare, patient safety and audit results.
- There was a varied view by patients of the food, with some but not all patients we met satisfied with what they were offered to eat and drink. One patient said they had been impressed with being offered either a small, medium or large portion and not "just given what you were given." A patient on Hutton ward said the food was enjoyable and said all the meals had been tasty. Of the seven patients we met on Steepholm ward, most said they found the food tasteless and the portions were quite small. They commented, however, that the sandwiches provided at tea were good. Food we saw being given to patients on the Saturday lunchtime was a full range of hot food to provide for what the patient had chosen the day before. This included soft food and salads. The housekeeper who was serving the meals said patients who had been admitted after the menu choices had been made would be catered for. They said there was either "plenty of the main hot meal for them to have", or "we will make sure we find them something they like as soon as possible." Snacks of cake and fruit were also available. A patient said the nurses had made them toast on a couple of occasions when they had not wanted anything more substantial. The trust had scored better than the NHS England average for food in the PLACE (patient-led assessments of the care environment) survey in both 2013 and 2014 and seen an improvement from one year to the next.
- Diversity of tastes, health, culture and religion were taken into account with provision of meals. The printed menu changed over a four-weekly programme and patients who had been in the hospital for over a week said they had been pleased with the variety. There was provision for vegetarians and vegans, and for people who had specific requirement, such as gluten-free diets. There were options available to cater for patients who required halal or kosher meals.
- Translation services were available. There was a telephone translation service provided for general or urgent translation needs. There were also translators available to visit the unit to provide either one-off

support for a specific situation, or a more planned longer-term service. The hospital had a number of staff who spoke different languages who would provide assistance if they were available at the appropriate time.

- Staff were trained and aware of the need for extra support for people with complex needs. There was a room available in the SAU, and used by the emergency department, for people with mental health needs to have quiet and confidential discussions with staff. There were side rooms on the wards for people who had needed more peace and quiet, or might have behavioural patterns that significantly disturbed other patients. To meet individual needs, the wards had staff with a range of link roles. They included nurses leading on such subjects as tissue viability, infection control, diabetes management, patients with a learning disability, and patients living with dementia.

Learning from complaints and concerns

- There were comprehensive and helpful leaflets available in all the wards we visited on how to make a complaint. The leaflet included advice on how to get help with an interpreter or how to obtain the leaflet in a different format. The form explained how consent may be needed from the patient for some levels of correspondence through family member when confidential information could be shared. There was also an area to complete to explain why a patient might not be able to give their own valid informed consent.
- Staff told us they were asked to contribute to complaints about their ward or unit. We saw incident reports or complaint investigations demonstrating staff involvement. The incident reports and root-cause analysis reports we read did not blame staff for errors or single out staff for specific criticism.
- Complaints were discussed in departmental meetings. However, in the Planned Care division 'cabinet' meetings for January and February 2015 and the quality and governance assurance report for December 2014 and January 2015, reports of complaints centred on whether they had been responded to in good time. There was a comment in one report about there being an increase in complaints about 'essential care' on one ward, but no actions to be taken to address this stated. In another report was a statement about communication continuing to be weak and reference to an action plan, but it was not discussed. There was a comment about patients complaining saying they were not seeing doctors every day, but no further remarks or explanation. There were no trends in complaints discussed and no actions set to learn from and improve care.

Are surgery services well-led?

Requires improvement

We have judged the governance of the surgery services as requiring improvement and some, but not all, aspects of the leadership. The approach to risk management in the department was improving but the register of risks had not been used proactively. There were a number of good departmental meetings held, but it was unclear if and how these fed into the overall clinical governance and provided board assurance. There was a poor strategy for the management of the main theatres which was leading to inefficiencies and stress for the staff involved.

There was a range of clinical audits undertaken, but no audit calendar for general audit of patient outcomes, care standards, and best practice. Good practice and shortcomings were identified from the audit work that was being produced, but there was no evidence to show how actions were progressed and changes made to improve patient outcomes. The theatre IT system did not provide staff with the tools to look at surgery outcomes and governance data. This issue had not been raised through the risk register.

There was mostly a good level of support for staff. The ward staff, day-case unit and surgical assessment unit were well supported through the different nursing teams, but main theatres had experienced recent frequent staff changes and this was difficult for a staff team who worked in a high-pressure environment.

There was, however, a strong and committed and experienced group of core staff. Staff were dedicated to their patients and one another and we were impressed with their loyalty and attitude. There were a number of excellent nurses recruited from overseas who had impressed patients and other staff alike. Staff were supported by an excellent monthly newsletter, which is one of the best examples we have seen.

Surgery

Due to the transaction process there was a pause on vision and strategy for the service. This was also the case for improvement and sustainability, although day-to-day activities, procedures and plans still continued.

Vision and strategy for this service

- The efficiency of the operating theatres was sub-optimal. Staff were aware of this, but had yet to find a solution to achieve improvements. The theatre utilisation over the three months was as low as 63% in March for one of the day case theatres and one of the four main theatres. This rose to a high point of no more than 76% in one of the other main theatres. Senior theatre staff told us the scheduling of theatres needed improvements for efficiency. We attended one of the weekly scheduling meetings where we heard the sometimes different priorities of the booking or access team (who were responsible for the RTT targets) and the managers responsible for staffing the theatres with the appropriate teams, including arranging for temporary staff.
- There was no agreement within the hospital trust to 'lock-down' or 'fix' theatre arrangements for any given period of time. Therefore, at the meeting we attended on a Thursday at midday, the scheduling for the following Tuesday (just following a bank holiday) was still not finalised. This system was leading to inefficiencies for both patients and the trust. The hospital also did not use the day-case unit in the strictest sense of the term. Some day-case procedures were carried out in the main theatre. The day-case unit was also used for a recovery from outpatient procedures such as bronchoscopies, interventional radiology and blood transfusions. Some main-theatre patients were also being brought to the day-case unit to recover. A number of staff were concerned about this, but we were not able to determine entirely the impact of this for the patient. It appeared the needs of the patients were being put first, but staff felt it led to complications and inefficiencies. Due to the experience of the staff in the theatre units, it was nevertheless being safely managed.
- The hospital trust had recognised since around 2010 it was not financially sustainable in its current stand-alone form. The vision and strategy for the surgery services was therefore very much tied up with the transaction process. The theatre refurbishment plans had gone ahead, but there were otherwise understandably limited plans for the future at the time of our inspection. In the context of a trust which was shortly to be acquired by another NHS provider, it was unsurprising that the long term vision for the service was unclear.

Governance, risk management and quality measurement

- There was a risk register in use, but the version provided to us demonstrated it was not being used effectively. It was not a standing agenda item at the clinical governance meeting, although we were told it was discussed at a separate risk meeting. The entries about identified risks were not all current and some had been resolved or were in the process of resolution, but still showing as high risk. Some entries were also not related to risk, such as a number of entries about the financial impact of theatre refurbishment and the downtime of one theatre at a time. This was recognised by the recently appointed general manager for surgery and head of nursing and the register was being reviewed.
- There was a range of governance and departmental meetings held within the division, but it was unclear if and how these fed into the overall clinical governance structure and provided board assurance. This included monthly meetings of the medical team which started with the anaesthesia team and then moved into a joint meeting with the general surgeons. Actions were agreed from the meeting and given a reference number. Outstanding actions were discussed at each meeting, although there was no time-limit on when they needed to be completed or their impact upon practice.
- There was a range of audits and some performance measures of aspects of care and safety within the service, although not in accordance with an approved audit calendar. There were useful ad hoc audits carried out by consultants and medical students which were reported at the anaesthesia governance and safety meetings. This had included preventing peri-operative hypothermia; anaesthesia consent; and compliance with post-op pain management. Although shortcomings with these procedures had been identified and actions proposed, there was no evidence of how these actions had progressed and whether patient outcomes had improved as a result of changes. There was, however, no evidence of standardised audit being carried out of general practice. For example, there was no audit of surgical site infections, returns to theatres, or the

outcomes of the enhanced recovery programme. There was no review of the use of NICE guidelines or best practice, or review of compliance with guidelines for theatre management from the Royal Colleges, such as the Royal College of Anaesthetists Accreditation Standards. There was an audit of compliance with consent, but no actions plans to address shortcomings or evidence of whether compliance had improved or deteriorated.

- Theatre and managerial staff described significant problems with extracting useful and valuable data from the theatre IT system used by the hospital. The system was relatively easy to use and worked well for day-to-day use. The utilisation of the theatre could be shown and where there were gaps. However, staff were not able to use the system to obtain reports much beyond the daily lists. We were told the IT system was one of the most frustrating areas for the management of the surgery services in providing data and governance information.
- Staff were included and informed about the running of the service. There were monthly meetings attended by a range of staff. The meetings were minuted and circulated. The structure of the internal organisation of the service had recently changed, but the minutes of a 'cabinet' meeting held for the previous set-up (the Planned Care directorate) showed a wide range of staff had been present, including senior management, matrons, ward managers, and lead clinicians. Staff at ward level said they had regular ward meetings and most staff got to attend on a rotation basis.

Leadership of service

- There was a varied level of support for the staff from their direct managers. The surgery wards were supported by an experienced and long-serving matron. The matron for theatres had recently left after only a short tenure. A new matron for theatres had been appointed and was starting in June 2015. In the meantime, the matron who had been appointed to an interim post to, latterly, manage the theatre refurbishment programme, had agreed to oversee the theatre division. There were new staff in the head of nursing and general manager posts who were recently appointed and beginning to find their feet. Staff said they were approachable and beginning to see where change was needed and prioritise tasks. We heard a lot of praise and respect for the director of nursing from all staff.
- There was support among senior staff for one another. Senior staff worked closely together, such as the band seven senior sisters across theatres, ICU and SAU, and also the wards teams.
- Nursing staff on the wards, including the SAU said they felt supported by the nurses in charge. There had been a relatively consistent team of ward and unit sisters and staff nurses. Although there had been a high use of bank and agency staff, the regular staff came across as well supported and putting the patient first in delivery of care.
- There was a variable view of support for the medical staff. Trainee doctors felt they were well supported by the consultant body, but not always listened to by the executive team. Consultants we met felt their work and the flexibility they showed had been appreciated by the directorate and executive team.

Culture within the service

- We found the staff to be committed to their patients and their wards or units. We were impressed with the attitude of the staff we met. There were friendly and approachable student nurses, and the patients we met commented on the helpfulness of the students. The junior trainee doctors we met were approachable and attentive. They showed an empathy with patients, and those we met came across as particularly appreciative of the frailty of a high proportion of patients, and sensitivity towards cognitive impairment. In all conversations with staff, the things that worried them were all connected to patient care. This included delays to patient discharge and managing risks for patient safety. Those things they were proud of were also related to care of patients. For example, the general manager of the surgery services was proud of the flexibility and willingness of the staff teams to changing plans at short notice in order to meet patient need and changing priorities.
- There were some anxieties among staff in the main theatre. The service had lost a matron in 2014 and the replacement had also recently left and this had been described by two staff as unsettling. Staff were working

overtime and said to be building up a lot of 'time owing'. The manager said it was not clear with the workforce vacancies how the staff were going to be able to take their time off. Theatre staff were, nevertheless, described by their manager as "committed and caring and fierce advocates for the patient."

- Not entirely as a result of, but linked with some of the issues with main theatre planning, staff were prepared to work extra hours or offer extra support to deliver safe, effective, caring and responsive care and treatment. Staff and patients said the staff, both nursing and clinical, went beyond their contractual workloads or job description to try to deliver good care for their patients. This included staff in all areas of the surgery division. Many staff described the hospital as a great place to work. This included not just nursing and medical staff, but also portering staff, members of the housekeeping team.

Public and staff engagement

- Patients took part in PLACE (patient-led assessments of the care environment), although the results did not relate to specific wards or the surgery services specifically. The results, which were mostly better than the NHS averages, were encouraging for staff, patients and the hospital trust.
- There was an excellent and comprehensive newsletter produced each month for staff. It included requests for nominations of staff for various 'celebration of success awards' which were running for their second year. There were messages from public bodies, such as Public Health England, awards and recognition for staff and wards, updates on new staff, messages from patients, training and policy updates, and charity news and updates.
- There were monthly open sessions with the trust chief executive with two sessions (and early and midday) each month.

Innovation, improvement and sustainability

- There were sustainable plans and improvements for operating theatres. The main-theatre refurbishment plan was one of the most recent improvements to be approved, and was underway. Some of the improvements had been postponed for financial constraint reasons and it would therefore take several years for the theatres and recovery room to be brought up to modern standards.
- The under-utilisation of the main theatres was having an impact on the financial sustainability of the service. Some theatre sessions were not being offered to external partners as the inefficiencies of the planning were not making them available to these partners in time for them to be effectively organised,

Critical care

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

Information about the service

The department of critical care at Weston General Hospital provided a service to patients who needed intensive care (described as level three care) or high dependency care (described as level two care). Patients would be admitted following complex surgery or in the event of medical and surgical emergencies. The critical care unit provided support for all inpatient specialities within the acute hospital and to the emergency department. The five-bed unit had three separate areas linked together. These consisted of two areas with two beds in each, and one single side room. The service was led by a senior sister and a consultant intensivist.

The critical care unit admitted around 300 patients each year, the majority of whom were medical patients. In the six months from July to December 2014, the department admitted around 38% of its patients following surgical procedures (12% elective and 26% emergency/urgent patients). All other admissions were for non-surgical patients.

There was a five-bedded high care unit located within a short stay medical ward, Harptree ward.

This unit accommodated patients who required enhanced levels of monitoring and clinical interventions. This included patients who were classified as level 2 critical care patients. These are patients who would normally be cared for on a high dependency unit or intensive care unit and includes patients who require single organ support.

On this inspection, we visited the critical care department and the high care unit on Wednesday 20, Thursday 21, Friday 22 May 2015 and made an unannounced visit on Saturday 30 May 2015. We spoke with a full range of staff, including the senior sister, consultants, doctors, trainee doctors, different grades of nursing staff, and healthcare assistants. We met the matron, and the lead consultant intensivist for critical care. We talked with the lead physiotherapist, the dietician and two nurses from the outreach team. Patients who were able to talk with us, and their relatives and friends told us about their experience of the unit. We observed care and looked at records and data.

Critical care

Summary of findings

We have judged the critical care services at Weston General Hospital as requiring improvement overall.

Patient safety required improvement overall. We had serious concerns about nurse staffing levels and skill mix to support high dependency patients on the high care unit on Harptree ward. Appropriate nurse to patient ratios were not consistently provided and staff did not have the necessary competencies to care for level 2 critical care patients. We raised our concerns immediately with the trust executive management team. They subsequently confirmed they had taken immediate action to ensure that appropriate nurse to staff ratios were maintained. However, we did not receive assurance that all nursing staff deployed to care for high dependency patients had all the necessary skills.

On the critical care unit there were good comprehensive patients notes produced by the nursing staff and allied healthcare professionals, although the medical notes required improvement. Infection control was good with low infection rates, despite some poor quality décor showing signs of age and wear. Risks to patients were assessed; their safety was monitored and maintained. There were sufficient nursing staff and trainee doctors who had good support from the consultants, although medical cover was being stretched and reliant upon the goodwill of the existing consultant team. There was a safe level of equipment, and although the unit did not meet some of the modern safety standards, it was being safely managed. Medical staff were not meeting trust targets for undertaking mandatory training updates. There was insufficient evidence of the use of incidents to learn lessons and drive improvements.

Effectiveness of critical care services required improvement to demonstrate patient care was delivered in accordance with best practice. Audit work needed to demonstrate the effectiveness of care with actions taken and lessons learned improving care. Mortality rates on the unit were higher than expected levels, and this had not been examined or reviewed overall. Patient length of stay was affected by delays in being able to discharge patients, although some patients were discharged earlier than optimal. Patients were well supported with nutrition, hydration and pain, but there was no team or clinician available to manage specialist acute pain conditions. Staff had the skills, knowledge and experience to deliver effective care and treatment through training and appraisals and revalidation of their competence, although there was limited professional development of nursing staff. People's consent was being sought in line with legislation and guidance.

The caring by staff was good. Feedback from people we met, including patients and their families, had been overwhelmingly positive. Patients said staff were kind, treated them with dignity and respect, and demonstrated compassion. Patients, their family or friends were involved with decision making. People were able to ask questions and raise anxieties and concerns. There were, however, few of the more recent developments in critical care being provided. There was, for example, no use of patient diaries or follow-up clinics. There was little provision of professional emotional support for patients.

The responsiveness of critical care services required improvement. As with many NHS hospitals there were bed pressures in the rest of the hospital. This meant a significant number of patients on the critical care unit were delayed on discharge to other wards and too many were being discharged at night. Critical care and some of the most unwell patients were not being considered sufficiently within bed planning in the hospital, and not being moved to critical care when they met the criteria for admission. Patients on the high care unit on Harptree ward were accommodated in a mixed sex bay with no separate toilet or shower facilities. There were very limited facilities for visitors or patients in the critical care unit. The critical care unit took account of the needs of different people including those in vulnerable circumstances. Complaints and concerns were listened to although it was unclear how they were being used to improve the quality of care.

The leadership and governance of critical care services required improvement. The governance framework did not ensure quality performance and risk were well understood. It was unclear how review of audits, incidents, complaints and other key information was used to learn and make changes to practice.

Critical care

The clinical leadership did not provide sufficient support to the nursing team with management of the unit. There was, however, a strong and committed and experienced group of core staff. Staff were dedicated to their patients and one another and we were impressed with their philosophy, loyalty and attitude.

Are critical care services safe?

Requires improvement

Whilst safety in the critical care unit was good, concerns about the staffing provision and critical care oversight of patients on the high care unit on Harptree ward meant safety there was inadequate. As a result of the swift response taken by the trust to mitigate the risks of these concerns we have rated safety in the critical care service overall as requiring improvement.

On the high care unit on Harptree ward there were insufficient numbers of suitably qualified nursing staff to provide safe care to patients admitted here. There were also concerns about the level of medical cover on the high care unit. Nursing staff told us that consultants attended the high care unit only when requested to do so but high dependency patients were not prioritised, reviewed first or seen by a consultant every day. Junior doctors felt unsupported and out of their depth. We raised concerns with the trust executive management team. They subsequently confirmed they had taken immediate action to ensure that appropriate nurse to staff ratios were maintained. However, we did not receive assurance that all nursing staff deployed to care for high dependency patients had all the necessary skills.

There were safe levels of nursing cover on the critical care unit but medical cover was being stretched and reliant upon the goodwill of the existing consultant team. There was good cover from the consultant intensivists but the reduction in their numbers meant the rota was unlikely to be sustainable into the future. Support for the junior doctors was good but they were covering too many responsibilities out-of-hours. Nursing staff were updating their training but medical staff were not meeting trust targets.

On the critical care unit there were good comprehensive patients' notes produced by the nursing staff and allied healthcare professionals, although the medical notes required improvement in some areas. Infection control was good with very low infection rates despite staff managing with some poor quality décor showing age and wear. There was a safe level of equipment and, although the unit did not meet some of the modern safety standards, this was being safely managed.

Critical care

Medicines on the critical care unit were safely managed although one arrangement for obtaining new medicines was not recommended practice. There was good nursing coverage with a low use of agency and bank staff. Risks of deteriorating patients were responded to appropriately and there was excellent support for patients from the allied health professionals, particularly the regular unit physiotherapist.

Staff said they were reporting incidents but there was little evidence within the safety agenda to show how they were reviewed and used to learn lessons and improve quality of care. Where there was evidence of care deteriorating, for example, with the recent rise of pressure ulcers, this was addressed on the unit and improving.

Incidents

- Staff were open and honest about reporting incidents. The majority of staff we spoke within critical care said there were no barriers to reporting incidents and they were encouraged to do so. Staff were able to describe what events they would report and gave examples of recent reports made. These had included evidence of emerging pressure ulcers and medication errors or near misses. The trust, overall, was slightly above (higher than) the NHS England average for reporting incidents. This could be taken as an indicator of staff proactively reporting incidents, including near misses as and when they should.
- Staff felt they were not blamed for errors or omissions. All staff we asked said they were not afraid to speak up when something went wrong or could have been done better. They were listened to, able to be fully honest and open, and treated fairly by their peers and managers.
- Actions and learning from incidents was discussed at a unit level but not always shared among staff in a formal process unless they were significantly serious incidents. Many of the staff we met felt there was poor feedback from the trust to incident reports. There was local feedback within the critical care team but nurses and doctors said that wider issues did not have good feedback.
- Incidents were reviewed on the unit for frequency and to identify patterns developing. A list was produced of the type of incidents occurring but there was no evidence to support how this information was being used to review practice and identify where changes were needed. Incidents were discussed with the nursing team at the daily safety briefing held each day and outcomes from any investigations shared. There was, however, no input at the meeting we observed from any of the medical team and the nursing staff said their attendance at these meetings was not regular.
- There was some good learning and teaching from the nursing team following incidents although this had an ad hoc and not systematic approach. Staff had, nevertheless, been enabled and encouraged to review some practice when recurring incidents were recognised and look for innovative ways demonstrate this. For example, one of the nursing team had developed a 'heads up approach to pressure ulcers'. This was in response to action agreed following an identified rise in skin damage and pressure ulcer development in the head area. These had generally occurred from the application of breathing equipment and aids. The nurse had used a model of a head to show the areas susceptible to pressure damage from masks, tubes and lines; such as the nostril, sides of the mouth and the tops of the ears. This had made staff more aware of examining patients for signs of pressure damage in these area and incidents were decreasing.
- Patient mortality and morbidity (M&M) was reviewed at monthly meetings by the medical team although there was no evidence to show how agreed actions were delivering improvement. The meeting minutes did not provide evidence of complete accountability of staff for all actions agreed. There was also no consideration of the slightly higher than predicted mortality rate for the unit within the discussions.
- We reviewed three sets of minutes provided from meetings in February, March and April 2015. These minutes only listed the cases discussed and how all were considered to meet classification of care A: good practice, from the National Confidential Enquiry into Patient Outcome and Death classification of care. Although no actions were therefore considered to be required in these cases, the unit was showing a higher than expected death rate by the Intensive Care National Audit and Research Centre (ICNARC, an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally). In the most recent report for July to December 2014, the unit was

above the expected mortality rate for similar units in two nationally recognised measures. We did not see this discussed or acknowledged in any governance reviews or meetings.

Duty of Candour

- Staff we met were aware of the new regulation relating to the Duty of Candour. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consequently, organisations were required to inform and to apologise to all relevant parties to specific patient safety incidents. There were few complaints or serious incidents within critical care and none in the time since the Duty had come into force. Staff said they understood, however, there was now a duty to be candid about any significant incidents or near misses and apologise to patients and relatives.

Safety thermometer

- As required, the hospital reported data on avoidable patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (including only the two more serious categories: grade three and four) and patient falls with harm. The hospital trust had shown a marked decrease (improvement) over time in both of these indicators over the last three years. Data for this snapshot report from the critical care unit reported one grade three hospital-acquired pressure ulcer in March 2015 but no other harm in the period we reviewed of November 2014 to April 2015.
- The critical care unit had, however, shown a recent increase in hospital-acquired pressure ulcers when measured across a whole month (as opposed to one given day in a month as per the safety thermometer data above). There had been two pressure ulcers in both December 2014 and January 2015, one in February, and an increase to four in March 2015. One of these (March 2015) was grade three, and the others were emerging problems of grade one and two, which were treated before they deteriorated further.
- Patients were safely supported from the risks of falls. There had never been a patient fall with harm on the critical care unit.

Cleanliness, infection control and hygiene

- Rates for unit-acquired infections were low. Data reported by the hospital to the Intensive Care National Audit and Research Centre (ICNARC, an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally) supported this evidence. Most rates of infection had, over time, been below (better than) the national average for similar units.
- There had been no unit-acquired methicillin resistant Staphylococcus aureus (MRSA) infections in the period from 2010 to the middle of 2013. There had been two in late 2013 and five in the first half of 2014. There were then no incidences of MRSA in the second half of 2014 (the most recent data available).
- There had been no unit-acquired Clostridium difficile recorded by ICNARC since the end of 2013, although the information from the critical care notice board said there had been a Clostridium difficile incident in June 2014 meaning the data reported to ICNARC was inaccurate. There had been no unit-acquired bacteraemia infections (those not MRSA) in the past five years.
- At the time of our inspection the unit was visibly clean. This included patient, visitor and staff areas. Equipment used both regularly and occasionally was clean, well-organised, and tidy. Patient bed spaces were visibly clean in both the easy and hard to reach areas such as beneath beds and on top of cupboards and high-level equipment. Bed linen was in good condition; visibly clean and free from stains or damage to the material. There was, however, a possible infection risk from the use of sticky tape in the clinical area for securing notices to the medicines' cupboards.
- Although the critical care unit was visibly clean the décor and environment was showing signs of age, wear and tear and some risks to infection prevention and control. There was chipped plaster and paint in most areas including the patient areas and the sluice. There was an outdated wallpaper patterned border circulating the tops of the walls. As the wallpaper border was lifting away from the walls in some areas it presented an

infection control risk to patients in the unit. The flooring was also scarred and damaged in places from mostly age-related deterioration. There were radiators in the unit all with damaged paint surfaces.

- Audits of cleaning were conducted and results produced but there were some contradictions in outcomes. One audit was reported through the Planned Care Division Infection Prevention and Control report produced quarterly for the infection control committee. Results were shown against national standards consisting of 49 elements ranging from medical equipment, beds, patient fans, and sinks. The audit was conducted by the housekeeping team. Results were shown categorised by the team responsible for the cleaning element. There were shortcomings identified recently in the elements of cleaning by the nursing staff and standards appeared to have deteriorated in 2015.
- Audits conducted by the nursing staff against 14 elements ranging from cleanliness of equipment, the environment, and storage, showed the unit scoring 100%. In the ward audit dashboard for November and December 2014, the unit was scoring 100% for cleaning. This was therefore contradictory to the housekeeping results above. There was no evidence linking these audits, reviewing their effectiveness, and saying how and why they differed.
- Patient bed areas were managed to prevent cross infection. Staff entering bed areas would have usually washed and sanitised their hands in that area. However, one sink was currently out of action so staff were washing their hands in another clinical area close by. Staff wore aprons and gloves put on and removed within the same bed space area. Patient bed spaces had been colour-coded to reduce the risk of cross contamination. Clinical guidelines and protocols were colour-matched in folders that remained in the same bed space. Each bed space had different colour aprons so staff were aware to use these only in the specific area. There was a good supply of personal protection equipment available for staff and visitors.
- Hand sanitising rules were followed. We observed doctors and nursing staff following policy by washing their hands between patient interactions, using anti-bacterial gel, and wearing disposable gloves and aprons at the patient's bedside. All staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow) when they were within the unit. Results for hand hygiene had scored 100% compliance in audits for 9 February to 16 March 2015.
- There was limited provision for patient isolation, although the one side room in a five-bed unit was not untypical provision in critical care units. As a result of the limited provision of isolation facilities for patients, visitors were required to wear personal protection equipment when coming into a patient's bed space, and remove them when leaving. We saw visitors observing hand sanitising requests on entering the unit, the bed spaces, and upon leaving the department.
- Reusable and new kit and equipment was stored and, where required, sealed to prevent cross-contamination. All disposable equipment was in sealed bags in trolleys, drawers or cupboards where possible to prevent damage to packaging.
- Clinical waste was well managed. Single-use items of equipment were disposed of appropriately either in clinical waste containers. None of the waste bins or containers we saw was unacceptably full and nursing staff said they were emptied regularly.

Environment and equipment

- The unit had a safe level of patient ventilators. The five-bed critical care unit was set up to be able to support all patients for intensive care (known as level three care). There were six ventilators on the unit so one available for each patient and a spare for times when a ventilator needed repair or maintenance.
- Although patients were safety cared for and treated, the facilities in the critical care unit did not meet a number of modern standards. They conformed to some of the Department of Health guidelines for critical care facilities but not others. Some of the ways the unit did meet guidelines were:
  - The main theatre complex was located immediately adjacent to the critical care department for accessing emergency support;
  - The bed spaces as they were now configured were of a suitable size for, in an emergency, giving up to five staff enough space to work safely with a patient;
  - All patients were visible from the nurses' station;
  - There were separate buttons for patient call bells and emergency calls;

- Two out of the five beds had electric patient hoist equipment;
- The bed space had a suitable flat screen monitor;
- The unit had the minimum safe level of infusion (three) and syringe pumps (four);
- Each bed had a feeding pump;
- There was a good level of mobile equipment including two haemodialysis/ haemofiltration machines, an electrocardiography machine, and a bedside echocardiography machine. There was a portable X-ray, ultrasound, defibrillator, non-invasive respiratory equipment (CPAP and BIPAP), vacuum dressings, and endoscopes available within the hospital.

The other ways the critical care unit failed to meet the guidelines were:

- Not all bed spaces had a suitable chair for patients to sit out. There was only one chair of the required standard on the unit;
- The equipment around the bed space was not located on ceiling-mounted pendants for optimal safety;
- There were insufficient oxygen, four-bar air, and vacuum outlets. The unit had two oxygen outlets, as opposed to three to four, one four-bar outlet as opposed to two, and one medical vacuum outlet as opposed to two to four.
- The bed spaces did not have their own sink. There was one sink in the side room and then one sink between two beds in the other areas. One of these was out of action at the time of our visit, but had been reported to the maintenance team;
- All sockets were switched as opposed to un-switched and no bed space had 28 available;
- There was no ability to easily control the unit temperature;
- There was no single-room specialist isolation facility with a specialist air change facility.

- The critical care unit was secure from the main hospital corridor. There was CCTV on the main doors to enable staff to see who was entering the unit. There was no reception area so staff tried to meet all visitors as they entered the unit particularly if they were entering for the first time.

- Patients' beds met safety requirements. The beds and mattresses met the standards of the Department of Health and the Faculty of Intensive Care Medicine. Each bed was capable of attaining different positions for patient safety and comfort and to assist staff. All beds had air mattresses to relieve pressure to the body when lying in the same position for long periods of time.

- The units had appropriate adult patient equipment for use in an emergency. There were resuscitation drugs and equipment including a defibrillator and a difficult airway intubation trolley located close enough to the unit in the operating theatre department. Resuscitation equipment was checked daily with records in place showing completion. The trolley containing the equipment had a handle to keep the drawers closed but this did not fully secure the unit to prevent tampering with the contained drugs or other equipment between checks.

- The critical care unit had equipment for use with children in the event of a medical emergency. This was equipment which would be collected and used by the emergency paediatric team. It was stored within critical care in order to be located near to those staff who would be required to attend or accompany a child in an emergency or retrieval to another hospital. The equipment had been regularly checked and sealed to prevent tampering.

- The critical care unit did not have technician support for equipment maintenance so the nursing staff were trained to decontaminate and set up ventilators. There were written procedures and instructions provided and staff were evaluated for their competence.

- In the areas we checked, all consumables and equipment with expiry dates were in date. The nurse we talked with about kit said the stores and trolleys were regularly checked for evidence of any damage to packaging (these were then disposed of) and for items approaching or past their expiry date. Staff said they endeavoured to use equipment first when it was approaching the use-by date. We observed consumables and equipment used in the department were kept to a minimum of those things used often in order to reduce waste and the risk of expired equipment.

- Like many small critical care units there was limited storage space for equipment. However, staff had worked hard to keep the environment as free from clutter and equipment used infrequently as possible.

Critical care

Medicines

- Medicines, including those requiring cool storage, were stored appropriately. Records showed medicines were kept at the correct temperature. Refrigeration temperatures were checked and recorded each day as required. Medicines were stored in locked cupboards in a clinical area and were well organised. The controlled drugs were kept in a suitable standard metal cabinet. Potassium was also stored, as required, under controlled drug requirements, and was locked away.
- Patient medicine records were well managed using standard drug charts. There were standard pre-printed charts for intravenous medicines which were often administered following standard protocols. The main drug charts were written-up by the medical staff. All of those we reviewed were completed, signed, and relatively legible.
- Controlled drugs were recorded clearly and stocks were accurate in all those we checked. We cross-referenced one of the drugs at random with a patient drug chart and found the drug had been administered on the occasions stated on the record.
- There was an arrangement for obtaining medicines which did not meet good practice guidance. When some medicines not available on the critical care unit were prescribed for a patient, the primary (that is only) patient prescription chart was sent through a pod system to the pharmacy for validation and supply. A medicine tracker system was available through the computer system to track and trace the status of the new prescription. Although this system had been well managed and worked relatively well, staff sometimes had to leave the department and go to the pharmacy to retrieve the chart and the medicines. Staff said there was a risk the chart could be mislaid or a medicine was not given at the prescribed time as the chart was not available at all times. The Department of Health guidance for critical care units recommended prescription orders were placed electronically to ensure availability at all times.

Records

- Patient notes were mostly well organised and completed, particularly by the nursing staff, although less so by the medical team. We reviewed four sets of patient notes. They were reviewed for their medical and nursing records and notes from the physiotherapists. Notes were held on paper and accompanied patients as they moved through the hospital. In those we reviewed the main negative findings were:
  - The time of review or decision were not consistently recorded by the doctors;
  - In the four sets of patient notes, most did not always have their 12-hourly consultant review documented in the evening;
  - Some documentation, for example, a peripheral vascular disease review, was not fully completed.

The positive findings were:

- Nursing notes were comprehensive and clear. The care bundle documentation such as sedation holds, pain scores, and delirium screening were well documented;
- There were well completed daily records made each day by the nurse in charge. This included a review of patient and ward. The review of the patient included checks of documentation completeness for key measures such as temperature, nutrition, hydration, venous thromboembolism, sedation and delirium. The ward review was carried out by the nurse in charge at four set times each day. This included discharges or transfers, planned admissions, checks on referrals being made to the outreach team, and staffing issues.
- There was good documentation and audit of central venous and peripherally inserted central catheters and tracheostomy insertions;
- There were well completed resuscitation forms. One we reviewed documented the discussion with the patient and their family. The patient spoke with us later following their discussion with the doctor. They confirmed all the comments written about any resuscitation in the event of a cardiac or respiratory arrest were true and reflected their views.
- There were excellent notes made by the physiotherapist. Patients had detailed management plans which were updated each day. Patient rehabilitation goals and measures of their function were recorded each day. Clear records had been produced so they could be handed over to ward-based physiotherapists when the patient was discharged back to the ward.
- The patients' treatment plans were clear and could be followed through the records. This included risk assessments, nursing care plans, and observations

which were up-to-date and all interactions documented. The prescription of medicines was included in patient notes which could be tracked to the patient's drug chart. Staff signed the records made so they were attributable to the member of staff caring for the patient.

- Discharge notes by the nursing staff contained the appropriate information to safely transfer the patient from critical care to the ward. This included any safety issues such as risks from falls or infection. It covered the standard elements of respiratory measures such as airway and breathing assessment and care, circulation data and care, any disability measures such as pain, sedation, nausea, and diabetes care. For some unexplained reason the pro-forma patient transfer document had the letters t and i missing from the form in any word these were used together. This meant the form was open to misinterpretation.
- The discharge notes we reviewed in patient notes made by the medical staff were not always fully completed and some contained insufficient detail of medical information to provide to the staff taking over the care of the patient. Doctors taking over the care of the patient would, in these circumstances, need to read the transcript of patient notes in order to make sure they had all the relevant information, rather than reviewing a detailed summary.
- Patient paper notes were held in the nurse's station to ensure confidentiality. Notes being used were supervised at all times by staff. Any electronic records or test results were also kept confidential and at no time did we see patient confidential information left visible or unaccompanied on any screens or boards.

Safeguarding

- All non-medical staff in critical care (all staff excluding doctors) were up-to-date with their training to recognise and respond in order to safeguard a vulnerable person. One hundred percent of the nursing staff, administrative and clerical staff, and additional clinical services staff had updated their adult and child safeguarding training by March 2015.
- Medical staff were falling short of the trust target of 90% for updating their training for adult and child safeguarding. We were not able to extract the individual data for medical staff working in critical care from the overall medical staff data, so we reviewed the data for the division in which they worked (Planned Care). The adult training had been completed by 73% of staff and 74% had completed the child training.
- There were policies, systems, and processes for reporting and recording abuse. The safeguarding adults at risk policy had been updated in February 2015 and was set for review in 2018. The policy highlighted the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The six principles of the new Care Act were described at the start of the policy. The policy listed definitions and types of abuse and who might be at risk. It was linked with the provisions of the Mental Capacity Act (2005) in relation to deciding if a person was vulnerable due to their lack of the mental capacity to make their own decisions. Staff were correctly directed to assume people had capacity to make their own decisions unless professionally assessed otherwise. The policy stated people were to be given all practicable help before anyone treated them as not being able to make their own decisions. The policies (including the policy for child safeguarding) clearly described the responsibilities of staff in reporting concerns for both adults and children, whom, as required, were subject to different procedures. There were checklists and flowcharts for staff to follow to ensure relevant information was captured and the appropriate people informed.
- Staff were clear about reporting safeguarding. The nursing staff were able to describe clearly what would alert them to possible abuse and what they would do with their concerns. They talked about signs of abuse that were sometimes more difficult to pick up, such as neglect and people who might be connected to the patient or a relative and themselves be vulnerable.

Mandatory training

- Staff were trained in a wide range of statutory and mandatory subjects at various intervals, although some were not meeting trust target levels for updating training. None of the courses for doctors (in the directorate in which critical care sat) were meeting trust targets. Staff were responsible for their own training being completed, and their annual review would not be signed-off by their line manager if update training had not been completed. The training included a wide range

of topics such as dementia awareness at different levels relating to the staff job role, Deprivation of Liberty and the Mental Capacity Act, life support, and health and safety topics.

- Compliance with some of the key topics at the end of March 2015 against a trust target of 90% showed non-medical staff (all staff excluding doctors) was variable. At one end of the range of topics, 100% of staff had updated their malnutrition screening, and 97% had updated infection control and moving and handling. At the other end of the range of compliance, only 56% had updated their advanced dementia training and 63% had updated their drug calculations (against a backdrop of a rise in incident reporting for medicine errors).
- At the end of March 2015 doctors were showing a failure to meet trust targets for all update training by a significant factor. Deprivation of Liberty Safeguards, Mental Capacity Act, advanced dementia awareness and VTE prophylaxis training had been updated by fewer than 30% of doctors.

Assessing and responding to patient risk

- The hospital had an outreach team to support all aspects of the acutely and critically ill patient pathway. This included early identification of patient deterioration, timely admissions to a critical care bed when required, and follow-up of patients post discharge. Not all of these staff in the outreach team were critical care trained nurses. The hospital policy stated the band seven nurse on duty should be a critical care sister/charge nurse. None of the band seven nurses were critical care trained although four out of the six band nurses were. The hospital had implemented and was using the national early warning score (NEWS) trigger system. This used a process of raising alerts through numerical scoring of patient observations. When a patient triggered the upper levels of the risk score the hospital outreach team were requested to attend the patient and support the staff caring for them.
- In Weston General Hospital the outreach team was not directly managed by critical care, as is recognised good practice, but was part of a wider team including the hospital out-of-hours staff. The outreach team now covered responding to deteriorating patients (including cardiac arrests) and were part of the team managing the hospital out of hours.
- Staff on the wards spoke highly of their colleagues in the outreach team and said they attended deteriorating patients promptly; did not take over the care of the patient but gave advice, guidance and support. They followed-up and reviewed all patients discharged from the critical care unit onto the wards the day after their discharge, or beyond, as did the dietician. Staff on the wards said this provided support and reassurance to those staff taking over the care of a patient who had been critically unwell or had high dependency needs.
- Audit of the use of the NEWS system by the outreach team had not been undertaken since December 2013. A snapshot audit of patients on the wards by outreach staff would have determined if the NEWS system was being used effectively and in a timely way. It would have provided assurance and the opportunity for learning if improvements were needed. One of the outreach staff said there had been retrospective reviews of deteriorating patients and any shortcomings were reported through the incident system.
- Patients' safety was assessed each day by the nursing team in both a twice daily review of each patient and a daily safety meeting. The daily nursing safety review covered each patient and looked at a range of safety indicators including medical requirements such as ventilator set-up; any non-invasive ventilation set-up; alarms being in working order; and tubes, pressure lines and infusions all running and operating as prescribed. Other areas such as the patient's bed space and equipment were checked for safety and cleanliness. We saw the checklists completed, signed and dated twice a day.
- The nursing team and medical staff assessed and responded well to patient risk. Ward rounds took place at regular intervals. There were two ward rounds led by the consultant on duty each day, morning and evening. There was input to the ward rounds from unit-based staff including a physiotherapist, trainee doctors and nurses, and the pharmacist if they were on the unit at the time. Other allied healthcare professionals were asked to attend when required.
- Patients were assessed and given preventative treatment for the development of recognised risks. This

included venous thromboembolism and chemoprophylaxis. Chemoprophylaxis is the giving of medicines to prevent disease or infection and includes provision of antibiotics and anticoagulants.

- Patients were monitored for different risk indicators. For example, each ventilated patient was assessed using capnography, which is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. It was available at each bed on the unit and was used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions. Continuous end-tidal carbon dioxide monitoring was employed in all patients with an artificial airway receiving ventilatory support (as recommended by the 2011 Royal College of Anaesthetists' fourth National Audit Project report).

Nursing staffing

- There were safe nursing staff levels on the critical care unit. However, on the high care unit on Harptree ward there were insufficient numbers of suitably qualified nursing staff to provide safe care to patients admitted here.
- Staff on Harptree ward expressed serious concerns about nurse staffing levels and skill mix in the high care area of the ward. This five-bedded bay accommodated patients who required enhanced levels of monitoring and clinical interventions. This included patients who were classified as level 2 critical care patients. This means patients who would normally be cared for on a high dependency unit or intensive care unit and includes patients who require single organ support.
- During the first day of our visit there were two level 2 patients on the ward and when we returned on day three this had increased to three level 2 patients. Staff told us there were supposed to be two registered nurses covering the high care area but on occasions there was one registered nurse supported by an assistant practitioner (band 4). They told us that when the registered nurse took a break, the assistant practitioner was left to care for five very unwell patients on their own. If they had concerns they had to summon assistance from a trained nurse in another bay or ask the nurse to return from their break. Information subsequently provided by the trust confirmed that the proportion of shifts where the required staffing levels had not been met from March to May 2015 was 11%, 10% and 9% respectively. Staff told us that only one registered nurse had appropriate post-registration qualifications or competencies to care for this level of patients and that staff had received no additional training to care for high dependency patients, for example, advanced life support. The trust told us that two staff employed on Harptree ward had completed a course in the management of ITU/CCU patients and that all staff underwent a competency-based training programme when the high care unit was developed. However, we were not provided with any evidence to support this.
- Following an external review commissioned by North Somerset Clinical Commissioning Group (CCG) in December 2013 the Royal College of Anaesthetists made the following recommendation: "The high care area embedded in the acute medical ward should focus on the delivery of level 1 care. All patients requiring level 2 care should be referred to the critical care team." The trust told us that the recommendations remained in draft, pending a comprehensive review of critical care services by the CCG.
- We reported our concerns to the trust executive management team at the end of our announced visit. They assured us they would take immediate action to ensure that this area was safe. When we returned for our unannounced visit, one bed had been removed from the high care bay, leaving four beds. This allowed a nurse to patient ratio of one to two. There were no level 2 patients on the ward on that day. There were two registered nurses staffing the bay and the hospital critical care outreach team had been instructed to provide cover to allow these nurses to take their breaks.
- Following our visits we asked the trust to clearly define the acuity/level of dependency of patients who could be admitted to high care, and the required staffing levels and competence of nursing staff to meet the needs of these patients.
- The trust produced a standing operating procedure (SOP) which confirmed that certain level 2 patients (as defined by the Department of Health document Comprehensive Critical Care: A Review of Adult Critical Care Services, 2000) would be admitted to high care. These were patients who required enhanced nursing intervention which could not be provided on a general

ward. The SOP identified that this included patients who required non-invasive respiratory support, cardiac support and drug infusions which required intensive monitoring. A recognised assessment tool had been used to assess the number of nurses required to care for high care patients and the SOP stated that the high care area would be staffed by two registered nurses. The trust confirmed that this level of staffing could be consistently provided from within the existing nurse staffing establishment.

- The standard operating procedure did not specify the specific post-registration nurse competencies required to care for patients admitted to the high care unit. The trust advised us that nurses had received additional training and assessment but they did not provide sufficient evidence to demonstrate that all staff had received the required level of training and that this training was regularly refreshed.
- We have requested regular updates from the trust on the actions they are taking as a result of the concerns raised about the high care unit.
- Patients on the critical care unit were nursed in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Therefore, patients assessed as needing intensive care (described as level three care) were cared for by one nurse at all times. Patients assessed as needing high dependency care (described as level two care) were cared for by one nurse for two patients. The nursing rotas demonstrated this acuity ratio was met although sometimes with the use of agency or bank staff. When shifts were unfilled there was a 'group messaging' service to enable staff to offer to cover. The staff we met said most shifts were covered among the substantive staff, and agency and bank cover was a last resort.
- Although, due to the small size of the unit, there was not always senior nursing oversight on all shifts, there was cover at key times. There was supernumerary nursing cover in the department by a band seven (sister/charge nurse) on Monday to Friday but not at weekends unless deemed necessary to support staff and meet patient need. The band six nurses were supported by a band seven senior sister. They were supported by a matron with responsibilities for other areas of the hospital including the surgery wards and surgical assessment unit.
- There was good handover among nurses. Nurses handed the patients over to the new shift following a set protocol. Patients were discussed in relation to updates on their risks, including communication, hygiene, malnutrition, fluid balance, pain, elimination, psychological markers, sleep or ability to rest, and risk of falls.

Medical staffing

- On Harptree ward concerns were expressed about medical cover for high dependency patients. Nursing staff told us that consultants attended the ward only when requested to do so but high dependency patients were not prioritised, reviewed first or seen by a consultant every day.
- A member of staff told us that foundation year 1 doctors were expected to review very sick patients in the high care unit which placed them "outside of their comfort zone and competence". They told us they had been asked to give a medicine which they were not comfortable with. There was no formal link with or support from the intensive care unit. We were told about an orthopaedic patient who had been transferred to the high care unit following a bleed. Their haemoglobin levels had dropped but they were reviewed only by a junior doctor who had no experience of treating high dependency patients. This put this patient at risk of not receiving the treatment they needed to address this potentially dangerous condition. A senior clinician told us that post-operative surgical patients in high care "get a bad deal". They told us it was sometimes difficult to get consultants to review their patients, especially at weekends.
- Following our visits we were assured by the trust that all patients would be reviewed by a consultant on a daily basis and medical staff would be supported by a consultant in intensive care who would review patients every day.
- There was full cover on the critical care unit from consultants and a dedicated consultant rota. The consultants were on duty from 8am to 6pm then on call from home. As recommended by the Faculty of Intensive Care Medicine Core Standards, there was a dedicated rota for working in critical care, and consultants worked in a five-day block. The intensivists worked one weekend in every five including on-call cover at night. In

the week there was either an intensivist or consultant anaesthetist on call out-of-hours. Trainee doctors said consultants would always attend the unit if asked to do so, and were always available on the phone for support and advice.

- The level of consultant cover on the critical care unit was currently being safely managed, but was recognised as not sustainable. There were five consultant intensivists on the current rota. Locum cover had been organised for the summer months when consultants would take holiday. The rota would reduce to four consultants from September 2015 and this number, considering on call rotas, weekend cover, and any sickness or special leave, would not provide sustainable cover.
- There was cover for the critical care unit from trainee doctors but with often too many other responsibilities within the hospital. A foundation year two (FY2) or anaesthetic core trainee doctor was on duty each day from 8am to 8pm and a second from 8pm to 8am. They were required to cover critical care, surgery wards, and accident and emergency. At times there had been only a junior core trainee resident within the hospital out-of-hours. Some of the on-call trainee doctors were not able to arrange inter-hospital transfers. This would then be managed by one of the on-call consultants. This was organised around an informal arrangement with the consultants. The level of trainee anaesthetist cover meant consultants were often staying at the hospital until 10pm, which, along with the small number of intensivists, added to the pressure on the consultant body.
- In accordance with the Faculty of Intensive Care Medicine Core Standards the clinical director (new into post) was only responsible for the management of the critical care unit. They were a consultant intensivist/ anaesthetist and as with almost all doctors working in critical care, they worked elsewhere in the hospital (as an anaesthetist in this case) but had no other clinical director responsibilities.
- There was a good consultant to patient ratio on the critical care unit. There was one consultant on duty/on call for the five beds. This was significantly better than the Core Standards recommended ratio of one consultant for a maximum of 15 beds.
- There was good support to trainee doctors on the critical care unit. There were seven specialist trainees within the surgery services department who worked on rotation in critical care. The trainee staff told us they had good 'hands-on' experience on the unit and a good induction when they started.

Allied health professional staffing

- There was good provision of physiotherapy for patients. A physiotherapist attended the unit each weekday from 8am to noon and was available if needed at other times of the week. There was an on-call service out of hours including nights and weekends.
- There was a good regular service from a dietician and a speech and language therapist was available if needed for a patient review. The dietician visited the unit each day and was on call during the week when needed. An emergency parenteral nutrition protocol had been produced for staff to use on the weekends should a naso-gastric regime need to be commenced.
- A member of the pharmacy team visited the critical care unit each day. They did not contribute to the ward round, as would have been best practice, but reviewed the patients' notes. They were available at all times during the week in the daytime to attend the ward if required and available on call at other times.

Major incident awareness and training

- The hospital trust had a major incident plan. Staff knew how to access and distribute the policy and in what circumstances it was relevant. The critical care senior sister was aware of their department's responsibilities and key roles in the event of a major incident.

Are critical care services effective?

Requires improvement

We have judged the effectiveness of critical care as requiring improvement. There were some good clinical audits undertaken but no evidence to show actions had been followed-up and what lessons were learned. The patient mortality rate was above, that is worse than, the expected level. Patient length of stay was mostly above the

Critical care

England average due to delays in being able to discharge patients. There was no dedicated clinician in the hospital for specialist pain management, although most patients reported good standards of pain relief.

There was a comprehensive programme of nursing audit. Patients were well supported around nutrition and hydration. Ventilation and other invasive procedures were carried out using recognised specialist equipment and national guidance. Patients were monitored for delirium and assessed for the need for continual sedation.

Appraisals for staff were mostly meeting trust targets and the General Medical Council revalidation of doctors was well underway. There was no clinical nurse educator on the unit. There was some local training and development but it had been recognised this needed to improve. There was good multidisciplinary working and staff had specialist roles to contribute to patient care. There was access to services to meet patient need across all the week and access to patient information such as their records and test results was good. Consent for patients was completed well and staff understood the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- The average length of stay of a patient on the unit had, for the previous five years, been just above (that is worse than) the national average. It is recognised as sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. Length of stay was measured by the Intensive Care National Audit and Research Centre (ICNARC, an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally). The measure was benchmarked against other similar units participating in the ICNARC programme specialising in adult general critical care. The mean average length of stay for all admissions in this hospital's critical care department in the second half of 2014 was 5.6 days, compared with the national mean average of around four days. Over the last five years the mean average for the department was around 5.8 days against a national mean average of around 5 days.

Patients on the critical care unit were safely ventilated using recognised specialist equipment and techniques.This included mechanical invasive ventilation to assist or replace spontaneous breathing using endotracheal tubes or tracheostomies.The unit also used non-invasive ventilation to help patients with their breathing using usually masks or similar devices.All ventilated patients were assessed in accordance with an audit protocol each week.The protocol required all patients who were ventilated to be reviewed on a random day each month with days of the week and shifts selected to be rotated.The ward round and observation charts were then reviewed along with direct observation of the patient.The records for January to May 2015 showed patients reviewed for the Institute for Healthcare Improvement care bundle markers; namely the elevation of the patient's head, peptic ulcer and venous thromboembolism prophylaxis, daily sedation hold, readiness to wean from the ventilation, and oral care.Patients were then reviewed for the Department of Health Saving Lives Campaign markers, namely appropriate humidification of inspired gas and management of tubing.The unit had scored 100% in these reviews over the five months checked.

- The critical care unit followed NHS guidance when monitoring sedated patients. Each sedated patient was subject to a 'sedation hold' each day using the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the doctor or nurse discontinuing the sedation infusion and monitoring the patient's response. Sedation was then continued or adjusted dependent upon how the patient reacted to the change. The results were recorded in the patient's notes and on the daily care record used for each patient.

- Patients admitted to the critical care unit were formally assessed for delirium, although this had only been recently introduced following an audit action plan. The Faculty of Intensive Care Medicine Core Standards recommended all patients were screened for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM – ICU). Clinical staff recognised the need for delirium screening as the condition was often one of the first indicators of a patient's health deteriorating. This was therefore introduced to the daily ward round sheet and a new protocol for both delirium screening and sedation was being produced.

- There was a weekly review of patients on the critical care unit for compliance with venous thromboembolism prophylaxis. This ensured patients who were at risk from

developing deep vein thrombosis were fully assessed and, where needed, provided with preventative care such as compression stockings and sequential compressions devices.

- Patient extubation (weaning them from their ventilator and removing their endotracheal tube) was assessed through a screening tool. The critical care unit had produced a new 'readiness for extubation protocol' which involved a nurse-led screening test to assess if a patient was ready to be extubated. This had been designed to reduce the period of intubation and length of stay in the unit. The new process was to be audited to determine if care had improved as planned.
- Unlike most critical care units, Weston General Hospital had not contributed to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) On the Right Trach: A review of the care received by patients who underwent a tracheostomy (2014). The unit had also not used the self-assessment tool from the audit to determine how it complied with best practice in tracheostomy care. There was no tracheostomy insertion guide on the unit, and this had been highlighted at one of the consultant meetings. However, the medical notes we reviewed for a patient with a tracheostomy were detailed and there were clear written instructions for the care of the patient.
- The critical care unit participated in and led on organ-donation work for the trust. The trust had a clinical lead for organ donation. It was supported by a specialist nurses for organ donation, but one based regionally and not with a base in the hospital. The trust was, nevertheless, part of the National Organ Donation programme led by NHS Blood and Transplant. It followed NICE guideline CG135: Organ donation for transplantation. We reviewed the most recently available NHS Blood and Transplant Actual and Potential Organ Donors report for the trust for April 2014 to March 2015. There had been seven patients in critical care eligible for organ donation during this period. Of these, six families were approached to discuss donation. Four of these families (66%) were approached with the involvement of the specialist nurse, compared with a national average of 78%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. Consent was then given by five of the six families approached. Two patients went on to be organ donors and seven organs were retrieved for donation and transplanted to six people. The average number of organs donated per donor was just above (that is slightly better than) the national average for successful organ donation in the UK. The trust donation rate had dropped compared with the 2013/14 year, but had improved over 2012/13.
- On the critical care unit there was a good range of local nursing audit undertaken. This included, for example, central and peripheral venous catheters (CVC and PVC) being audited for document checks of signs of infection; whether an assessment had been made each day for continuation of the cannula; and whether the instrument set was labelled and not in use for more than 72 hours. Aseptic non-touch technique (ANTT) was evaluated when staff administered IV drugs; the use of protective clothing (PPE) and hand hygiene at the point of care was audited; and methicillin resistant Staphylococcus aureus (MRSA) management was checked. The audit results were mostly good, although some improvements were needed. For example, management of MRSA; which had not achieved 100% in the period we reviewed from 9 February to 23 March 2015. In the most recent audit this related to the MRSA status not being recorded in medical and nursing records. Audit of central and peripheral venous catheters and aseptic non-touch technique had improved to score 100% in late March 2015. Results were presented in the Planned Care Directorate Infection Prevention and Control report for January to March 2015. There were, however, no comments from the report to indicate the shortcomings identified from the audit were noted or actions had been agreed to reverse the decline in compliance.
- There was a range of audit of documentation by the nursing team with mostly good results reported on the ward audit dashboard. Documentation was reviewed for example, for recording of pressure ulcer care, falls and other risk assessments, malnutrition screening. In the three months from November 2014 to January 2015, the audit for malnutrition screening was the only one that did not meet 100% for more than one month, as it fell below full compliance over December and January. Pain documentation appeared on the ward audit dashboard but there was no audit against this category.

Critical care

Pain relief

- Pain relief had been well managed on the critical care unit although without input from a specialist team. Patients we were able to speak with said they had been asked regularly by staff if they were in any pain. Nursing staff said, and we observed, patients who were awake were regularly checked for pain. Observations were recorded and formal assessments made at regular intervals. Pain was managed with different protocols depending upon the patient's treatment. For example, a patient may have patient controlled analgesia managed through an infusion pump. Although clinical staff in critical care were experienced in pain management there was no specialist clinician available to manage acute conditions. The hospital trust had recently advertised for a specialist nurse in pain management though the post had yet to be filled.

Nutrition and hydration

- Appropriate guidance and protocols were followed on the critical care unit to ensure patients had the right levels of hydration and nutrition. There was a guide for nutritional screening to look for specific risks particularly around under-nutrition or excessive weight loss. A protocol had been produced by the dietetics staff with specialist knowledge in nutrition to decide whether a patient needed to be fed through a tube or line (enteral or parenteral feeding). There was an emergency parenteral nutrition protocol produced for staff to use on the weekends should a naso-gastric regime need to be commenced. The dietician commented upon the excellent attention to fluid balance levels and malnutrition scoring by the nursing staff in the critical care unit.
- For patients able to take their own fluids, drinks were available on bedside tables and within reach. Patients who were able to eat were brought menus and able to choose meals. There were protected mealtimes for patients to give them a quiet period over lunch.
- Adults receiving intravenous fluid therapy were cared for by healthcare professionals competent in assessing patients' fluids and electrolyte needs. Staff were competent in prescribing and administering intravenous fluids and monitoring the patient. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 Statement 2: intravenous therapy in hospital.

Patient outcomes

- The critical care unit produced data to determine patient outcomes against recognised national indicators. It demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards. This participation provided the unit with data benchmarked against other units in the programme (95% of NHS hospitals) and units similar in size and case mix. The data presented was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to come through the results.
- Mortality levels of the critical care unit in the year 2014 were higher than (that is worse than) the national average for similar units and above expected levels. The latest ICNARC Case Mix Programme showed levels of mortality had been slightly above the average for each quarter of 2014. Post-unit hospital deaths had also recently been above those of similar units but these levels had fluctuated over time. These were patients who died before ultimate discharge from hospital excluding those discharged for palliative care. In the first three quarter of 2014 they were at or just below national level before going slightly above in the last quarter.
- Data showed some patients were discharged from the critical care unit earlier than was optimal. This data did not include patients who had self-discharged against medical advice. Statistics from ICNARC described a variable number of patients discharged prematurely and the number had not been zero for more than two years. Over all of 2014 there had been more patients discharged early when compared with the national average but the unit was more in line with other similar units.
- Readmissions of patients to the critical care unit before they had left other wards in the hospital were not a cause for concern. Although some patients were discharged earlier than was optimal, the early readmissions to the unit (those readmitted within 48

hours of discharge) for the 12 months to December 2014 were below, that is better than, the national and similar-unit average overall. The late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) were around 5% in 2014. This was much the same as the national and similar-unit average. It must also be considered that a number of these patients could have returned to the unit for conditions unrelated to their original admission.

Competent staff

- Annual appraisal rates for the nursing staff team were good but had recently dropped just below the trust target for the registered nurses. Due to the way the data was provided to us, the appraisal results included the hospital out of hours' team with the critical care team (including outreach staff). Results for March 2015 showed 88% of nursing staff having had their appraisal and 100% of healthcare assistants. This was against a trust target of 90%. In the previous month, 97% of nurses had received an annual appraisal.
- Medical staff were evaluated for their competence. The revalidation programme had been implemented. This was a recent initiative of the General Medical Council where all UK licenced doctors are required to demonstrate they are up to date and fit to practise. This is tested by doctors participating in a robust annual appraisal leading to revalidation by the GMC every five years. Appraisals of medical staff were carried out each year and evidence demonstrated they were up-to-date. Data for medical staff was not provided to us by our core service segregation, but the appraisal rate for all medical staff at the trust was 97%.
- Although this was a small critical care unit there was no clinical nurse educator among the nursing team. The Faculty of Intensive Care Medicine Core Standards for Intensive Care guidelines state each critical care unit should have a qualified experienced nurse to deliver training and practice development to the department. This was, however, a small critical care unit and among the smallest in the country. The senior sister was proactive in organising internal and external training for staff. One of the band seven nurses was involved in education and training but not in a formal role where specific time was set aside for this. Equipment providers also delivered training to staff on specific kit. This was, however, ad hoc and not following an agreed programme.
- There was an acceptable level of nursing staff trained in post-registration critical care. The Core Standards guidance was for at least 50% of the nursing staff achieving this award, and this was achieved among the substantive team.
- There was a good induction and orientation programme for new nursing staff on the critical care unit . New nurses were allocated a mentor from the experienced staff team. When the mentor was not working the same shift as the new member of staff, they would get support from other nurses on duty. The induction programme covered a range of topics including health and safety, equipment training, medicines' management, documentation protocols, and infection control. New staff were required to complete checklists signed off by trained staff as they worked through their training and competency assessments.
- The critical care unit had a wide range of nurses with link and champion roles. These were band six nurses who were able to provide support and additional responsibility on a variety of different areas. There were at least 15 link roles identified in the unit. They included nurses leading on such subjects as manual handling, organ donation, palliative care, tissue viability, infection control, nutrition, pain management, venous thromboembolism, and diabetes, among others. There were 'champions' among the nurses for patients living with dementia, patient dignity, and patient falls. These were proactive roles for nurses who would be expected to be involved in all the circumstances relating to these areas.

Multidisciplinary working

- There was a dedicated physiotherapist for critical care. There was one main physiotherapist working regularly in critical care each day with appropriate cover when they were away. The physiotherapist attended the unit each morning from 8am to noon each day (excluding weekends) and members of the team were on call by rotation. The physiotherapist attended the units each day to review weaning plans, early mobilisation and

rehabilitation for patients. There was full physiotherapy input into weaning plans which were well documented within patient records. Medical and nursing staff spoke highly of the skills of the unit physiotherapist.

- Good multidisciplinary work produced effective care. The critical care unit had input into patient care and treatment from the pharmacist, dietician, speech and language therapists and other specialist consultants and doctors as required. There was daily support on a Monday to Friday from a microbiologist (a healthcare scientist concerned with infection prevention and management).

Seven-day services

- A consultant intensivist was available across the whole week. When they were not on duty in the unit, there was good cover from the consultant intensivist team. Consultants lived within a 30 minute journey of the unit when they were at home but on call or would otherwise be resident in the hospital. Trainee doctors said the consultants frequently took calls or attended the unit when needed.
- There were arrangements for pharmacy services across the whole week. In weekdays, the pharmacy team were available on site in the day time. Arrangements were in place for the supply of medicines when the pharmacy was closed. A pharmacist was also available on call in the evenings, at night and on weekends.
- Access to clinical investigation services was available across the whole week. This included X-rays, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, endoscopy, and echocardiograms (ultrasound heart scans).
- Therapy staff were available across the whole week. If therapy staff were off duty, there was access to certain staff out-of-hours through on-call rotas. Otherwise, therapy staff (including physiotherapists, occupational therapists, speech and language therapists and dieticians) were on duty on weekdays. Therapy staff organised plans for patients needing specific therapies to be continued over the weekends or at night.

Access to information

- Access to patients' diagnostic and screening tests was good. Critical care staff said results were usually provided quickly and urgent results were given the right priority.
- Patient records were usually available in good time. Staff said records were provided relatively quickly in emergency admissions (all patient records were on paper for patients coming from other wards or new admissions).
- There was a range of booklets, leaflets and information for both patients and families, although little information about critical care on the trust website. The leaflets provided explained aspects of the environment and specific treatments. Patients and relatives were also provided with the booklet produced by the intensive care support charity organisation ICU Steps (supported by the Department of Health). This was a guide to intensive care for both patients and their families which was available to order in 15 different languages. This booklet could also be downloaded from the organisation's website.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled. A review of consent forms in patient notes showed they had been correctly completed by an appropriate member of the medical team.
- Staff had a good understanding and guidance to follow in relation to mental capacity assessments. There were patient mental capacity assessment forms which led on to considerations of how decisions were then made in the patient's best interests. The forms followed the provisions of the Mental Capacity Act (2005) in that they recognised a patient's mental capacity to make decisions could be temporary and related to the decision in question and not all future decisions. There were arrangements within the hospital to provide an

Independent Mental Capacity Advocate (IMCA) if a decision was needed in a patient's best interests and the patient had no family or friends to speak for them at the time.

- There was a good understanding among staff of the Deprivation of Liberty Safeguards (DOLS) and when to apply them. This had been done recently in appropriate circumstances. The senior sister and consultant lead at the time had a meeting with the hospital adult safeguarding lead to discuss DOLS. This had resulted in more awareness of when a deprivation could be taking place and a revision to the unit's paperwork.

However, the protocol the hospital was following did not meet the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.The trust had produced a flowchart with, a report stated, local agreement with North Somerset Council.This stated patients who were expected to be in hospital for less than five days were excluded from applications to the local authority for any deprivation of their liberty.It also excluded patients who had a discharge date in the near future.The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards state applications to deprive a person of their liberty must be made when the deprivation is either planned or taking place.There are no exclusions in law around time spent in hospital or approaching discharge.The law states, in certain circumstances, hospitals are able to make urgent authorisations of their own for up to seven days in response to sudden unforeseen needs.However, this part of the legislation was not being considered.

- The critical care unit had aids to protect patients if restraint was needed. Staff were directed to the hospital's restraint policy if this was considered as necessary to keep a patient safe. There were 'mittens' for use as a last resort when a patient was known to be or assessed as at risk from pulling out their medical devices, such as tubes and lines. None of the staff could, however, recall resorting to the use of mittens. However, they knew a risk assessment would be undertaken for the patient following any use of restraint of any type.

Are critical care services caring?

Good

The caring by staff was good. Feedback from people we met, including patients and their families, had been overwhelmingly positive. Patients said staff were kind, treated them with dignity and respect, and demonstrated compassion. Patients, their family or friends were involved with decision making. People were able to ask questions and raise anxieties and concerns.

There were, however, few of the more recent developments in critical care provided. There was, for example, no use of patient diaries or follow-up clinics. There was little provision of professional emotional support for patients.

Compassionate care

- We observed good attention from all staff to patient dignity. When staff in the critical care unit had to carry out any personal care, they did so with curtains drawn around patients. Doors and blinds were closed in the side room when necessary. Staff politely asked visitors to move to the waiting area for a short time when they were giving personal care. The visitors we met confirmed staff had been sensitive and thoughtful to patient dignity at all times. A patient we met who had been on the unit for a few days said staff were always attentive to privacy and dignity. They commented how, even when the curtains were closed, they were still respectful of dignity. They said "it doesn't mean they then do everything to you without a care. They still treat us like we are still here."

- Patients and relatives we met spoke highly of the service they received. Due to the nature of critical care units we often cannot talk to as many patients as we might in other settings. However, the three patients we were able to speak with said staff were compassionate. One patient remarked on how staff had been "light-hearted" and made them "feel comfortable and quite safe and no fears of anything". They had been able to sleep well at night since they had been on the unit and staff had been quiet and respectful. They said they would "recommend

the hospital to everyone." Although this patient said they had been able to sleep, two other patients commented on it having being a little too noisy at night on occasion.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them. They were able to ask questions and always got answers they could follow.
- Friends and relatives of patients were kept informed and involved with decisions when appropriate. They said they were able to ask questions and could telephone the unit when they were anxious or wanted an update. One patient remarked on how their family had been able to phone at any time for an update. Staff had also brought the unit's phone to them so they could talk with their relative.

Emotional support

- There was access to a multi-faith chaplaincy for patients and their relatives and carers. The chaplaincy team were available in the daytime from Monday to Saturday, and held a service for patients on the Sunday at 11am. The chaplain visited the hospital areas each Saturday to tell patients and visitors about the service and, if they asked to go, made sure they were enabled to attend.
- There was support for patients with cancer from a team of Macmillan nurses based at the hospital. They had a large resource of knowledge and experience to draw up on to provide advice and emotional support.
- There was support from the palliative care team and specialist nurses. Staff told us these nurses had visited the wards and provided support to patients and families. They were also able to contact and obtain guidance and advice from social services to further support people where this was needed.
- There was a mental-health liaison team in the hospital for patients with identified needs. There was a specialist mental health nurse available who worked with and could escalate issues to a psychiatrist. They were also able to liaise with the vulnerable adults' team to support patients who might be at risk.
- The department was not using any of the more recent developments in emotional support for patients. For example, it was not yet using patient diaries. Critical care research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Patient diaries have been introduced in some units to provide comfort to both patients and also their relatives both during the stay and post discharge. Diaries are said to not only fill the memory gap, but also be a caring intervention which can promote holistic nursing. There was also no provision for follow-up of patients who had left the hospital after, possibly, a long-term stay in intensive care. Follow-up clinics have been shown to help with patients' longer-term psychological recovery. This was particularly for patients who were unconscious for part or most of their stay or unable to communicate in their normal way due to, for example, use of a tracheostomy.

Are critical care services responsive?

Requires improvement

The responsiveness of critical care services required improvement. As with many NHS hospitals, there were bed pressures in the rest of the hospital that meant a significant number of patients were delayed on discharge to other wards. Too many patients were being discharged at night. Critical care and some of the most unwell patients were not being considered sufficiently within bed planning in the hospital, and not being moved to critical care when they met the criteria for admission.

There were, however, few operations cancelled due to a lack of a critical care bed, although this was from a low overall requirement for beds for elective surgery patients.

In addition delays to patient discharge from the critical care unit meant that patients there were at risk of There were very limited facilities for visitors or patients in the critical care unit. When meeting needs, the unit took account of different people and personalised care. This included those patients in vulnerable circumstances. Update training around dementia awareness was, however, not meeting

trust targets for nurses or doctors. There was no provision of specialist support to patients who might be suffering from the psychological problems or anxieties often associated with admission to critical care.

Complaints and concerns were listened to, although it was unclear how they were being used to improve the quality of care.

Service planning and delivery to meet the needs of local people

- There was limited provision for visitors to the critical care unit. There was only one small waiting area on the unit for all visitors. There were no facilities for visitors, such as a kitchen, to make hot drinks or prepare food. The nursing staff had, however, provided visitors with a 'tea trolley' with provisions for making hot drinks and there was a toilet close to the waiting room. There were no facilities for overnight accommodation for visitors, but staff would help them arrange nearby hotel or guest house accommodation. A visitor we met who had come from outside the UK said the staff were "fantastic. Can't fault them" but the facilities for visitors were "really woeful". They remarked upon how staff were very apologetic about the lack of space for visitors, but it made the breaking of bad news "hard as there were other visitors here as well." One of the sisters told us some charitable funding had been made available by the organ donation team and this would be used to update the relatives' room and provided a television and new chairs.
- The critical care unit had introduced new equipment to better meet patient's needs. This had included the introduction of haemofiltration in the last three years. This meant patients needing renal replacement therapy for acute kidney injury were able to be treated and not transferred elsewhere. This practice did, however, add pressure to the small department who had been enabled to treat and therefore admit more patients, but without any additional bed space to meet demand.
- The service met some but not all of the recommendations of the Department of Health guidelines for modern critical care units as they relate to meeting patient needs. These included:
  - Bed spaces were capable of giving reasonable visual and auditory privacy;
  - There was natural daylight for four out of five bed spaces (not in the side room);
  - All patients were able to see a clock which also showed the date;
- There was, however, no enclosed storage at the bedside for consumables or medicines. There were no facilities for patients within the critical care unit including toilets or showers. Some patients accommodated in the critical care unit were fit for discharge to a ward and relatively mobile. There were no facilities for these patients to wash or shower. They only had use of the visitors' toilet or washing/shower facilities in one of the adjacent wards.
- On the high care unit male and female patients were accommodated without segregation. This was not defined as a breach of department of health guidance on eliminating mixed sex accommodation (2010) because there was an acceptable justification as defined by the guidance. This states there is an acceptable justification (for not providing single sex accommodation) "where a nurse must be physically present in the room/bay at all times". There were no toilet or shower facilities in this bay, although single sex facilities were available in other parts of the ward.
- There were facilities for staff to work and rest on the critical care unit. There were staff offices and changing rooms. Senior staff often shared offices but they said there was always somewhere available for private conversations. There was a staff rest room and a revamped kitchen for staff with access to hot and cold drinks and food storage and preparation areas.
- The hospital had the ability to temporarily increase its capacity to care for critically-ill patients in a major incident such as a pandemic flu crisis or serious public incident. This would involve using the recovery unit in the main theatre unit directly adjacent to the unit where staff were trained in caring for critically ill patients and would be supported by the critical care team. The unit also had the facilities to increase the bed numbers from five to six in an emergency. There was a spare ventilator and provision of oxygen and other facilities in one area of the unit where a bed could be accommodated.

Meeting people's individual needs

- There was a nursing philosophy for the service around meeting people's individual needs. The philosophy

stated all patients were individuals with respect to be given to their own cultural, personal and spiritual beliefs. All patients could expect an equal and high standard of care to meet their needs. The nurses were expected to be advocates for the patient but encourage and respect family involvement.

- The patient and their family/friends were involved with personalising the care for the individual patient. There were forms completed in patient notes recording more personal details, such as what the patient liked to be called, their hobbies and interests, what food and drinks they liked, the radio station or music they liked, and any TV programmes they enjoyed or disliked. The patient's usual daily routine at home was also discussed including when they woke-up, went to bed and their degree of independence.
- There were relatively simple resources to enable people to communicate. The critical care unit had Passy Muir valves which had been used effectively to enable people to speak when fitted with a tracheostomy. There were wipe-clean boards for writing messages, and picture books if found to help.
- Translation services were provided through a contract with a third party organised by the hospital trust. Information on using the services was provided on the trust intranet. Staff said they had rarely used the service so were not able to comment on whether it was appropriate or effective, but other staff told them they had found it worked well.
- There were good plans in place on the critical care unit for admitting and supporting patients with a learning disability. A recent patient admission had involved close links with and support from the carers and relatives. If the patient would usually have not needed one-to-one nursing care from a medical point, this would nevertheless be reviewed and provided if considered appropriate and available.
- Staff had been provided with advanced trained in dementia awareness, although uptake of the three-year update course was not meeting trust targets. This was one of the mandatory update training sessions with a poor uptake from most staff on the unit. All healthcare staff were up to date with their training, but only 56% of the nursing staff had completed this. Only 29% of doctors in the division in which critical care sat (Planned Care) had completed their update advanced training and 36% had completed their general training. There was no evidence, however, to suggest staff would not care for and support patients living with dementia with anything other than understanding and empathy. There was a 'dementia champion' among the band six nurses who proactively provided support and advice. A member of the unit's cleaning team told us they had undertaken their face-to-face dementia training in the previous September 2015 and all hospital cleaning staff were required to undertake this session.
- Some adjustments from recognised good practice had been made for patients and visitors living with dementia. The hospital had recognised how staff wearing yellow name badges helped people living with dementia and this had been introduced. There were also clocks all patients could see with the date included to help with orientation.
- There was no critical-care-specific support available to patients with psychological problems or anxieties. There is increasing evidence showing the psychological impact of a critical care admission can be severe. Patients can experience extreme stress and altered states of consciousness. Patients are exposed to many stressors in critical care and acute stress in critical care has been shown to be one of the strongest risk factors for poor psychological outcomes after intensive care. The National Institute for Health and Clinical Excellence (NICE) guideline CG83 states that patients should be assessed during their critical care stay for acute psychological symptoms. There is also evidence that the critical care experience is difficult for families and a critical care psychologist can play a big role in communicating and working with distressed families.

Access and flow

- Critical care bed management was not given sufficient consideration in overall hospital bed planning. The situation within the critical care department was not factored into escalation plans for bed management when the hospital was experiencing high demand. Decisions regarding discharge, for example, were overturned without reference to staff in the department.
- Patients were not always in the best place for their care. There was poor communication about patient acuity between medical wards and critical care. For example,

during our visit there were patients being cared for on the high care unit of Harptree medical ward. These patients and others who were described to us from recent weeks were receiving care that would put them in a category close to or meeting the Faculty of Intensive Care Medicine Core Standards of high dependency care (known as level two). However, during our inspection, there were two patients accommodated on the critical care unit who were well enough for discharge to a ward. Staff on the critical care unit were not aware of patients on the high care unit and vice versa. The lack of critical care input into the high care unit meant some of the most unwell patients in the hospital were being managed without the input of the critical care doctors and nursing staff. There was no attempt to transfer these patients to the area where they would have received the optimal care for their medical needs when there were beds available in critical care. Some surgical patients had also been cared for in medical high care unit when admission to the critical care unit would have been more appropriate.

- We were told a business case had been presented to expand provision of level two services in the hospital, but this had not progressed.
- The discharge of patients from critical care was not always achieved at the right time for the patient and a high proportion were moved at night. Studies have shown discharge at night can increase the risk of mortality; disorientate and cause stress to patients; and be detrimental to the handover of the patient. Data about out-of-hours discharges was provided to the Intensive Care National Audit and Research Centre (ICNARC) data for the second half of 2014. Discharges out-of-hours (between 10pm and 7am) showed the unit had been almost always continually above (that is worse than) the national and similar-unit average for night-time discharge over the last five years. In the first, second and last quarter of 2014 there was a peak of around 25-30% of all patient discharges taking place at night.
- Similar to most critical care units in England, ICNARC reported a high level of delayed discharges from the unit. For the year to December 2014, between 70 and 80% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. That was above (worse than) the national average of around 60% and the similar-unit average of around 40%. Four hours is the indicator used for comparison with other units and set by ICNARC. It is used to demonstrate the ability, or otherwise, to move patients out of critical care in a timely way. Although patients remained well cared for in critical care, when they were medically fit to be discharged elsewhere, the unit was not the best place for them. The delays were, however, mostly less than 24 hours (40%) although some were longer. There were 11% of patients who waited between three and seven-plus days for discharge from the unit. The rate of delayed discharges had been high for the last five years and had not met the national or similar-unit average since early 2010. There was a lack of recognition that once they were fit for discharge to the ward, patients were classed as having breached single sex requirements as set out by the Chief Nursing Officer of the Department of Health. As such these were not reported to the clinical commissioning group.
- Admissions of patients to the unit were relatively stable. The number of admissions to critical care since 2010 had been, on average, 70 patients per quarter. ICNARC data from the second half of 2014 reported no patients transferred into the unit from an HDU or ICU in another hospital for non-clinical reasons. The unit had accepted patients in this category on only two occasions in the last five years. The unit was therefore mostly managing its own patients and predictable admissions. Patients were sometimes transferred to other units for clinical reasons although these were around the similar-unit average. Usually transfers out to other units were for patients to be accommodated closer to home or for specialist care. There had been a rise in non-clinical transfers out for the last two years to December 2014. These were usually patients transferred to other units as the hospital did not have a bed available to accommodate them. There were three patients transferred in the last quarter of 2014, although this was not dissimilar to the national picture.
- There were few planned operations cancelled due to lack of a critical care bed. The hospital carried out only around 1,300 planned operations each year and only around 30 patients had needed admission to critical care in 2014. There had been one cancellation in January 2015 but none reported otherwise between September 2014 and February 2015.

Critical care

Learning from complaints and concerns

- Like most critical care units there had been infrequent complaints. Of the three we reviewed two related to communication between staff and relatives. Staff contributed to investigations and responses to complaints about their unit.
- There were comprehensive and helpful leaflets available about making a complaint with other information in the unit's main corridor. The leaflet included advice on how to get help with an interpreter or how to obtain the leaflet in a different format. The complaint form explained how consent may be needed from the patient for some levels of correspondence through family member when confidential information could be shared. There was also an area to complete to explain why a patient might not be able to give their own valid informed consent.
- Complaints were discussed in departmental meetings. However, in the Planned Care division 'cabinet' meetings for January and February 2015 and the quality and governance assurance report for December 2014 and January 2015, reports of complaints centred on whether they had been responded to in good time. There was a standing agenda item in the consultants' meeting held each month around complaints. These however, had discussed the nature of any compliant and did not recognise or identify learning or actions.

Are critical care services well-led?

Requires improvement

The leadership and governance of critical care services required improvement. Whilst significant concerns had been identified regarding the high care unit, the swift action taken by the trust to mitigate the risks identified meant that we did not rate the well-led domain as inadequate.

The governance framework did not ensure quality performance and risk were well understood. It was unclear how review of audits, incidents, complaints and other key information was used to learn and make changes to practice. There was a strong reliance placed upon incident reporting as the source of information about quality care. This was against a backdrop of uncertainty about whether all staff regularly reported incidents. There was no focus upon getting structured feedback from patients and their families to use for driving improvements. However, some of the feedback had led to small improvements.

The clinical leadership did not provide sufficient support to the nursing team with management of the unit. There was, however, a strong and committed and experienced group of core staff. Staff were dedicated to their patients and one another and we were impressed with their philosophy, loyalty and attitude.

Vision and strategy for this service

- Since approximately 2010, the hospital trust had recognised it was not financially sustainable in its current stand-alone form. The vision and strategy for the critical care services was therefore very much tied up with the transaction process.
- The nursing team had a philosophy for the service. The ultimate aim was to "strive towards providing quality of life for both patients, and relatives/friends."

Governance, risk management and quality measurement

- To enable the critical care unit to see how it performed against other similar units, and national averages, the unit participated in a national database for adult critical care. This was as recommended by the Faculty of Intensive Care Medicine Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported the data supplied was well completed and of good quality.
- There was a range of governance and departmental meetings held for critical care but it was unclear if and how the governance process fed into the overall clinical governance structure and provided board assurance. There were monthly consultant meetings but no evidence of critical care having a 'voice' in overall clinical governance. At the meetings of the directorate in which critical care sat there was no specific report from critical care. Learning and changes to practice from incidents, near-misses, audits, complaints and other key sources were not evident. The focus of the meetings where these items were discussed was around how incidents were being 'closed down' or complaints

responded to in line with policy. There was an over-reliance on the incident reporting system as the primary source of governance information. In discussions we had with the senior staff around being able to demonstrate how the unit was assessed for safely, effectiveness, and responsiveness, the conversation came back to the review of incidents as the primary source of information. It was therefore unclear how potential risks could be identified if they had not been reported as an incident.

However, the incident reporting system was only one source of information and relied upon staff to report incidents.The reliance upon this system was set against a backdrop of a number of the nursing staff saying the doctors were not proactive at reporting incidents.A review of the critical care incident reports over four months would suggest this was the case although the person reporting the incident was not shown.The incidents we reviewed appeared mostly to have originated with the nursing staff and trainee doctors.

- There was a risk register in use but the version provided to us demonstrated it was not being used effectively. It was not a standing agenda item at the clinical governance meeting, although we were told it was discussed at a separate risk meeting. The clinical lead was not aware of the content of the risk register, which, like a number of tasks in critical care, was led by the nurses without consultant input. The entries about identified risks were not all current and some had been resolved or were in the process of resolution but still showing as high risk. For example, there was an entry from April 2014 about a specific risk. There were controls in place and some assurance of how it was being managed. But it remained rated with a likelihood factor of 'four' which was one below the highest possible likelihood. There was no evidence of this risk rated as serious by the department being considered outside of the department by senior management. It was not included within the corporate risk register along with the other significant risk of delayed admission for patients; which was also not captured at corporate level.
- There were weekly governance meetings run by the matron. However, there were no minutes taken at these meetings and therefore no evidence to show what had been discussed. The matron said the meeting was held to review the incident reporting system, which, as mentioned above, appeared to be the main source of information for risk and governance.
- There was a range of audits and some performance measures of aspects of care and safety within the service although not in accordance with an approved audit calendar. There were useful ad hoc audits carried out by consultants and medical students which were reported at the anaesthesia governance and safety meetings. However, in minutes we read for February, March and April 2015, none of the audits related to critical care. There was no evidence of standardised audit being carried out of general practice. The unit had not been audited against the Faculty of Intensive Care Medicine Core Standards to determine where there were gaps in how the unit performed against these standards. There was no audit against the Department of Health guidance for the set-up and environment of critical care departments (Health Building Note HBN 04-02) to determine where the unit was not meeting the criteria for best practice. As a result, there were no items on the risk register showing where there were any gaps against recognised guidance or standards. There was no review of the use of NICE guidelines (such as CG83: Rehabilitation after critical illness or CG50: Acutely ill patients in hospital) to check practice was compliant.

Leadership of service

- The nursing leadership of the critical care unit was strong. The senior sister and their team demonstrated a strong commitment to their staff, their patients and one another. They were visible on the unit and available to staff. The consultants and doctors we spoke with had a high regard and respect for the senior sister and the nursing team, and the allied health professionals.
- In terms of commitment from the executive team we felt critical care was not given sufficient focus. The process for bed escalation and surgery planning did not factor in the considerations for critical care. Critical care was based within the surgery directorate and, although this was not unusual in NHS structures, there was little cooperation between the unit and the medical wards, where there were also acutely unwell patients.
- The nursing team on the critical care unit did not get enough support for this inspection from the intensivist

clinical lead. The clinical lead of the unit did not make themselves available until the end of the visit. The nurses and doctors came across as working in isolation from each other and not approaching the unit as one team. There was a good multidisciplinary approach to patient care, but not to the running of the unit. The meetings held were either for nurses or doctors, and there were no 'unit' meetings. From this perspective the unit was highly nurse-led and there did not appear to be input from the doctors beyond patient care. The unit matron had been covering a night shift at short notice to cover sickness, and as a result the inspection was left to the senior sister to manage. There was no input or attendance from the clinical lead until we requested a meeting on the final day.

Culture within the service

- We found the staff to be committed to their patients and the provision of quality critical care. There was a high level of morale. We were impressed with the attitude of the majority of staff we met. They were friendly and approachable. In all conversations with staff the things that worried them were all connected to patient care. This included delays to patient discharge and managing risks for patient safety. Those things they were proud of were also related to care of patients.
- Trainee doctors were well supported on the unit. We were told consultants were easy to contact when trainee doctors needed advice. Nurses were also supportive and helpful to trainee medical staff.
- There was good commitment and partnership working from the consultants. This was a small unit and consultants were enabled to focus upon the patient quality care and treatment.

Public and staff engagement

- There was not a proactive approach to getting written structured feedback from patients or relatives about their experience of the unit. There was no process to obtain measureable data for staff to use to see what patients and relatives thought when asked specific questions.
- The unit advertised where it had made improvements following informal feedback from patients or relatives. There was a 'you said, we did' notice on the wall in the main corridor of the unit. For example, some informal feedback from patients and relatives who had talked with staff had led to a bid for charitable funds to update the relatives' waiting area. This bid had been successful and work was due to commence to provide new chairs and a television. The unit had also purchased new TV aerials in order to improve the patient TV reception. A new radio and CD players had also been provided along with updated rehabilitation games and puzzles.
- There was an excellent and comprehensive newsletter produced each month for staff. It included requests for nominations of staff for various 'celebration of success awards' which were running for their second year. There were messages from public bodies, such as Public Health England, awards and recognition for staff and wards, updates on new staff, messages from patients, training and policy updates, and charity news and updates.
- Staff were included and informed about the running of the service. There were monthly meetings attended by a range of staff. The meetings were minuted and circulated. The structure of the internal organisation of the service had recently changed, but the minutes of a 'cabinet' meeting held for the previous directorate set-up (the Planned Care directorate) showed a wide range of staff had been present, including senior management, matrons, ward managers, and lead clinicians.
- There were monthly open sessions with the trust's chief executive with two sessions (early and midday) each month.

Innovation, improvement and sustainability

- The unit had improved patient care by introducing haemodialysis/haemofiltration care to reduce the need to move patients with acute kidney injury to other hospitals.
- There were some questions around the sustainability of the service. The level of consultant cover was currently being safely managed, but was recognised as not sustainable in the longer term. There were also no strategic plans to upgrade the unit to meet modern critical care standards, or even redecorate to improve infection control.

Maternity and gynaecology

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

Information about the service

Weston General Hospital's gynaecology services were small and provided planned day or inpatient care and treatment and emergency care to approximately 750 patients per year. The service was managed from within the trust's surgical directorate. The gynaecological team at Weston General Hospital worked with University Hospitals Bristol NHS Foundation Trust to provide gynaecology cancer services for local people. Some treatments such as chemotherapy were provided at Weston General Hospital, whilst complex surgery was provided at University Hospitals Bristol NHS Foundation Trust. Day case surgical termination of pregnancy services were provided to women referred by the trust's antenatal screening service or through referrals from Marie Stopes clinics. Surgical terminations were restricted to pregnancies up to 12 weeks. Terminations of pregnancies above 12 weeks were referred to St Michaels Hospital (part of University Hospitals Bristol NHS Foundation Trust). There was no dedicated gynaecology ward, so inpatient cases were admitted where there was bed availability.

Weston General Hospital's maternity care was provided by a freestanding midwifery led unit (not in the same building as a consultant obstetric unit; FMU) called Ashcombe Birth Centre. This included two delivery rooms; one with a birth pool and en suite shower room and the other with a large bath en suite room. There were two, four bedded bays, with shared bathroom facilities and two single en suite rooms. A range of antenatal, perinatal and postnatal services were provided including assessment and care from a three bedded Day Assessment Unit and an Early Pregnancy Advice Centre.

Choice of place of birth for low risk pregnancies was at the birth centre at Weston General Hospital, a home birth or at St Michaels Hospital in Bristol (part of University Hospitals Bristol NHS Foundation Trust). The Ashcombe Birth Centre only accepted women assessed as having low risk pregnancies. There were approximately 230 births per year at Ashcombe Birth Centre or home births supported by the trust midwives. This was the lowest figure compared to all other trusts in England. The ratio of midwives to births was 1:9, compared to the England average of 1:29. However, the midwives provided antenatal and postnatal care for approximately 1, 500 women per year. The majority of these (approximately 1, 200) chose to deliver at St Michaels Hospital, but received ante and postnatal care through the midwifery service at Weston General Hospital.

Women assessed as having high risk pregnancies received consultant obstetric led antenatal and perinatal care. The majority of women attended St Michaels Hospital in Bristol, approximately 23 miles from Weston. One obstetric consultant led antenatal clinic was provided at Weston General Hospital once per week. Low risk antenatal and postnatal care was provided by midwives at different venues to provide women with personal choice. This could be provided from Ashcombe Birth Centre, the woman's' at home, GP surgery or from one of seven Children's Centre's in the local area.

During our inspection we spoke with patients, relatives and a range of staff working across the gynaecology and

maternity services. These included; six patients and two of their partners, and two relatives. We spoke with three consultants, ten midwives and one nurse, two maternity support workers, one health care support worker and two ward clerks. In addition we spoke with the head of midwifery and midwifery matron. We reviewed a variety of patient records including; one gynaecology medical record, four safeguarding files, three maternity medical records and six sets of maternity patient transfer records. Before, during, and after our inspection we held a number of focus groups and reviewed the trust's performance information.

Summary of findings

Overall we have judged safety, responsive, effective, caring and well-led to be good for maternity and gynaecology services. Patients' and relatives' feedback was positive regarding all care and treatment. Patients said they were consulted and involved with their care. We saw discussions of consultations and records of the patient's choices and preferences documented in records.

Midwives followed comprehensive risk assessment processes from the initial booking appointment through to post natal care. There were clear escalation policies which were followed and all care was provided in line with national guidance and policy. The centre worked closely with St Michaels Hospital, Bristol which received the majority women with high risk pregnancies. The Head of Midwifery managed both services but was based at Bristol.

The national recommended ratio of Supervisor of Midwives (SoM) to midwives is 1:15, and this was not being achieved (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). The ratio of SoM to midwives at Weston General Hospital was 1:21. This was due to SoM caseloads being shared between Weston General Hospital and St Michaels Hospital, Bristol. Three additional SoM were being trained.

During January 2015 Ashcombe Birth Centre was closed for three days, and the 10 post natal beds were used by medical patients for a further seven days. This was in response to intense trust wide service pressures. The beds were redeployed to medical patients during this time.

There was good communication between the medical and nursing staff, and maternity support workers. Team working was described as effective and good. The ratio of supervisors to midwives (SoM) did not meet recommended guidelines but plans were in place to address this. There were comprehensive risk, quality and governance structures in place. There was evidence to show incidents were interrogated for service

improvements and systems were in place to share information and learning. Midwives said they were positively supported and there was a good and open culture.

Gynaecology was a small consultant led service; the majority of treatments provided were for hysterectomy and diagnostic procedures. There had been one never event for wrong site surgery during June 2014. This had been investigated and subsequent actions and learning put in place. Audit processes during 2014, had identified the service had not been compliant with regulations to submit termination notifications to the Department of Health. This had resulted from an administration staffing review. New procedures and staff training had been put in place.

Are maternity and gynaecology services safe?

Good

Overall we have judged the midwifery and gynaecology services were safe**.** Incident reporting was understood by midwives. Appropriate actions and learning were taken in relation to incidents which were regularly monitored and reviewed. All clinical areas were appropriately equipped to provide safe care and appeared clean. No incidents had ever been recorded relating to falls, pressure ulcers or hospital acquired infections.

As there was no dedicated gynaecology ward; incidents, cleanliness and infection control and safety thermometer information for the gynaecology service was represented in surgical and medical reports.

Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. Compliance with statutory training was not fully met but all the midwives had advanced neonatal life support training. There were adequate numbers of midwives who provided 1:1 care during established labour. Risk assessments were completed at the initial booking and continually evaluated throughout the antenatal, perinatal and postnatal care. Processes were in place and followed to respond appropriately to emergencies.

Incidents

- All the midwives we spoke with said they were encouraged to report incidents and understood the processes to follow. Incidents were reported on the trust's electronic reporting system. Maternity staff demonstrated an awareness of what type of issues constituted a reportable incident such as third and fourth degree tears and post-partum haemorrhages. The types of reportable incidents were viewable from a drop down list which was part of the electronic system.
- There was a focus on learning from incidents. The focus was on reflecting on situations and looking for ways to improve safety and practice. Midwives felt confident with these systems with some staff reporting their own errors on the electronic incident reporting system

- Midwives confirmed they received feedback from incidents via email. Where appropriate the patient safety midwife or midwifery matron discussed incidents with individual midwives. This increased understanding, context and learning from incidents. Learning to be shared with the team was emailed to the whole team. In addition, we saw records which showed incident learning was discussed during handovers or team meetings.
- Incidents reported were monitored regularly (weekly) by the patient risk midwife. A monthly incident summary was emailed to all staff with key points from this being added to the monthly maternity governance meeting, which all midwives were encouraged to attend.
- There were processes in place to regularly review and monitor incidents and take appropriate actions to reduce risks. We looked at the incident data for February to March 2015. This information was summarised on a dashboard by event type and detail. Senior midwives said this enabled a clear overview of any peaks or trends. These were then investigated and reported on more thoroughly by the patient risk midwife. The dashboard was used with other information which was updated daily. This showed what immediate actions had been taken to redress the impact of incidents. For example; one incident stated incorrect blood test results had been written in one patients hand held notes. The immediate action taken was to re-check the test results, record the right results, revaluate risks and the care plan (no change) and inform the patient.
- There was one never event for the gynaecology service. A never event is a serious incident which should never occur because strong systems are available nationally to prevent them. This was for a wrong site surgery during June 2014. This had been investigated and subsequent actions put in place. We spoke with the consultants about this, who demonstrated an understanding of the details and subsequent learning.
- There were no mortality and morbidity meetings as the maternity service was small. However, we were told by senior midwives that if there was an incident resulting in harm a root cause analysis was completed. Actions and learning were subsequently fed into governance and team meetings.

Duty of candour

- Midwives we spoke with demonstrated an understanding of Duty of Candour responsibilities. This new regulation was introduced in November 2014. It requires staff to be open, transparent and candid with patients and relatives when things went wrong. We saw this demonstrated in a letter sent to a patient. Within this, an apology had been made, an explanation of the circumstances and subsequent actions taken to prevent reoccurrence. The patient was offered additional contact and support.

Safety thermometer

- Ashcombe Birth Centre participated in the NHS safety thermometer. This was a process to collect patient safety information in relation to falls, hospital acquired infections, and venous thromboembolism (VTE) and pressure ulcers. We looked at the data recorded in the last year and up to April 2015 which showed good compliance levels with no incidents ever recorded related to falls or pressure ulcers.
- Patient safety information was displayed in clinical areas for patients, visitors or staff to view and see how well the birth centre was performing and delivering on preventable safety issues.

Cleanliness, infection control and hygiene

- All areas of the midwifery service appeared visibly clean. The midwifery care assistants (MCA) were responsible for cleaning equipment in the two birth rooms. We spoke with two MCA who demonstrated a clear understanding of the processes to be followed to maintain hygiene and prevent the spread and control of infections. Cleaning staff had responsibility for cleaning floors, bathrooms and communal areas.
- The birthing pool looked visibly clean. This was decontaminated by the MCA. We saw daily cleaning audits of the birthing pool were completed.
- Ashcombe Birth Centre had never reported any incidents of Methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections.
- Those patients we asked confirmed they saw staff washed their hands and wore personal protective clothing such as gloves and aprons before providing treatment or care. Antibacterial hand cleaner was available throughout clinical areas and we observed staff and visitors using this.

- Hand hygiene was promoted. Hand sanitiser was available in all clinical areas, which we saw used was used frequently by staff. Sanitiser was also placed by the CCTV intercom outside Ashcombe Birth Unit. We observed all visitors to the ward were asked to use the hand sanitiser before being given entry.
- Regular hygiene and infection control audits were maintained and learning and actions demonstrated. We saw records which showed the cleanliness of the environment was assessed every month and an annual cleaning audit was completed. We looked at the last annual audit dated July 2014 which documented what actions had been taken when cleaning issues had been identified. We reviewed the last three cleaning audit compliance scores which were January; 94%, February; 94% and March; 69%. The dip in cleaning compliance during March was attributed to a new focus and learning for this audit, which had been completed by a student midwife instead. Subsequent action plans were implemented.

Environment and equipment

- The environment was safe. The Birthplace national study (2011) compared midwifery led units and obstetric units. Results showed, providing women were correctly assessed, there were no significant differences in adverse perinatal outcomes between the services.
- There were two delivery rooms. The Waterlily birth room contained a birth pool, a birth couch and en suite shower room. The Lavender birth room had a bed and large bath en suite room. There were two, four bedded bays, with shared bathroom facilities and two single en suite rooms. All areas were appropriate for use.
- The delivery suite environment was organised and equipment was stored appropriately. A range of equipment to aid labour was available in both birth rooms. This included a birthing couch, and birthing balls and stools.
- Emergency resuscitation equipment was accessible in all clinical areas. The delivery suite had adult emergency resuscitation equipment and two baby resuscitaires. Daily safety checks of this equipment were documented.
- Other suitable equipment was available in the three bedded Day Assessment Unit, the Early Pregnancy Advice Centre and the ultrasound area. This included cardiotochograph equipment for fetal heart monitoring
- Procedures and processes were in place to prevent unauthorised access to Ashcombe Birth Centre. Areas were accessible with a swipe card for staff and controlled by a buzzer for patients and visitors. CCTV was used in the maternity areas. When visitors arrived at Ashcombe, staff escorted them onto the ward. Staff checked patients knew visitors prior to allowing them into bays and rooms.
- Newborn babies stayed with their mothers. We saw the trust had a baby abduction procedure which midwives staff were familiar with.

Medicines

- Medicines were stored safely in locked cupboards and within the resuscitation trolleys. Midwives told us they had adequate stocks of medicines on the unit and had no issues with the pharmacy services
- Medicines that required storage at low temperatures were kept in a dedicated locked fridge. The fridge temperature was checked daily.

Records

- Gynaecology and midwifery medical records and patient information was stored safely in staffed or lockable rooms or in lockable records trolleys. These were accessible to all staff who needed to access them.
- Pregnant women had hand held records which were provided at their initial booking of ante natal care and maintained through to completion of post natal care by community midwives. All necessary risk assessments were evident and regularly reviewed. Risks were recorded as discussed with patients. This enabled clinicians to have the most up to date and relevant information when reviewing care.
- We reviewed a variety of patient records including; one gynaecology medical record, four safeguarding files, three maternity medical records and six sets of maternity patient transfer records. These records were organised with clear plans of care. Referrals to other professions or services had been made where necessary and information shared appropriately.

Maternity and gynaecology

Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. We saw when concerns had been identified, appropriate referrals had been made and these were fully documented in patient records. One staff member explained how one woman attending an antenatal clinic had left written information with the midwife to read after her appointment. This related to domestic abuse. The midwife explained how they followed the safeguarding processes, which subsequently enabled to woman to leave her home and move to a place of safety.
- One senior midwife had a lead role for safeguarding and worked closely with the lead midwife for substance misuse. We saw comprehensive documentation in records demonstrating how issues had been identified and appropriate services and professionals alerted. Staff documented how they worked collaboratively with other professionals including local authorities, community drug and alcohol services, and GPs.
- Staff said the close working relationships with community midwives enabled people in vulnerable circumstances to be identified early through antenatal clinics.
- Mandatory safeguarding training had not been completed by all maternity staff. Midwives attended safeguarding training, level two and where appropriate, level three. Records dated 30th April 2015 showed 82.35% of staff were in date with level two, and 78.95% with level three. Both these figures were below the trusts compliance tolerance levels of 90%. The head of midwifery told us there were some issues with the availability of mandatory training and with accessing online training. These issues had been escalated and were being addressed.
- Women were assessed for mental health issues as part of antenatal, perinatal and post natal care. If issues were identified, women were referred to St Michaels Hospital, Bristol where there were specialist mental health services.

Mandatory training

- Compliance with statutory training was not fully met. This included basic adult life support, fire, health and safety, infection control, moving and handling and safeguarding children. The trusts compliance target for midwives mandatory training was 90%. Data showed compliance rates for this training ranging from 80% (fire and safeguarding children) and 88% (adult basic life support). The head of midwifery told us there were some issues with the availability of the trusts mandatory training, which was being reviewed.
- Maternity staff attended an additional day's mandatory skills and drills prompt training (practical emergency obstetric training). Part of this day included a skills session on evacuating a collapsed woman from the birthing pool. This training was organised by the specialist practice development midwife who ensured attendance by all staff.
- All the midwives were trained and in date with Neonatal Advanced Life Support as required by the UK Resuscitation Council and attended annual update training.
- The compliance with mandatory training for the gynaecology consultants was not available

Assessing and responding to patient risk

- Risk assessments were completed at the initial booking and continually evaluated throughout the antenatal period. From January 2014 to December 2014 there were a total of 200 births at the birth centre. Of these 99.5% (199) were a normal, spontaneous delivery.
- The delivery type for the remaining 0.05% (1) was unknown, but was not recorded as a breech, caesarean, forceps or ventouse delivery (Hospital Episode Statistics). The England national average for normal spontaneous delivery was 60.1%.
- Midwives told us they had adequate stocks of medicines on the unit and had no issues with the pharmacy services.
- Data showed midwives consistently provided one to one care for women in established labour. Midwives said this enabled constant monitoring and prompt reactions to minimise potential risks.
- Escalation processes were in place to safely respond to clinical concerns identified during antenatal care. The consultants were on a rota to provide obstetric advice to the midwives who managed the maternity Day

Assessment Unit when it was open. This was from 9am to 5pm, Monday to Friday. However, there were occasions when the consultants were not readily available due to other clinical commitments. On these occasions women were alternatively sent to St Michaels Hospital in Bristol for a consultant review.

- There were clear escalation policies in place and midwives followed these in response to maternal emergencies in Ashcombe Birth Centre. All the midwives routinely working in the unit were trained in Neonatal Advanced Life Support as required by the UK Resuscitation Council. In the event of unexpected maternal complications or collapse, the emergency hospital resuscitation team were contacted and processes were followed to stabilise conditions to enable transfer to St Michaels Hospital, Bristol. All women were accompanied by a midwife during transfers in an ambulance. The midwife stayed with the woman until all care had been transferred to staff at St Michaels.
- Midwives were familiar with guidelines for the emergency management of a cord prolapse, post-partum haemorrhage and actions to take to transfer a woman to a consultant led unit by ambulance. We saw these guidelines were in date and appropriately referenced to other national standards and guidance.
- All women had comprehensive risk assessments which were started at the first booking appointment and reviewed with every subsequent contact with a midwife. This included screening for pre-eclampsia, gestational diabetes, venous thromboembolism, female genital mutilation and medical conditions. Other risk factors were also discussed including; previous obstetric history, social issues, screening for domestic abuse and mental health.

Midwifery staffing

- There was adequate midwifery staffing levels to safely meet the needs of pregnant women using the service. There were 23.39 whole time equivalent (WTE) midwives providing routine intrapartum care. In addition there was one midwifery matron and 3.98 specialist midwives. Of these 3.58 WTE provided intrapartum care as part of the escalation process or during their time on call.
- Processes were in place which ensured the safe number of midwives were available at all times. Any shortfalls in midwifery staffing due to leave or sickness were covered by the offers from substantive midwives temporarily increasing their hours (the majority worked part time). If staffing issues could not be covered this way, an escalation policy was followed. This utilised the specialist midwives or midwifery matron to fill any staffing gaps. The birth centre did not use agency staff.
- The midwife to birth ratio of 1:9 was the lowest in the country. However, the midwifery service also provided antenatal and postnatal care for approximately 1,500 women per year. Of these approximately 230 deliveries were at Ashcombe Birth Centre or home births. Approximately 1,200 women delivered at St Michaels Hospital in Bristol.
- The Head of Midwifery role was employed in a dual lead role for Weston General Hospital and University Hospitals Bristol NHS Trust.
- There were good communication systems in place on the birthing unit. Midwives worked a combination of long shifts (12 hours) and early and late shifts. Handovers were held at the start of each shift (morning and evening). During handovers, a communication record, used to list significant information and patient records were referred to. Staff said this ensured they had all relevant information needed to provide safe care.

Medical staffing

- There were adequate medical staffing levels to safely meet the needs of patients. A total of 3.8 WTE consultants' gynaecology obstetricians were employed. There were four junior doctors working with the gynaecology team with clinics and in theatre during the day. The consultants provided on call gynaecology advice during out of hours.
- The consultant led services were small. The service was audited during 2014 by reviewing previous admission data for a six month period. This showed 744 patients had received care and treatment. Most patients 55% (413) were treated as elective day case admissions and 16% (116) as elective admissions. The majority of treatments provided were for hysterectomy and diagnostic procedures. Surgical terminations were provided for women as a result of antenatal screening

and for women referred from Marie Stopes sexual health services. Nearly a third of patients, 29% (215) received emergency care, mostly for abdominal pain or complications in pregnancy.

- The consultants provided one obstetric outpatient clinic per week at Weston General hospital. This was for women with high risk pregnancies who would go on to deliver their babies at St Michaels Hospital Bristol, which was part of University Hospitals Bristol NHS Foundation Trust.

Other staff

- There were sufficient other staff employed in roles which supported the midwifery and gynaecology services.
- The trust had a service level agreement with University Hospitals Bristol NHS Foundation Trust to provide specialist gynaecology nursing support. One nurse worked one day per week, supporting medical staff with gynaecology oncology patients.
- There was one WTE Band four administrator, 2.88 WTE Band two administrators with 0.38 Band two vacancy.
- There were 6.44 whole time equivalent Band two and three, midwifery support workers. These staff assisted midwives in the Ashcombe Birth Centre and the community. There was 0.67 midwifery support worker vacancy.

Major incident awareness and training

- Senior midwives (Band 7 and above) were aware of the trusts major incident plan and how to access this, but had not been included in training.
- Learning was demonstrated from the closure of Ashcombe Birth Centre as a result of acute whole trust service pressures during January 2015. A risk assessment process had been completed based on the experiences and learning of midwives. This had reviewed the processes involved escalating the midwife unit into a medical inpatient area, and the subsequent reopening of maternity beds. This included patient risks and subsequent actions related to dignity and privacy, infection control, security and communication.

Are maternity and gynaecology services effective?

Good

Overall we have judged gynaecology and midwifery services as effective. Ashcombe Birth Centre was a midwifery led unit open 24 hours a day at all times. Policies and guidelines had been developed in line with national policy. These were available on the trusts intranet and staff demonstrated they knew how to access them. A range of equipment and medicines were available to provide pain relief in labour. The midwifery services had achieved full accreditation with UNICEF UK breast feeding standards. There was good communication between the medical and nursing staff, and maternity support workers. Team working was described as good. The ratio of supervisors to midwives (SoM) did not meet recommended guidelines but plans were in place to address this.

Evidence-based care and treatment

- Weston General Hospital's maternity care was provided by a freestanding midwifery led unit (not in the same building as a consultant obstetric unit; FMU) called Ashcombe Birth Centre. Women identified as having low risk pregnancies could choose to deliver their baby at home or at Ashcombe. A midwifery led unit is regarded as the safest option for low risk pregnancies (Maternity Matters, 2007, DoH, Birthplace; 2011, NICE clinical guidance 190). Women identified as having high risk pregnancies were booked to deliver their babies at consultant led services, the majority of which chose St Michaels Hospital in Bristol.
- Policies and guidelines had been developed in line with national policy. These included the National Institute for Heath and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologist (RCOG); Safer Childbirth (2007), The Care of Women Requesting Induced Abortion (RCOG) and the Termination of Pregnancy for Fetal Abnormality (DoH, 2010) guidance.
- Policies and procedures were available on the trusts intranet and staff demonstrated they knew how to access them.

- Processes and procedures followed by staff showed women received care in line with NICE quality standards 22 (for routine antenatal care) and 37 (postnatal care) and NICE clinical guidance 190 for intrapartum care.
- Care was seen to be provided in line with RCOG guidelines; Safer Childbirth. This included the organisation and delivery of care in labour, staffing levels, roles and equipment.

Pain relief

- There was appropriate pain relief available for a freestanding midwifery led unit. Women booked to deliver at Ashcombe Birth Centre understood medicinal pain relief was limited and did not include the option for an epidural.
- Entonox (gas and air) was piped into both birthing rooms. Entonox was also available in cylinders to support women who wished to remain mobile during labour.
- Pethidine injections were available to women to help manage and relieve pain.
- Each of the two birthing rooms was equipped with mood lighting, air conditioning and a music docking station. These facilitated comfort and individual choice during labour. Women were encouraged to bring music of their choice for relaxation.
- All the midwives and midwifery healthcare assistants routinely working in the unit had been trained to use aromatherapy oils. Midwives told us women benefited from aromatherapy during birth and postnatally.
- Water was used effectively to alleviate pain in labour. A birthing pool and birthing couch were available in one room. The other birth room had a bed and large bath in the en suite bathroom. In addition, birthing stools and balls were available in both rooms to relieve and manage pain in labour. Records dated April 2014 to March 2015 recorded 233 births at the Ashcombe Birth Centre. Of these 87 women laboured in water and 64 women delivered in water.
- The birth centre had three Transcutaneous Electrical Nerve Stimulation (TENS) machines which were available to relieve discomfort and pain during labour.

Nutrition and hydration

- Women were supported with their personal choices to feed their babies and encouraged to breastfeed following best practice guidance. The midwifery services had full accreditation (level 3) with the UNICEF UK Baby Friendly Initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed by UNICEF. This process assessment involved interviewing mothers about the care they had received and reviewing policies, guidance and internal audits.
- There was a milk storage fridge for expressed milk and made-up feeds
- Hot and cold drinks and snacks were available at all times on Ashcombe Birthing Centre. Patients told us they were offered plenty of hot and cold drinks and water jugs were changed and replenished frequently.
- Snacks and drinks were available 24 hours a day in between set meal times. We saw information on a drinks station in Ashcombe Birth Centre informing patients and partners that if they required food or snacks to notify staff and this would be provided.

Patient outcomes

- The maternity services provided effective care, treatment and support to pregnant women living in the locality, before, during and after birth. Between April 2013 and March 2014 there were 216 births within the community and the hospital. This was a decrease of 12.2% compared to the previous year (246). In the same period, there were 3,068 midwifery outpatient appointments of which, 91.5% (2, 806) of these were attended.
- From January 2014 to December 2014 there were a total of 200 births at the birth centre. Of these 99.5% (199) were a normal, spontaneous delivery.
- There were clear reasons for the transfer of women to St Michaels Hospital in Bristol. The percentage of women transferred to a consultant led unit during labour was closely monitored on a weekly basis. The patient risk midwife said they reviewed all transfer information to check the decision making was both appropriate and timely. Any learning from this was discussed with individual midwives and shared with the team where appropriate. The patient safety midwife told us the

transfer rate from the maternity services from April 2014 to March 2015 was overall 20%. This compared to a national average of 24% for units of the same type (NICE guidelines, CG190, 2014).

- The percentage of women transferred out of the Day Assessment Unit or the Ashcombe Birth Centre was at an acceptable level. The last audit of transfers was completed for the period 1 April 2013 to 31 March 2014. In total there were 127 transfers. Of these 72 were from the Day Unit, and 55 from Ashcombe. Out of the 72 transfers from Day Unit, 40% (29) were reviewed and discharged home with a plan and 60% (43) were admitted. Of the 55 women who were transferred in labour, 62% (34) required either instrumental or operative delivery. Those women (21) who progressed to a normal vaginal delivery still required a level of monitoring beyond that offered by Ashcombe.

Competent staff

- Midwives employed to work at Ashcombe Birth Centre had the necessary skills and experience to practice autonomously. The midwifery matron told us only experienced band six midwives were able to apply for vacancies on the unit. This was because there was no consultant input and consequently maternal, fetal and baby risk assessments had to be completed and reviewed, comprehensively and competently at all times
- Midwives had the necessary skills to complete new born baby checks. There were four fully trained midwives (and two in training) with the NHS Newborn and Physical Examination Programme. These checks were completed to detect and promptly treat a number of congenital medical conditions.
- Midwives were being supported to have an annual appraisal. The trust had an appraisal compliance rate of 85%. Data showed compliance was achieved from April 2013 to March 2014 (89.13%) but not quite achieved from April 2014 to March 2015 (82.61). The midwifery matron said the service was aiming to improve these figures. The percentage of midwives in date with their annual appraisal during April 2015 was 88.89%.
- The ratio of supervisors to midwives (SoM) did not meet recommended guidelines. The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SoM). By law midwives must have a named SoM with whom they meet once a year to consider their practice. The recommended ratio of SoM to midwives was 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). There were four SoM at Weston General Hospital. However these SoM shared responsibilities with University Hospitals Bristol NHS Foundation Trust which had increased the size of the supervisory teams. The SoM caseloads were 1:21, which was above the level recommended levels. The Head of Midwifery told us three additional midwifes had nearly completed the SoM training and once practicing, the caseload numbers would reduce.
- The four SoM provided safe support despite not being fully supported by the trust with their roles. Weston General Hospital was one of only two employing organisations out of 17 in the south west region that did not provide protected time for SoM to complete their investigatory and supervisory duties. However, the SoM worked hard to ensure midwives had their annual reviews, with 97% in date with this.

Multidisciplinary working

- The maternity staff were proud of their team working. Communication between professionals was described as “good” and “excellent”. At the start of each shift on the delivery unit there was a handover between all staff (twice a day). We saw there were communication books to share and pass on additional information for midwives working on the unit and those working in the community.
- The midwives had regular contact with the Consultant Obstetrician Gynaecologists. This was because part of the consultant roles included weekly antenatal clinics for high risk women who would deliver at St Michaels Hospital, Bristol. The consultants also provided on call advice to the Day Assessment Unit. Relationships were between the midwives and consultants were described and good and professional.
- The midwives worked effectively with services in the community. Antenatal and postnatal care was offered at one of seven children’s centres in the locality or at the woman’s GP surgery. Midwives had good relationships with GPs and were often included in GP practice meetings.
- The midwives worked effectively with the ambulance services and the consultant led services at St Michaels

Hospital in Bristol. Midwives from Ashcombe Birth Centre or the community accompanied any woman who needed to be transferred by ambulance to St Michaels Hospital. The midwives worked with other these other staff to ensure care was safely and effectively handed over.

- Postnatal care in the community was coordinated effectively. The community administrator had systems in place to keep the community midwives updated. These processes ensured clinical information was passed to the community midwives. For example, sonography or other test results and delivery and discharge information from Ashcombe Birth Centre or St Michaels Hospital, Bristol. This enabled women to receive coordinated and effective care in a community setting of their choice.

Seven-day services

- The Ashcombe Birth Centre provided an effective and responsive service based on the individual needs of pregnant women. The unit was open 24 hours a day, seven days per week at all times. This service included a 24 hour midwife advice line, on call midwives and supervisor of midwives
- There were sufficient additional midwifery services to meet patients' needs. The Early Pregnancy Advice Centre was located next to Ashcombe and was managed by midwives. The Early Pregnancy Advice Centre was open from 9am to 5pm Monday to Friday and provided 36 clinics per week. These included first trimester date scanning, hearing and screening clinics and one consultant clinic per week for women with high risk pregnancies who were booked to deliver at St Michaels Hospital in Bristol.
- The Day Assessment Unit was managed by midwives and was next to Ashcombe Birth Centre. This service was open 9am to 5pm and enabled women to attend for additional checks and tests when required. For example; fetal Doppler checks for reduced fetal movements and scans for fetal position.
- Imaging services were provided by trained sonographers and were available near the Early Pregnancy Advice Centre 9am to 5pm, Monday to Friday. Midwives told us this service was required out of hours; ultrasonographers could be accessed via the X-ray department in the hospital.
- Two midwives were always on duty in Ashcombe and in the community. Three midwives were on call at all times to provide additional support as required with home births and transfers from Ashcombe to St Michaels Hospital, Bristol

Access to information

- Medical records were accessible and available for maternity clinics. Administration staff told us they requested patients' previous medical records after a 12 week scan had been completed. If there were none, or the woman was new to the area, a set was made by administrators. Staff confirmed the record requests were prompt and usually supplied within the same day. Staff said this ensured all information was readily available for any consultations. Medical records were stored in the maternity centre until the woman was discharged from the midwives care.
- Pregnant women carried their own records which were provided when booking in. These were used by all clinicians involved with care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for post natal care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the correct processes to gain consent. The six patients we spoke with all confirmed that staff had asked for permission before proceeding with any care or treatment.
- Procedures to gain consent were documented. The 13 records we reviewed clearly documented discussions regarding consent before carrying out any examination or procedure.

Are maternity and gynaecology services caring?

Good

Feedback from patients and relatives regarding care, treatment and support received was positive. Staff cared for pregnant women before, during and after birth with kindness, compassion, dignity and respect. Patients told us

they felt involved with their care, had their wishes respected and understood options for care and treatment. Counselling and support was available to women who attended the Early Pregnancy Assessment Centre and for surgical terminations.

Compassionate care

- We spoke with five women who had gynaecology treatment or maternity care. All spoke positively regarding their experiences saying staff had been compassionate, kind and helpful. One woman told us; "the service I have received has been excellent. I have been supported by very caring staff who have been very accommodating to my visitors. Staff have gone out of their way to make sure everyone is comfortable and provided tea and coffee for everyone when they visit."
- Ashcombe Birth Centre completed a survey based on a sample of 50 births registered prior to the end of August 2014. The purpose of the survey was to review women's experiences of intrapartum and postnatal care, 36% (18) responded. Women reported they received dignified care, and 100% gave staff the maximum positive score on the survey. The majority of feedback was positive, comments included; "I received excellent care and would not have considered going anywhere else. I was treated with care and attention and made to feel that no worry or concern was unfounded" and "The staff at Ashcombe were warm and encouraging and enabled me to take control of my labour - I felt they respected my space and I found it a wonderful calm experience."
- Systems were in place to provide compassionate support to women who miscarried. The Early Pregnancy Assessment Centre liaised every day with the community administrator. We saw records which showed how the community midwives were kept informed of women who had miscarried. Home visits were then arranged to provide additional support and advice.
- The maternity Friends and Family test showed consistent high levels of satisfaction with antenatal, perinatal and postnatal care at Ashcombe Birth Centre and in the community. However, the percentage of patients completing score cards was low; approximately 19% overall. The Friends and Family test for May 2015 scored 100% (extremely likely to recommend) for antenatal care (35 responses), 100% for perinatal care (10 responses), 100% for postnatal care on Ashcombe (14 responses) and 100% for postnatal care in the community (14 responses).

Understanding and involvement of patients and those close to them

- One gynaecology patient told us medical and nursing staff had explained issues well and they fully understood all information relating to their care and treatment. We saw discussions of consultations and records of the patient's choices and preferences documented in records.
- We looked at three sets of maternity records, which fully documented discussions with patients and their preferences and choices regarding care during and after delivery. All the women we spoke with said they felt their decisions were listened too and respected by midwives. On occasions when choices and decisions could not be followed, this was fully understood to be based on safely managing risks.

Emotional support

- There was a high level of satisfaction by women who received care on Ashcombe. There are many positive comments about staff, which included; "Everything went brilliantly. The student midwife stayed on past her shift to deliver my baby and she was just fantastic. I wanted a water birth and this is what happened. There were times when I thought I couldn't do it, but the midwives gave me the greatest support and encouragement and made me believe in myself. Even though my husband was with me all the time, I needed those midwives for support, they really absolutely great. Another woman said; "The experience was all positive and I would definitely recommend this place to anyone. The midwives were patient, kind and very reassuring which helped me enormously."
- We heard midwives provided emotional support to women telephoning Ashcombe for advice. Women's individual concerns were promptly identified and responded to in a reassuring and positive way. Women calling triage talked with in an unhurried manner, midwives prompted callers to ask questions and checked if information was understood. If appropriate,

they suggested women come into triage in order to provide personal reassurance. Women were encouraged to call back with any concerns however minor they perceived them to be.

- Specific midwives had responsibility for managing the Early Pregnancy Assessment Centre. These midwives had additional counselling and bereavement training which we were told supported breaking bad news to women and their partners.

Are maternity and gynaecology services responsive?

Good

Overall, we have judged services to be responsive. The birth centre was open and appropriately staffed 24 hours a day, all year round. Midwives worked flexible to provide choice to women of where they wished to receive their antenatal, perinatal and postnatal care. All women received 1:1 care and support during established labour. The six patients we spoke with told us staff provided personalised care and treatment. Appropriate processes were followed to investigate, respond to and learn from complaints. During January 2015 Ashcombe Birth Centre was closed for three days, and the 10 post natal beds were used by medical patients for a further seven days. This was in response to intense trust wide service pressures. The beds were redeployed to medical patients during this time.

Service planning and delivery to meet the needs of local people

- The community midwives (employed by the trust) provided care in community venues to suit individual needs. This included at patient's homes, at their GP practice or in one of seven community children's centres. The delivery of care in these venues provided additional opportunities to engage with local people.
- For women whose first language was not English; maternity information was provided in other languages. Staff said interpreters were used regularly to support women in the hospital and community.
- Systems were in place to review service plans to meet the needs of local people. The midwifery matron attended the Maternity Voices (formally; Maternity Services Liaison Committee) which was also attended by members of the public and local maternity commissioners. We saw from meeting minutes that discussions regarding maternity trends were a regular agenda item. For example; national and local birth rates were discussed as well as public health data such as maternal smoking rates at time of birth. Actions were made to make maternity services responsive to local needs. For example; how to provide women with balanced and complete information on the availability of different types of services, and the advantages and disadvantages of each.

Access and flow

- The maternity triage telephone service was open 24 hours a day, all year round for pregnant women to call with concerns or queries. This service supported effective flow through to the different maternity services.
- The birth centre was open and appropriately staffed 24 hours a day, all year round. All women, 100%, received 1:1 care and support during established labour.
- Midwives worked flexible to provide choice to women of where they wished to receive their antenatal, perinatal and postnatal care. Shifts were coordinated every day to ensure there were safe and sufficient numbers of midwives to respond to patient's needs.
- During January 2015 Ashcombe Birth Centre was closed for three days, and the 10 post natal beds were used by medical patients for a further seven days. This was in response to intense trust wide service pressures. The beds were redeployed to medical patients during this time. This was in response to intense trust wide service pressures. The beds were redeployed to medical patients during this time. Three women were known to have been redirected to St Michaels Hospital for labour care during this time. This figure would not include others who did not contact the service as they were already aware of the closure.

Meeting people's individual needs

- Patients told us staff provided personalised care and treatment. We spoke with six patients and two of their partners. We were told staff checked how patients

personal choice and how they preferred to receive their care. New mothers told us they had birth plans and midwives had followed these as much as possible without compromising safety.

- The two single on suite rooms on Ashcombe Birth Centre were prioritised for women who had delivered at the centre for the first night post natal. These rooms were equipped with sleeper chairs to for partners to stay overnight if they wished. At other times these rooms were available for parents to stay in at a cost of between £50.00 and £74.50 per night.
- We saw notices providing advice for patients and relatives on how to access food and drink. We were told this information had been put in place in response to patient feedback and an identified gap in patient information. We saw this documented in the patient survey completed by Ashcombe during 2014**.**
- Translation services and maternity information was available in languages other than English. The midwives told us they used a telephone translation service called 'Big Word', which was prompt and effective. We saw information written in different languages was available for women in the Early Pregnancy Advice Clinic and the Day Assessment Unit.
- An information and welcome pack was provided to each woman staying on Ashcombe. This included a variety of information for new mothers. For example; information on post natal exercises, aromatherapy oils, bed sharing with the baby, registering the birth, feeding and communication, supervision of midwives, and what to do if there were any concerns.
- The safety thermometer board on Ashcombe had been extended to include additional information on; staffing levels, details of the midwife in charge, friends and family results, 'you said, we did' information, contact details to make a compliment or raise a concern and breast feeding information. This information was updated every day and displayed for patients and visitors to view and contribute to.
- Counselling services were available for women who attended Weston General Hospital for surgical abortions. Counselling support was accessible before and after procedures from the Marie Stopes family planning centre in Stoke Gifford, Bristol.
- Midwives assessed women for mental health issues throughout the maternity care pathway. If issues were detected, women were referred to St Michael's hospital where specialist support was available.

Learning from complaints and concerns

- Appropriate processes were followed to investigate, respond to and learn from complaints. There were eight complaints during 2014, and four recorded for January and February 2015. All complaints were reviewed by the midwifery matron. We saw complaints were investigated and actions recorded. Complaint information was kept under review and monitored as part of the monthly team and governance meetings. Learning points from complaints were disseminated during staff meetings and newsletters.
- We saw complaint information leaflets were available in all patient areas.

Are maternity and gynaecology services well-led?

Good

There were comprehensive risk, quality and governance structures in place. The maternity risk midwife led outstanding governance processes. There was evidence to show incidents were incidents were interrogated for service improvements and systems were in place to share information and learning. Staff described leadership and support as good, with senior managers visible and approachable. The staff we spoke with were proud of the care they provided and spoke of positive team working between professionals and across. There was evidence of positive working cultures and innovations and actions taken to make service improvements.

Vision and strategy for this service

- Both the gynaecology and maternity had service line strategies in place. Midwives demonstrated a broad understanding of the maternity vison and strategy and of the trusts core values. All the midwives stated their goal was to provide high quality, 1:1, person-centred midwifery care.

Governance, risk management and quality measurement

- Senior staff (Matron and above) demonstrated an understanding of current service risks. We looked at incidents and risks recorded within the maternity and gynaecology services. We spoke with senior staff who demonstrated an awareness of what issues had been currently reported and subsequent actions planned to reduce further risks. We saw maternity policies and procedures were in date and ratified.
- Systems and processes were in place to both escalate concerns and pass on relevant information to trust wide risk management committees. A maternity safety report was produced by the patient safety midwife ever month. This contained a summary of incidents, including analysis, transfers, risk register information, audit, guidelines, national safety alerts and issues relating to patient dignity. This safety report was sent to all maternity staff and the obstetricians, the trust governance team, director of nursing and the divisional manager (surgery).
- The multidisciplinary maternity governance group met monthly and had developed a service risk management strategy. This clearly identified duties and responsibilities for the management of clinical risks. We reviewed maternity governance meeting minutes and actions were in place to minimise risks and improve practice. For example; changes made to emergency procedures following national guidance updates.
- The patient risk midwife was responsible for the majority of governance and quality measures and had outstanding processes in place. This person demonstrated a clear oversight of all current issues. We saw there were thorough processes and audit trails in place for risk, governance and quality information. We saw evidence of how information was thoroughly interrogated for service and safety improvements. For example; the number of neonatal readmissions was investigated following a review of incident reports. The babies had been readmitted due to loss of weight and non-establishment of feeding. A thorough review of the data revealed, all the babies readmitted to Ashcombe Birth Centre had been born at St Michaels Hospital, Bristol. This information was shared with St Michael's midwives who put in place learning and action plans.
- Record keeping audits on Ashcombe was audited every month. Ten patient records were randomly selected and reviewed against a list of criteria. This included patient details, completion of risk assessments and clinical information. We looked at the record keeping audit information and how issues had been feed into the maternity governance meetings and patient safety report. For example; it had been identified that antenatal and postnatal records in the community had not been subjected to any audit or evaluation. A monthly review process for community records was subsequently developed to address this.
- An audit completed by one of the consultant gynaecologist obstetricians during July 2014 identified national guidance had not been followed for termination of pregnancies. The notification and grounds for carrying out an abortion forms (HSA1 and HSA4) had not been submitted to the Department of Health (DoH). Upon investigation it was clear this had not been done since December 2011 following changes with administration staff. The DoH, CQC and Trust Development Authority (TDA) were notified. Staff training and new processes were actioned and have continued to be monitored to ensure the trust is compliant with the law and regulations.

The gynaecology regular governance and quality processes were less identifiable as these were merged with surgical and medical information

Leadership of service

- The midwifery matron was respected as an experienced and professional person. Midwives we spoke with said the matron had good leadership skills, was visible and approachable. Midwives said the matron promoted effective team working across the service. All the midwives we spoke with said team working was supportive the service was a good one to work for.
- The senior leads for midwifery (band seven and above) were visible and present in clinical areas. They demonstrated a good understanding of current clinical activity and priorities on the days of our inspection.

Culture within the service

- The culture was focused on providing person centred care and support to pregnant women before, during and after birth. All the midwives and other staff were clear regarding this aim and focus. The atmosphere

throughout all the departments at Ashcombe Birth Centre was relaxed but responsive to patient's needs. Student midwives we spoke with said they aspired to work in the unit.

- The midwives we spoke with were proud of the service and the care they provided. Staff said the trust was good to work for and they felt supported by both colleagues and mangers.

Public and staff engagement

- Systems were in place to engage with the public and staff and use this information to develop maternity services. Ashcombe Birth Centre worked with Maternity Voices (formally; Maternity Services Liaison Committee). This group met four times a year and was attended by members of the public, local maternity commissioners and maternity professionals. The group reviewed and compared maternity issues and services in detail for the Bristol, South Gloucestershire and North Somerset areas. The group made recommendations for maternity practice, and action plans to put these improvements into practice. For example, how Ashcombe was responding to public health issues such as, pregnancy rates in teenagers and smoking in pregnancy. Actions and outcomes for these groups were reviewed by Maternity Voices and the data was compared against other local maternity services.
- The midwives we spoke with said they felt able to express their opinions and raise concerns. There were regular forums for staff to engage in discussions. Midwives were encouraged to attend monthly staff and governance meetings. In addition, midwives were sent a weekly newsletter ("Matrons Musings"), and the patient safety midwife emailed clinical risk updates when required ("Safety Pin"). We saw recent copies of these which included clinical updates, lone working updates and new contact details for services.

Innovation, improvement and sustainability

- The consultants were concerned the small gynaecology service provided at Western General would not be sufficient to attract high calibre consultants to sustain the service long term.
- The midwifery service supported innovation to improve practice and care. Two midwives had developed the 'Shine' (s**elf-help, independence, nutrition and exercise) service. This was a 10 week programme of lifestyle education and advice for pregnant women with a BMI or 30 or more or with gestational diabetes. This innovative service had** been shortlisted for a Royal College of Midwives Public Health Award, 2015.
- The midwifery service supported research and development to improve practice and care. The midwives took part in a pilot study with regards to the development of an antenatal mental health pathway. This work identified women who were at risk of antenatal anxiety and increased midwives confidence addressing issues. This work was published in the Community Practitioner journal, April 2015 (Early intervention for increased antenatal anxiety associated with foetal development risk, p42-46).
- Four midwifery staff had been nominated for internal staff achievement awards.

Services for children and young people

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

Information about the service

Children's clinical services at Weston General Hospital were located at the Seashore Centre. The unit was opened in 2007 to provide care closer to home for local children aged between birth and 16 years and their families. It was open on Monday to Friday between 9am and 8pm. Referrals were received directly from GPs and other health professionals, from the emergency department and from other neighbouring hospitals. It comprised a six bed, four cot day care unit and an outpatients' department.

Staffing comprised of three paediatric consultants, seven paediatric nurses and five administrators. A paediatric dietician held clinics on the unit and a range of other clinics were held on the unit, for example orthotics, eye clinics, tongue tie clinics and clinics run by the community team.

A waiting room was available with a television, toys and games. On the day assessment unit there were toys, DVDs, books and electronic games. There was also a quiet activity room for parents to breast feed.

During our inspection we spoke with 13 parents and six children and young people. We also spoke with staff, including nurses, consultants, managers and support staff. We visited all the areas within the children's unit. We observed care and looked at records and also other documents provided by the trust.

Summary of findings

Services for children and young people were judged to be good overall.

The caring and of the service was rated as outstanding, and safety, effectiveness, responsiveness and leadership were rated as good. Treatment and care were delivered in accordance with best practice and recognised national guidelines. Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the highest quality of care were encouraged and acknowledged.

Children, young people and their families were respected and valued as individuals. Feedback from those who used the service had been exceptionally positive. Staff went above and beyond their usual duties to ensure children and young people received compassionate care. Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families.

The leadership and culture of the unit drove improvement and the delivery of high-quality individual care.

All staff were committed to children, young people and their families and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the unit as a place to work. They spoke highly of the culture and levels of engagement.

Services for children and young people

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

The unit was clean and well organised and suitable for children and young people. Staff adhered to infection prevention and control policies and protocols.

Are services for children and young people safe?

Good

Overall we have judged the safety of children and young people's services as good. There were systems in place for recording and learning lessons from incidents and staff told us they were encouraged to report incidents.

We saw that parents were fully informed prior to consent being obtained and that nursing and medical records had been completed appropriately and in line with each individual child's needs.

Staff we spoke with were knowledgeable about the trust safeguarding process and were clear about their responsibilities. Mandatory training was monitored each month and all staff were compliant with their training.

The unit was clean and well organised. Staff adhered to infection prevention and control policies and protocols. There were good levels of nursing although there were concerns about the number of consultants.

Systems were in place for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs and prescription forms.

Incidents

- Staff were open, transparent and honest about incidents. Systems were in place to make sure that incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them. Staff told us they were able to get feedback on incidents they reported. However, feedback was variable and this had been identified as a problem and work was in progress to improve this.
- We saw evidence that learning was discussed through departmental, speciality and unit governance meetings. For example, an independent review of the service by the Royal College of Paediatrics and Child Health was invited in 2012 following the death of a child in 2010 after discharge from the unit. A coroner's report in 2011 found that contributory factors to the death included failure to follow National Institute for Health and Care Excellence (NICE) guidelines, failure to initiate regular

observations and to appreciate the significance of those that were taken. The trust took a number of steps to address the failings including two-hourly observations recorded on admission sheets; a paediatric early warning system to ensure that action was taken on abnormal observations; and initiation of an audit of the relevant NICE guidelines. The review identified further recommendations which the trust had incorporated in an action plan which was regularly reviewed at the Paediatric Business and Governance Group.

Duty of Candour

- Staff demonstrated an understanding of Duty of Candour responsibilities. This new regulation was introduced in November 2014. It requires staff to be open, transparent and candid with patients and relatives when things went wrong. We did not however, see evidence of any instances where the Duty of Candour had been employed within the service.

Cleanliness, infection control and hygiene

- At the time of our inspection the unit was visibly clean, well-organised and tidy.
- Used disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said they were emptied regularly and none of the bins or containers we saw were unacceptably full.
- We observed doctors and nursing staff washing their hands and using anti-bacterial gel. Children and their parents were asked to use alcohol gel when arriving on the unit and this was freely available and clearly visible.

Environment and equipment

- The unit had secure access to maintain the safety of children and young people. It was bright, welcoming and suitable for children and young people. A range of toys and activities were available. A picture board of photographs of all staff working that day was positioned by the entrance to the unit. The photographs were changed daily and while we were visiting they were being changed to reflect the day's staffing.
- There was resuscitation equipment appropriate for babies, children and young people. The trolley had been checked each day and the check recorded.

Medicines

- Medicines, including those requiring cool storage, were stored appropriately. During our inspection we found that medicines were stored securely in locked rooms that were only accessible by staff. Controlled drugs were stored in separate locked cupboards and were checked daily by two qualified nurses. Where medicines were needed to be stored in a fridge, the fridge temperatures had been checked consistently.

Records

- Records were stored safely in the office to ensure confidentiality and security. They were clear, legible and ordered. We reviewed five sets of notes and checked current and historic information. Documents were clearly written in chronological order and treatment plans were clear. The quality of documentation was regularly reviewed with feedback during recent months advising staff to ensure that they explained why something had not been done.
- Records demonstrated communications with parents. We also saw a message record sheet that was used to record any messages between the parents and /or carers.
- Staff were able to access a shared network drive containing all clinical letters sent to children and young people who were being seen both on the unit and in the community. This ensured access to a comprehensive record for all disciplines involved in treatment and care.

Safeguarding

- Staff we spoke with were knowledgeable about the trust safeguarding process and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of child abuse and what actions they would take should they have safeguarding concerns about a child or young person.
- Staff were trained to recognise and respond in order to safeguard children and young people. Records indicated that safeguarding training to at least level 3 was up to date for all staff. The ward manager had completed level 4 training. There was a safeguarding lead nurse for the trust who supported a programme for safeguarding supervision and peer review. Staff were aware of and able to access supervision and review and this was embedding across the unit.

- Child sexual exploitation training level 1 had been attended by one nurse during the week of our visit and there were plans for feedback to the wider team to assess whether the course was suitable for the rest of the team to complete.

Staff shortages within community paediatrics had presented a risk to levels of safeguarding care and resulted in a temporary outsourcing of safeguarding to Taunton & Somerset NHS Foundation Trust.The staffing situation had stabilised and safeguarding had been repatriated in September 2014.Practices used at Taunton were adopted and incorporated into a re-design of a child protection pathway.

- All safeguarding referrals requiring a medical examination were performed by a community paediatrician and held on the Seashore Centre. Staff worked collaboratively with other professional including local authorities, community clinicians and GPs. A system had been introduced using a "Green dot folder" to identify children and young people with safeguarding plans and or Looked after Children.

Mandatory training

- Staff training records were monitored each month to review attendance and expiry dates, thereby ensuring compliance with mandatory training. All staff told us they were up-to-date with their mandatory training. This meant that staff remained up-to-date with their skills and knowledge to enable them to care for children and young people appropriately.
- Other training in subjects appropriate to the needs of the unit had been undertaken, including on-line training in Female Genital Mutilation (FGM), meningitis and paediatric blood transfusion competency. Training on administering subcutaneous methotrexate for inflammatory arthritis had been attended by a nurse on the unit.
- Nursing staff told us about a journal club that had recently started where they were able to share their knowledge. Staff also felt they had created a good learning environment for students. We spoke to a student nurse who commented how effective the training and placement had been. Training and development of consultant medical staff took place through networks with Bristol Children's Hospital.

Assessing and responding to patient risk

- Risk assessments were completed and evaluated. Clear processes were in place to deal with deteriorating children. Paediatric Early Warning Scores (PEWS) were in place. Details of the escalation required, depending on the scores, were in place on each PEWS chart. Each chart recorded the necessary observations such as pulse, temperature and respirations.
- All nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support.

Nursing staffing

- We were told that there was adequate nursing staff to safely meet the needs of children and young people. At the time of the inspection nursing was 6 hours below the funded establishment. However, the ward manager currently covered the shortfall and was always flexible to provide cover. The shortfall did not adversely impact on the care of children and young people.
- A senior nurse was always present in the unit which meant senior nursing advice was always available. The director of nursing also visited the unit every Wednesday.
- There was a low staff turnover evidenced by the presence of a number of the team who had been working on the unit since it opened in 2007.

Medical staffing

- At the time of our inspection the unit had three consultants. The consultants worked between 9am and 5pm when holding clinics and there was always a consultant working between 9am and 8pm each day.
- Trainee GPs on rotation had been introduced on the unit to support the service.
- Staff shared their concerns about the fragility of the medical rota that had little room for manoeuvre in terms of capacity. They felt this had impacted on the development of the service.

Major incident awareness and training

- The staff we spoke to were aware of the trust major incident plan and how to access this, but had not been included in training.

Services for children and young people

- Contingency plans were developed at local level. There was a plan in place to cancel clinics or close the unit if there was inadequate medical cover due to sickness or holidays.

Are services for children and young people effective?

Good

Overall we judged the service as good. Treatment by all staff was delivered in accordance with best practice and recognised national guidelines. Children and young people were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for children and young people. There were robust governance arrangements in place.

Staff skills and competence were examined and staff were supported to obtain new skills and share best practice. All staff were treated with respect and their views and opinions heard and valued.

Children, young people and their parents understood what was happening to them and were involved in decisions about treatment and care.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Paediatrics and Child Health. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. Staff also told us they could access on line protocols and policies that were used at the Bristol Children's Hospital.
- Staff attended a number of regular meetings. We saw minutes of a nurses' meeting that was held every three months to discuss safeguarding, link roles taken on by nurses, nurse in charge roles, standard operating procedures and supervision. Minutes were also available for monthly clinical governance meetings where governance, safeguarding, performance and audits were discussed. The team were working through NICE guidelines to check compliance and in the minutes we saw details outlining the design of asthma plans for the unit.
- Monthly meetings between the unit and the emergency department were held to monitor the pathway for children presenting in the emergency department ensuring early transfer to the unit. A teaching schedule for paediatricians to lead regular 15 -30 minute teaching sessions in the emergency department was being designed

Nutrition and hydration

- Drinks and meals were provided for older children. Parents of younger children were encouraged to bring bottles and feeds with them to their appointments where possible.

Patient outcomes

- Clinical pathways were in place for the most common reasons where children presented to hospital including head injury, abdominal pain and fever. These gave clear and consistent guidance about how to treat these conditions.
- A number of regular audits were carried out on the unit to monitor performance and maintain standards. We saw details of a febrile child audit that was carried out every two months for the period January 2014 to February 2015 to audit nursing and medical performance and monitor standards. We also saw results from a feverish child audit between January 2013 to April 2015 where notes of children under 5 years who presented with a feverish illness, either as the main complaint or as a feature of the presenting complaint, were audited. Results were consistently at 100% with two areas showing reduced results. These were the assessment of hydration and the traffic light scoring system.
- Details of a day case documentation audit from May 2014 to April 2015 were also available. This looked at a comprehensive list of documentation including a designated nurse, blood pressure attempted, observation tool completed, discharge safety netting. Overall standards were good. Results were summarised every two months and information circulated to the team identifying areas to watch. For example the quality of information recorded had been highlighted as an

area for improvement together with a reminder to document if blood pressure had been done as this had remained at 70% since the November – December 2014 audit.

Competent staff

- There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and that there was good teamwork.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed on a monthly basis of training completed and alerted to those staff requiring updates. Staff told us that they had received a comprehensive induction to the unit.
- Staff told us that they received regular access to supervision and appraisals and received regular face-to-face feedback.
- All consultants were trained in advanced paediatric life support (APLS) and all nursing staff were trained in paediatric life support (PLS).

Multidisciplinary working

- We saw examples of team working across other departments such as the emergency department, and joint working with the community team to assist them with the shortage of rooms at Drove Road. Discussions were underway with the community team about the space required.
- There was a clear pathway for referral to the Bristol Children's Hospital for mental health admission and a good working relationship with the Community and Adolescent Mental Health Services (CAMHS).

Transition

- A transition policy had been drafted with implementation expected shortly. The Medical Director had been assigned as the trust executive lead for transition and would head up the steering group. From the minutes of the Clinical Governance meeting held on 14 April 2015 we saw that consultants had agreed to go through the lists of their patients who were over 14 years to confirm who should be on the transition pathway.

Access to information

- A number of advice sheets for parents were seen during our visit, for example discharge information sheets and advice sheets where a child had a temperature with details of the Amber and Red flag symptoms. Parents told us that this information was "very reassuring" and helped them "to know what to look out for and what to do if things got worse."

Consent

- Staff told us they obtained consent from children, young people and their parents / carers prior to commencing care or treatment. Staff were aware of the principles of Gillick competence and the Fraser guidelines that were used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. Staff used these where appropriate.
- We saw from the records that consent was obtained from parents for each child or young person.
- The parents that we spoke to during this inspection all told us that the consultant staff had explained any procedures to them fully before asking for consent forms to be signed. The children we spoke to during this inspection also told us that the doctors had explained things to them directly in a way they could understand. Staff told us about how they dealt with consent issues for young people who did not want to tell their parents. They always tried to sensitively manage the situation while ensuring that the young person received the help they needed.

Are services for children and young people caring?

Outstanding ☆

We have judged the care given to children, young people and their parents as outstanding. There was a strong, visible person centred culture. Children and young people were treated as individuals and as part of a family. Relationships between children and young people, their families and staff were strong, cating and supportive.

Staff were both creative and determined to deliver care that met the needs of individual children and young people. Feedback from children, young people and parents

was continually and exceptionally positive. They praised the way the staff really understood the needs of their children, and involved the whole family in their care. Staff were said to go the extra mile and the care children and young people received exceeded their expectations and those of their families.

Staff were passionate about delivering high quality care and went above and beyond their usual duties to ensure children and young people experienced high quality care

Staff were skilled to be able to communicate well with children and young people to reduce their anxieties and keep them informed of what was happening and involved in their care. Children, young people and their families were active partners in their care. Staff were fully committed to working in partnership with children, young people and their families. Parents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible.

All staff recognised the impact that care and treatment had on a child or young person and their family, and were able to offer emotional support and understanding.

Compassionate care

- Children, young people and their parents we met spoke highly of the service they received. The NHS Friends and Family Test and user feedback forms showed that families consistently found the staff to be efficient, friendly and helpful. Exit cards completed said they would recommend the service to friends and family.
- Staff told us that the questionnaire box was regularly emptied and we noted that the box contained three questionnaires from the clinic that day. The comments were all positive with one parent suggesting that a "seven day service should be available."
- During our inspection we observed excellent interactions between staff, children, young people and their families. We saw that these interactions were very caring, respectful and compassionate. The staff were skilled in talking and caring for children and young people. Parents were encouraged to provide as much care for their children as they felt able to, whilst young people were encouraged to be as independent as possible.
- All the feedback we received from the parents we spoke to was unanimous in its praise for the care their children received. The comments we received included "the staff have been fantastic", "very happy with the care given to my child", "I've come here for 5 years and they have always been wonderful", "They always do what they say."
- The children and young people we spoke to told us how good the staff had been in looking after them. Comments from children and young people included "it's been a good experience", "the staff help me when I need them", "I like playing with the toys … the staff are nice and explain things to me."
- Care from the nursing and medical staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

Patient understanding and involvement

- We observed staff explaining things to parents, children and young people in a way they could understand. For example, during a complex explanation, time was allowed for either the child or their parents to ask whatever questions they wanted to.
- Parents were encouraged to be involved in the care of their children as much as they felt able to. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke to all confirmed this was the case.
- Parents, children and young people told us the nurse who was looking after them always introduced themselves.

Emotional support

- We observed staff providing emotional support to children, young people and their parents during their visit to the unit. Children's individual concerns were promptly identified and responded to in a positive and reassuring way.
- One parent whose child regularly attended the unit told us that "nothing was too much trouble for the staff … from the doctors and nurses to the administration team." They particularly valued the follow-up phone call from the ward manager the day after an emergency visit to the unit.

Services for children and young people

- Another parent told us that staff "seemed to know when I needed a shoulder to cry on" and were able to provide "support during a particularly difficult time."

Are services for children and young people responsive?

Good

The service responded well to children, young people and their families.

Children and young people's needs were central to the planning and delivery of care. Services were tailored to meet their needs and were delivered in a flexible way and at a time that suited them and their parents.

The facilities were excellent for children, young people and their families.

There were no barriers for those making a complaint. Staff actively invited feedback from children and their parents and were very open to learning and improvement. There were, however, few complaints made to the unit. Those that had been made were fully investigated and responded to with compassion.

Service planning and delivery to meet the needs of local people

- Staff were proud to tell us that during the last three years only three clinics had been cancelled and they tried as much as possible to prevent children and young people taking too much time away from school. To this end tests were done on the same day as the clinic appointment avoiding a return visit to the unit. Administration of subcutaneous methotrexate for the treatment of inflammatory arthritis was now available on the unit and carried out on Friday afternoons after school. This also avoided children missing school and enabled recovery over the weekend, and also avoided a journey to the Bristol Children's Hospital.
- Parents told us that staff always tried to arrange appointments at a time to suit them and their children. This flexibility ensured that as little time as possible was taken away from the child's school day or from the parent's working day.
- The ward manager had introduced a system where all children attending as an emergency received a follow-up phone call the next day to ensure that all was well with the child and their parents. Parents told us how reassuring this had been.
- Parents told us how useful it was to receive a text message to remind them about an appointment.
- A triage system was in place where staff spoke with a GP directly if they had concerns about a child they had seen in clinic. Information was handed over to the doctor on duty that day thereby ensuring continuity of care.
- Where young people with developmental or psychological issues had not transitioned, services were extended to those beyond the age of 16 years.
- The environment was designed to meet the needs of children and young people and their families. The unit provided a wide range of age-appropriate toys and activities for children and young people.

Access and flow

- There was open access in place for some children who were well known to the unit to enable direct access to the unit. Staff told us this worked well for the child, family, GP and the service. One parent confirmed how valuable this access had been for her child.
- There was flexibility in the referral cut off time from the emergency department to the unit. Referrals were generally finished at 5pm. However, where children required transfer to the Bristol Children's Hospital a doctor and a nurse would always stay on the unit until the child was transferred.
- Paediatric resuscitation between 9am and 8pm on weekdays was delivered by the unit in concert with the emergency Department. Both were staffed by consultants with the necessary resuscitation skills and both were supported by the on call consultant anaesthetist.

Meeting people's individual needs

- Children and young people were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs. Comprehensive appointments where tests were

completed after clinic appointments avoided multiple visits to the unit and children having certain treatments were arranged for Fridays after school to aid recovery over the weekend.

Learning from complaints and concerns

- Child friendly comment cards were available for children and young people to complete and information was available about how to make a complaint, and how it would be dealt with. There were, however, few complaints made to the unit. Those that were made were fully investigated with lessons learnt when things went wrong.
- Staff were aware of complaints that had been made and any learning that had resulted. The staff we spoke to were all aware of the complaints system within the trust and the service provided by the Patient Advice and Liaison Service (PALS). They were able to explain what they would do when concerns were raised by parents. Staff told us that they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the trust's complaints process.

Are services for children and young people well-led?

Good

We have judged the leadership of the children and young people's service as good. The leadership, governance and culture were used to drive and improve the delivery of high-quality care. The ward manager was committed to the children and young people in her care, her staff and the unit.

All staff were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.

There was a high level of staff satisfaction with staff saying they were proud of the unit as a place to work. All the staff were complimentary about the nursing and medical leadership. Staff also told us they received support from the divisional management team and the trust's director of nursing.

Children and young people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

Vision and strategy for this service

- Staff had a good understanding of the trust's core values and the team were very proud of the unit philosophy where "each child is important and should be cared for as an individual and as part of a family" and staff had a "responsibility to create a caring and supportive environment."
- Through the content of governance papers and talking with staff, we saw the leadership of the unit reflected the requirement to deliver safe, effective, caring and responsive services.
- Staff were concerned about the future and the transaction process. They feared a "watering down" of the service they had worked so hard to develop.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance with regular meetings attended. We saw minutes from these meetings which showed that issues affecting the service were discussed and actions taken.
- We saw that regular auditing took place with evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.
- Clinical policies and guidelines were available for all staff via the trust's intranet system.
- The unit understood, recognised and reported its risks. A risk register was in place and we noted that this had been kept up to date.
- Staff were included and informed about the running of the unit. There was a range of unit and divisional meetings held at regular intervals. All meetings were minuted. There were clinical governance meetings, departmental business and governance meetings. The minutes were recorded and covered a range of subjects including clinical matters, budget discussions, staffing levels and skills, the risk register and any serious incidents arising

Services for children and young people

Leadership of service

- The nursing leadership of the unit by the ward manager was strong and committed. Staff told us the ward manager was a "very supportive and approachable" and a "fantastic leader."
- Staff told us that the trust's director of nursing was very visible.

Culture within the service

- The staff we spoke to during this inspection told us that they were very proud to work on the unit and of the care they provided to children and young people.
- The team told us that they were always keen to learn and develop the service. The ward manager told us that the team were very innovative and trying to find ways of being "bigger and better." Innovation and improvement was encouraged with a positive approach to achieving best practice.
- Staff said they were encouraged to raise concerns. There was an open reporting culture within the trust. All staff felt comfortable about raising any concerns with their line manager.
- It was apparent during our inspection that all the staff had the child, young person and their families at the centre of everything they did.
- Staff said that "nothing was too much trouble for the patients or each other."
- The senior management team encouraged the team to be central to the development of the service. There was a democratic approach on the unit with all nursing staff wearing the same uniform with no deviation depending on grade.

Public and staff engagement

- Systems were in place to engage with the public and staff. Comment cards were available on the unit for parents and children to complete. We saw three completed questionnaires that were positive about their experience that day. One suggested a 24-hour service should be available.
- Staff felt able to express their opinions and raise concerns through unit and trust-wide forums, and were confident in sharing innovation and learning. Staff also completed the annual NHS staff survey.
- All staff said they felt valued and part of the team.

Innovation, improvement and sustainability

- Staff were clear that their focus was on improving the quality of care for children, young people and their families. They felt there was scope to develop extended services.
- Despite the uncertainties about the future of the service they were prepared for change and would continue to drive for high-quality care.

End of life care

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

Information about the service

End of life care at Weston Hospital is managed and led by a specialist palliative care team. The team provide a service and advice and support to clinical staff throughout the hospital. The team consists of two specialist consultants who both worked part time and three specialist nurses. The team provide support and advice for patients and relatives at the request of clinical staff. In addition there was an extended multi-disciplinary palliative care team which includes the hospital chaplain, a dietician and a representative from acute oncology. Other services contributing to the palliative care work of the hospital are the bereavement service and the Macmillan information service. Both consultants also worked at the local hospice, which had close ties with the hospital. The team provided support and input across all the wards in the hospital.

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It includes nursing care, specialist palliative care, and bereavement support and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months, patients whose death is imminent and those with advanced, progressive and incurable conditions, general frailty and co-existing conditions that mean they are expected to die within the12 months, existing conditions if they are at risk of dying form a sudden acute crisis in their condition and life threatening acute conditions caused by sudden catastrophic events.

We met with all the members of the specialist palliative care team, the bereavement office, the chaplaincy service, the mortuary staff and the Macmillan information service. We visited five wards and spoke with five relatives and four patients. We also spoke with 10 nursing and healthcare staff who were working on the wards and two consultants. As part of the inspection we visited the hospital chapel and the hospital mortuary.

End of life care

Summary of findings

Overall we rated the end of life service provided by the trust as good.

Following the withdrawal of the Liverpool Care Pathway the trust had developed its own policies and strategies around delivering care consistent with the latest nationally agreed guidance. The team have developed a range of tools to support these objectives. This included individualised end of life care plans which included new documentation such as symptom based observation charts. Better information for patients and relatives had been developed and action taken to get improved feedback from bereaved relatives. There was a hospital Specialist Palliative Care Team (SPCT) that supported staff on the wards by responding to referrals. They also provided some training.

There was an improvement plan and strategy in place for end of life services and leadership was provided on this. Members of the specialist palliative care team were clear about their objectives of their services, where improvements needed to be made and were well respected throughout the hospital. Staff were positive about the responsiveness of the team to referrals and the quality of advice and support that was provided.

We found there was inconsistency in the completion of the documentation relating to end of life patients. In some patient records there was limited recording of personalised care plans and little or no recording of spiritual needs. We found that not all ward staff were fully familiar with requirements of recording a patients end of life wishes. A new format was being implemented across the trust which was being positively received by staff but there were sections of the new documentation that were not being fully completed. There was also inconsistent knowledge amongst staff about the process and use for advanced care planning for patients who had life limiting illnesses but were not expected to die within the next few days. There was insufficient understanding on the wards that "end of life" includes those expected to die in the next twelve months, and so these patients were not being well identified or their needs assessed.

There was a problem for some patients of delayed discharge of, up to 6 weeks in some cases. Whilst the hospital staff were efficient in processing and preparing patients for discharge, problems with local provision of care packages caused delays. This meant that some patients died in hospital when their preferred location would have been home.

There were occasions when patients receiving end of life care were moved within the hospital and died shortly afterwards. These were the result of the pressures of high bed occupancy and the so called "black" escalation as result of the pressure of admissions through the emergency department. Staff tried to ensure that no patient died alone but we told that there were times when this had happened due to the pressure of work the ward staff were under.

Whilst many staff demonstrated they had excellent understanding of the aims, objectives and principles of end of life care, training for this area was no longer provided.

The specialist palliative care team provided input on the junior doctors course and also attempted to provide short "bite size" training for staff on the wards. On several of the ward there were nurse "end of life champions" who provided advice and support but the training they had completed was run three years previously and was not currently planned to be repeated.

There were many examples of excellent professional multi-disciplinary working with staff exchanging information and providing advice and support. The chaplaincy service was well organised and included in the palliative care multi-disciplinary team meetings. However we found that the expertise of the service was not fully utilised within the hospital and there was a lack of clarity for some staff around the role of the service and the defining of a patients spiritual needs.

End of life care

Are end of life care services safe?

Good

The specialist palliative care team (known in the trust as the SPCT) reviewed incidents at team meetings and recorded any learning. Some staff felt they did not always get the appropriate feedback after reporting incidents.

New documentation for the completion of individualised end of life care planning had been introduced across the whole trust from January 2015. Additionally from March 2015 a new form called the Treatment Escalation Plan (TEP) had been introduced across three wards. This was specifically for patients assessed as nearing the end of life. There were some inconsistencies in the completion of all of this the paperwork. We found varying amounts of detail recorded about advanced wishes, spiritual needs, final treatment plans and information about discussions with patients and relatives about decisions that had been made.

In the ten patient records we looked at we saw that the "do not attempt cardio—pulmonary resuscitation" (DNACPR) forms were in place and had been completed fully and signed by a consultant.

Incidents

- Staff we spoke with were clear about the process for reporting incidents and the range of occurrences that required reporting. Not all staff said they received feedback from incidents they had reported. During our inspection we were made aware of two incidents that had been reported in the previous week that were related to patients end of life care. The specialist palliative care multidisciplinary team had yet to be informed about these.
- Where the team were made aware of incidents relating to end of life care these were discussed by the specialist palliative care multi-disciplinary team and were a standing item on the monthly multidisciplinary team meetings. We saw a documented example of learning that was disseminated to ward staff regarding medication.
- Nursing staff were aware of the duty of candour regulations and all staff we spoke with said they believed they worked in an open culture. Staff told us they were confident about reporting concerns.

Environment and equipment

- The mortuary was well organised and appeared clean and well maintained. Equipment servicing was up to date and recorded.
- Access to the mortuary was controlled by use of a hospital pass key but once inside the access to the refrigerator area was not lockable and the fridges were also not fitted with locks. The mortuary technician told us that the trust had planned to put a coded access on this area but this had not yet been actioned.
- Infection control processes were in place and there was an agreed cleaning schedule for the refrigerated area and also the autopsy room. We were told that the infection control lead for the trust periodically visited and completed an audit but these records were not available in the mortuary itself.
- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end of 2015. An alternative had been provided in all the wards across the trust and guidance about the use of the new equipment was provided on every ward. Staff we spoke with said that requests for the new drivers were responded to quickly by the team.

Medicines

- Medication was discussed at the palliative care monthly multidisciplinary tem meetings. For example at meeting in January 2015 it had been agreed that "Just in Case " medications (medicines given to palliative care patients who were being discharged) should be provided in separate packaging so they were more easily identifiable. This had been organised in agreement with the pharmacy service.
- We also saw that the benefits and side effects of certain medicines were discussed by the team.
- The lead specialist nurse had a designated task of monitoring the independent nurse prescribing practice within the team. They also had responsibility for ensuring that updates were completed in accordance with Nursing and Midwifery Council guidelines.
- In the information pack giving to every ward from the specialist palliative care multidisciplinary team there was advice and guidance for staff in relation to medication.

End of life care

- We looked at ten sets of patient's records and the medication recording had been fully recorded.

Records

- Individualised end of life care planning had been introduced across all wards in the trust. There was guidance prompts available on every ward to help with the completion of the forms. The forms contained information including the name of the consultant responsible for the patients and the records of conversations with the patient or relatives around plans for treatments. Details could be recorded about spiritual or individual wishes. It could also be recorded if a patient required referring to the palliative care team. For patients approaching the end of life there was a "symptom based observation chart" that was available if required. This provided a record of pain assessment, noisy chest secretions, agitation, nausea, mouth care and bed positioning. This was colour coded for three stages, "no action required", "action-give medication and review in one hour" and "escalation-if PRN medication has not been effective, please refer to palliative care team". The care plan included the do not attempt cardio-pulmonary resuscitation" (DNACPR) forms.
- We looked at a sample of ten patients' records, of whom five had all the new documentation formats in place. We found inconsistencies in the recording. It was also not always recorded who had been involved in the decision making. There was evidence of some personalised planning but some files had no entries against emotional/spiritual needs, or a person's preferred place of dying or any information about religious preferences.
- We saw that the DNCPR sections of the form had been completed and been signed by a consultant although on four of the ten forms we looked at there was no record of who had been involved in the decision making.
- In the critical care ward all the DNACPR forms had been completed fully and there was also information recorded about discussions that had occurred with the patient or their family.
- We saw that in the patient files nutritional and mobility assessments had been completed and were being regularly reviewed and updated when required. We saw that notes from clinical staff were recorded clearly and sensitively.
- Patients who had input from the specialist palliative care multidisciplinary team had clearly recorded guidance in place and also records of conversations.

Safeguarding

- Staff in the specialist palliative care multidisciplinary team and other staff we spoke to on the wards had completed their mandatory training on safeguarding and were aware of how to report concerns and the pathways to use to escalate concerns.

Mandatory training

- All the staff within the specialist palliative care team were up to date with their mandatory training. We saw records to verify this.

Assessing and responding to patient risk

- The patient records included assessments of needs that were regularly updated to minimise risks and maximise symptom control. All assessments were dated and signed when reviewed.
- For patients where the progression of their illness was clear the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible. The ceiling of care was discussed with the patient and relatives and this was documented.

Nursing and medical staff

- There were two palliative care consultants who both also worked in the community. They provided leadership and support to the team. There were positive links between the hospital and the local hospice, where the consultants also worked. For example out of hours advice was available to hospital clinical staff via the telephone.
- The specialist palliative care team consisted of a lead nurse and two specialist nurses. There was also a funded post for an additional specialist nurse who was working on a project involving the implementation of the new treatment escalation plan. There were also nurses who were designated as end of life "champions" working on the wards.
- The extended multi-disciplinary team included representatives from the acute oncology service, the chaplain and a MDT co-ordinator.

Major incident awareness and training

End of life care

- There was an escalation plan in place for the mortuary in case of a major emergency. This was reviewed annually. Additional external storage facilities had been identified and agreed.

Are end of life care services effective?

Good

End of life care needs were assessed and appropriate levels of advice and support were provided by the palliative care team. Patients care and treatment plans were regularly reviewed and had their pain and other symptoms managed effectively.

Practice and documentation was developed in line with national guidance.

Staff working on the wards were provided with advice and support from a skilled and knowledgeable specialist palliative care team. Effective multi-disciplinary working and good communication between different teams promoted the quality of care and treatment provided to patients.

Evidence-based care and treatment

- Following the withdrawal of the Liverpool Care Pathway the trust had introduced its own format of individualised end of life care planning. The operational policy of the specialist palliative care team stated that they were committed to delivering the best care consistent with the recommendations of the report "One Chance to Get it Right" published by the Leadership Alliance in June 2014. Guidance and prompts for staff for new care planning documentation and the provision of training for ward staff are designed to work towards delivering the five priorities for care of the dying person identified in the national report. The five priorities: "recognise that a person is dying, appropriate communication, making decisions involving the appropriate people, holistic care of the whole family and finally the producing of an individualised end of life plan" were being promoted in the approach of the team and in the documentation that had been introduced.
- The individualised end of life care planning documentation was introduced across the whole trust from January 2015. A prompt sheet with best practice guidance was supplied to every ward. This required entries to be made in a patient's medical notes. Additional recording documentation called the "symptom based observation chart" had also been introduced which was to be used when a patient is approaching the end of their life. This helped staff to monitor the need to escalate care if required. There were also prompts on this record to remind staff they may need to record or address emotional or spiritual or needs or contact family members. There was a reminder also that more complex issues should be recorded in the medical notes.
- Additionally on three wards a new form had been introduced from March 2015 called the Treatment Escalation Plan (TEP). This form was divided into three sections and was designed to establish the ceiling of care to be provided to a dying patient. The preliminary team decision on the level of care was recorded, discussions with patients and relatives about advance wishes, mental capacity and a description of the treatment plan to be followed. These plans were signed by a consultant. On the wards were these plans had been introduced staff were required to sign to confirm they had read the new forms and guidance. We saw that full list of signatures were in place and staff we spoke with were fully aware of the new documentation.
- All patients who were on the caseload of the specialist palliative care multidisciplinary team were discussed at the weekly multidisciplinary team meeting. All patients were allocated a key-worker from one of the specialist team nurse team. The patient and relatives were given the contact details for the key-worker
- Nursing staff and consultants we spoke with were positive about the introduction of the new treatment escalation plan. Nursing staff said that the new format would help with decision making around end of life care for patients.
- The specialist palliative care multidisciplinary team was using the new documentation and guidance packs to promote the understanding and associated practice that end of life care included the recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. This was in line with the department of Health End of Life Strategy (2008) and the National Institute of Health and Care Excellence quality standards for end of life care (2011).

End of life care

Pain relief

- Patients who were identified as requiring end of life care were prescribed anticipatory medicines. These "when required" medicines were prescribed in advance of need to be available to manage changes in patients pain or symptoms.
- Information was provided to staff in relation to pain management and for the medications used for pain relief**.** Every ward had morphine, midazolam and hyoscine medication available. All wards had a copy of the hospital protocol for the use of medicines.
- Patients were provided with pressure relieving mattresses. These were correctly maintained and serviced.
- Ward staff explained how they had quick access to, and adequate supplies of syringe drivers and the medicines to be used with them.
- Two patients we spoke with explained how the nursing staff had explained to them about the medication used for their pain relief and the possible side effects. They were aware of how to report their discomfort and said the ward staff responded quickly when they had requested additional pain relief.

Nutrition and hydration

- We saw in the patient records we looked at that nutritional assessments had been completed and were regularly updated. Patient's drinks were regularly replenished.

Patient outcomes

- The specialist palliative care multidisciplinary team accepted all referrals and responded promptly and took a clinical decision about the level of involvement that was required. Some referrals resulted in the provision of advice and support for staff rather than any direct involvement with the patient concerned.
- The referral data produced by the trust showed that there was increased understanding that the end of life pathways were not just for cancer patients but for any patients diagnosed with life threatening conditions. The number of non-cancer related referrals had increased from 11% to 25% over the previous 12 months.
- The trust attempted to support patients to achieve their preferred place of death through discharge to home, hospice or nursing home or remaining in hospital. However, problems with delayed discharge due to the lack of community care provision sometimes compromised these objectives.
- The trust had not participated in the Royal College of Physicians' National Care of the Dying audit in the year prior to our inspections but had resumed their participation for the following year. They had delayed participation whilst they implemented their replacement plans for the Liverpool Care Pathway. The audit scored the trust against seven organisational and ten clinical key performance indicators.

Competent staff

- Staff working within the specialist palliative care multidisciplinary team and the clinical staff on the wards were skilled in, and knowledgeable about, providing end of life care.
- The nurses on the specialist palliative care team were qualified in end of life care and two members were working towards further qualifications. Qualifications included a masters degree in end of life care and communication skills and also a master's degree in health studies.
- The team had appointed an additional nurse in recent months as they had acquired funding for a project nurse to support the implementation of the new treatment escalation plan which was being introduced throughout the hospital.
- The team provided "bite size" training to staff on the wards through brief sessions that were arranged on an occasional basis. There was no formal schedule for these sessions. End of life training was not part of the mandatory training that staff were required to complete.
- The service was in transition with regard to training as the previously provided training, "Quality End of Life Care for All", had been discontinued and there was not yet a dedicated alternative for this. However all staff we spoke with on the wards had received some end of life training.
- We were told that a case had been made by the palliative care staff to include an end of life communication training course as part of the mandatory training undertaken by all staff but so far this had been unsuccessful.
- The specialist palliative care multidisciplinary team had provided every ward with an information pack covering all aspects of care for end of life patients. This covered

documentation around care planning and information and guidance around medication. This guidance was regularly updated and provided support and guidance for end of life care and decision making. We saw that this information was available on all the inpatient wards. The guidance continued information on making a referral to the specialist palliative care multidisciplinary team, individualised care plans, rapid discharge planning, contact details for different religions or faiths, guidance for advanced care planning and information about the new syringe pumps that were in place. Clinical guidance was also provided, for example around the treatment of malignant hypercalcaemia and the management of diabetes.

- Three of the wards we visited had a nurse who was a designated "end of life champion". These staff had undertaken the "Quality End of Life Care for All" training. Staff on other wards had undertaken training from the specialist palliative care team. Staff on all wards said that the specialist palliative care team were easily accessible to provide support, advice and guidance.
- Nursing staff were aware of the objective to increase the use of advanced care planning for patients who were admitted with life limiting illnesses but who were likely to be discharged and were not yet in need of palliative care.
- We were told that the arrangements for staff supervision in the specialist palliative care team were in transition and that the team currently operated a system of group supervision. The team also met together on a daily basis and could discuss issues and individual cases at various points during the day.
- Members of the team told us they had completed their annual appraisals and we saw the records which confirmed this.
- The palliative care consultants provided training for the trusts medical staff. This included input on the junior's doctor's course.
- Members of the specialist palliative care team felt that the high number of locum doctors affected the effectiveness of the end of life care strategy as it was not possible to ensure that all were fully aware of the work of the team or the support that was available. However, we were also told that many of the locum medical staff, particularly those that had worked a considerable time for the trust, had fully engaged with the team and the work they did.
- We spoke with medical staff, including locum consultants, and all were aware of the palliative care team and knew how to seek advice and support. We found there was some inconsistency in the understanding of the documentation for identifying end of life patients. For example two junior staff nurses we spoke with were unclear about the term "advanced care planning" or the paperwork that was required for the new treatment escalation plan document.

Access to Information

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Patients we spoke with said they were able to access their medical records should they want to. We were told they had been included in decisions about their care and decisions about their care confirmed with them.

Multidisciplinary working

- Ward nursing staff, medical staff and healthcare assistants all spoke positively about the specialist palliative care multidisciplinary team. Two ward managers explained how having the bespoke team had improved practice and knowledge and also the communication with patients and relatives. One nurse gave an example of how consultants would usually speak to the specialist palliative care multidisciplinary team first before delivering bad or distressing news to patient or relative. A consultant we spoke with told us the palliative care consultants were always available for advice and support and that the communication with the team was excellent. If they were not immediately available they responded very promptly.
- There was evidence of effective internal multi-disciplinary working. For example the specialist palliative care multidisciplinary team met with staff from acute oncology every weekday morning. The operational policy for the specialist palliative care multidisciplinary team listed the core members of the group and also had list of extended members who could be invited to meetings when a need was identified. This included for example, an occupational therapist.

End of life care

- The specialist palliative care multidisciplinary team had regular contact with a local hospice, where the two palliative care consultants on the team also worked part time.
- The Macmillan advice centre was located in the hospital. The nurse running this service met regularly with the cancer nurse specialist from the oncology service and also had regular contact with the specialist palliative care team. They also attended bi-monthly palliative care forum meetings. Staff who attended this meetings said they were very effective in sharing developmental issues and themes around the around oncology and end of life care generally.
- The chaplaincy service also attended the monthly palliative care team meetings. However the chaplaincy service was not very integrated into the overall team and there was little evidence of collaborative working.

Seven-day services

- The specialist palliative care multidisciplinary team was available as a five day service between 9.00hrs and 17.00hrs. Patients and relatives were also given the number of a 24 hour helpline service run by a local hospice.
- Advice for clinical staff out of hours was available by contacting a local hospice and speaking to the senior nurse. This information was available on the wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the process and procedures to be followed if a patient's ability to provide informed consent was in doubt. When a patient was not able to give informed consent decisions were made by clinical staff with the involvement of the family if possible. Medical staff would be involved if a capacity assessment was required. We saw that information about a person's capacity were recorded in the patient notes. We saw in the records that when families had been involved in discussion and decisions this had been recorded.
- Nursing staff had completed training on the Mental Capacity Act 2005.

Are end of life care services caring?

Good

Compassionate and sensitive end of life care and support was provided by staff. Patients felt informed about their diagnosis and treatment and were communicated with appropriately.

Patients and relatives were supported by staff and also signposted to other services which could be of benefit to them.

Compassionate care

- We spoke with five patients and four relatives and all said the care they had received, or observed, had been compassionate. The patients told us they were treated with dignity and respect by all the staff on the wards.
- Relatives said they were accommodated as best as the staff could manage, with flexible visiting times and when possible the provision of a collapsible bed to sleep in overnight.
- We observed staff interacting with patients in a professional and caring manner.
- One patient explained how the news of their diagnosis had been explained to them. They said the consultant had been sensitive but also very clear and direct, which they said they really appreciated. The consultant had also arranged for a nurse to be present to provide additional support.
- The mortuary staff explained how they managed and arranged visits for relatives who wished to view the deceased. Great effort was made to ensure that visitors were comfortable and had the privacy they required. Visits were generally co-ordinated with the bereavement service and the mortuary staff made sure they were well prepared for any viewings.

Understanding and involvement of patients and those close to them

- All patients having a clinic appointment with a consultant or one of the nurse specialists were offered a written record or summary of their consultation. Patients were also offered the opportunity of having a copy of their discharge summary and treatment plan.
- The patients and relatives we spoke with said they felt the hospital staff explained any matters to do with their

illness or treatment in an informative and understanding manner. We were told that that there was clarity about diagnosis and treatment. Relatives also said they had been directed by the nursing staff to the Macmillan advice centre in the hospital and also provided with various information leaflets.

Emotional support

- The chaplain and the team of five volunteers visited the wards and would talk to patients and relatives to provide support. The contacts with patients were recorded. The records showed there was between two hundred and three hundred contacts with patients every month. There was a lack of clarity over the approach of the chaplaincy service when identifying patients they could possibly have role with to support. The chaplain explained that he was not allowed to "solicit" when visiting wards, whilst nursing staff we spoke felt the service could be more proactive in making itself and the service it provided know to patients and relatives.
- The bereavement service provided support to relatives through advice and information but following the issuing of the death certificate there was no further follow up work with families.

Are end of life care services responsive?

Requires improvement

End of life care required improvement in being responsive to patients. The specialist palliative care team responded quickly to referrals that were made and ward staff were positive about the support, advice and input provided.

There were occasions when patients at the end of life were moved between wards to accommodate new admissions. There was at times a lack of clarity to staff of how the bed management policy was operated and how decisions to move some patients had been made.

There were long delays of up to six weeks for the discharge of some patients due to a lack of capacity in the community to provide care packages. Whilst the hospital completed rapid discharge documentation quickly the delays meant that the patients preferred place of dying was not being achieved. The problem of delayed discharges had been put on the hospitals and the specialist palliative care team risk register. The trust did not monitor the timescales for rapid discharge for patients at the end of their life or the number of patients achieving their preferred place of dying. Despite this the trust was aware of the barriers to rapid discharge and action was being taken in the form of additional support and training for staff within the trust as well as working with partners to improve this.

There were occasions when patients at the end of life could not be provided with a side room due to a lack of availability.

There was a lack of recording and identifying of the spiritual needs of patients.

Service planning and delivery to meet the needs of local people

- The trust is located in the area of North Somerset which had a rate of 41% of people dying in hospital, which was 10 % lower than the national average. The figure for the number of cancer patient dying in hospital was 26%, which was 13% below the national average.
- In the twelve month period between April 2014 and March 2015 the specialist palliative care team had 578 patients on their case load. Of these 150 patients had died in hospital and 242 had been discharged home. Fifty five patients had been discharged to nursing homes, and fifty nine to hospice care. A further sixty patients went to residential care or had no further intervention from the team.
- The team audited their involvement with patients and this showed they were able to respond quickly to request for help, support and guidance. The records showed they had seen 453 of these patients within the day of referral, 97 within 48 hours and 21 within 48 hours. Of these it was recorded that a total of 423 cases could be designated as complex and difficult using the team's criteria for measuring the level of intervention being required.
- The team also audited the reasons for referrals being made. The highest figures were 252 for pain and symptom control and 161 for continuity of care.
- The impact of the new processes, documentation and training implemented by the team were reflected in the increase in the use of the specialist palliative care team. The total number of referrals had increased by 18% on the previous twelve months. The audits showed that the

number of requests for advice about advance care planning had trebled in the previous twelve months and the number of patients being referred to be put on an end of life care pathway had risen by 89%

- The percentage of patients referred to the specialist palliative care team that died during admission has remained fairly consistent, between 26% and 33%. The number of patients discharged to die at home had risen from 219 to 242 in the previous 12 months.
- There was no audited information about how many patients achieved their preferred place of dying but staff explained the problems they had with organising discharges quickly into the community. There were patients who died in the hospital who would have preferred to have been discharged home for their last days but this was not always achieved. We were told that whilst the various paperwork and procedures could be completed quickly in the hospital there were delays of up to 6 weeks for the discharge of some patients. This was due to the lack of capacity in the local community to provide the staff for the required care packages. We were told it was particularly difficult if a patient was returning home and needed a staffing intensive package. On two of the wards we visited the medical staff told us that 50% of the patients were designated as "green to go", meaning they could be discharged from the hospital when the community care arrangements were put into place. On all the wards we visited staff were aware of patients who had died whilst waiting to be discharged. The issue of delayed discharges had been placed on the specialist palliative care team and hospital risk register and was being reviewed at regular intervals. The risk register identified five issues. These were: the wards being able to recognise that patients were able to return home to die; the consultants understanding and following of end of life care plans; ward staff understanding of when to make referrals to the specialist palliative care team; wards ensuring patients die where they wish by being discharged quickly enough; and the delays in the provision of care packages in the local community.
- The training provided by the team and the information and guidance provided to the wards were contributing to the addressing of these issues but it was recognised that work needed to be completed with outside partners to improve the provision of care packages in the community for patients who wished to die at home.
- The specialist palliative care team were completing an audit of the number of patients having a delayed hospital discharge and this would also show the number of patients who were successfully rapidly discharged. This information was not available at the time of our inspection. The team told us they were able to support rapid discharge and could prepare the required documentation at short notice but the trust did not record the number of rapid discharges that were completed.

Meeting people's individual needs

- The audits of referrals to the specialist palliative care multidisciplinary team showed that the team responded quickly and within their targets for all referrals, which was to see patients within 48 hours. Audits showed there had been an increase of 47% in patients seen on the same day as the referral was made during the previous twelve months. Staff on the ward explained how the team replied quickly to referrals or for requests for advice. There were three levels of referral, simple, more complex and complex and difficult. The team audited against these criteria and the data showed in the previous 12 months 40 patients had been seen at level 1, 115 at level 2 and 423 at level three. This was in total an increase of 100 patients on the previous year.
- We were told that some confident medical teams did not always refer to the team if they felt there was not a need. All ward staff we spoke with said the communication with the specialist palliative care multidisciplinary team was excellent and worked well. Staff were very positive about the advice and support that was provided.
- The majority of referrals were for cancer patients with 140 referrals out of the 578 being for non-related cancer in the last twelve months. This was an increase from the previous twelve month period when 58 out of the 478 referrals were for non-cancer patients. This increase reflected the greater role and profile of the specialist palliative care multidisciplinary team through the hospital. The team had been working to encourage these referrals through their work with staff on the wards.
- Staff were aware of the key responsibility to recognise the patient that may be dying and communicate with the person about decisions or actions that accorded with their wishes. Whilst staff were positive about the

new documentation and the support and advice available we were told that patients still died without being identified as at end of life and therefore appropriate care planning was not completed. In particular those expected to die within the next twelve months were not being well identified**.** On the stroke ward staff said they recalled at least four patients in the previous four months who had died without being identified as at end of life. Staff felt this was result of the busyness of the ward, the high bed occupancy and the number of patients who were waiting to be discharged**.**

- Where possible patients receiving palliative care were given side rooms though this was not always possible. This was due to the number of rooms available and the priority at times of these rooms needing to be used for isolation purposes. Visiting relatives were made as comfortable as possible. During our visit we spoke with two groups of relatives who had been provided with z-beds for them to stay overnight. Relatives were also given concessionary parking for extended stays.
- Staff told us that they tried to ensure that patients did not die alone but said they were times during busy periods when this could happen.
- A Macmillan Advice Centre was located within the hospital and was open five days a week. This was a nurse run service that provided information and education material for patients, relatives and staff. We were told that between ten and twenty enquiries were received every day, two thirds from patients and relatives and third from clinical staff. Information was provided on a range of areas including benefits, travel insurance, transport and the side effects of treatment. Information packs were available which provided advice to patients and relatives about fatigue, stress and relaxation and sleeping patterns. The service also provided a pack called an "Emotional Support Pack" which provided information about various avenues of support, including spiritual and religious, that were available in the community. It also signposted the counselling service that was commissioned by the trust that was free to patients and relatives affected by cancer.
- The specialist palliative care multidisciplinary team had a variety of written information available for patients and relatives. This included material about self-help groups, information about support services and psychological services and information about local palliative care services.
- The Macmillan Advice Centre located in the hospital was available for patients, relatives or professionals to drop in and speak to the nurse running service.
- The trust had within the previous twelve months commissioned a counselling service for patients and relatives affected by cancer. This was available as a free service and funding had been agreed for a 5 year period. This was seen as an important improvement by the Macmillan advice centre staff who said they had seen a high take up of this service since its inception. We were told the initial feedback had been very positive from patients and relatives using this service.
- There was a shortfall in identifying, recording and addressing the spiritual needs of patients. In the 10 patient records we looked at for people receiving end of life care there was no recording against the designated section for spiritual needs. The hospital chaplaincy service was underused. For example, the service had received no referrals from the hospital bereavement service in the twelve months prior to our inspection. There was a lack of clarity for some staff between the difference between religious and spiritual needs. The hospital chaplain had completed training in palliative care and attended the monthly palliative multidisciplinary team meetings but otherwise did not work closely with the specialist palliative care multidisciplinary team. The chaplaincy service had produced a document providing information about the definition of spiritually, which included sections on spiritual needs, spiritual pain and distress and advice on how to patients and relatives with these areas. This information was not widely disseminated, for example, none of the information was contained in the guidance packs the specialist palliative care multidisciplinary team had provided for all the wards.
- There was a lack of confidence among most ward staff about how to have appropriate conversations with patients facing the end of their lives, in order to elicit their emotional and spiritual needs. Regional funding for provision of communication courses had been withdrawn . The available expertise of the hospital and hospice chaplaincy services were not being fully used to address this shortfall.
- The chaplaincy service had a 7 day rota in place in the hospital. This included slots that were covered by local

clergy and the hospital chaplain. For patients who requested multi-faith contacts staff were required to go through the hospital switch-board that had a list of contacts supplied by the chaplaincy service.
- The hospital chapel was well signposted and easily accessible. There was a memorial book and also prayer request slips that could be completed. It had been adapted to provide Islamic prayer when required.
- In the mortuary area there was a viewing room and waiting area for relatives who wished to pay their last respects to the deceased.

Access and flow

- Staff working on the wards were clear about the process to be followed if they wished to make a referral to the specialist palliative care multidisciplinary team. Staff were positive about the prompt response from the team.
- There were clear procedures in place to organise rapid discharges and the specialist palliative care multidisciplinary team were able to support the completion and organisation of these. The delays to discharge were as result of the lack of available care packages in the community.
- Staff we spoke to in the specialist palliative care multidisciplinary team and clinical staff working on the wards were unclear as to how the hospital bed management policy in terms of moving patient between wards was being implemented. Staff said they were frustrated when patients had to be moved when they considered it inappropriate as the person was approaching the end of their life. One such recent move had been reported as incident by one of the nursing staff.
- A private ward, Waterside, was used occasionally for end of life patients. Members of the specialist palliative care multidisciplinary team expressed reservations about the appropriateness of this ward as there was not a private room for relatives to meet in. However there was a link nurse for end of life care working on the ward.
- There were occasions when people approaching the end of their life were moved from one ward to another. Whilst members of the specialist palliative care multidisciplinary team told us they would try prevent this from happening if they knew about it, we were made aware of two such occurrences that had happened the week before our visit. These had happened during a period when the hospital was under extreme pressure and in "black escalation" due to the pressure on the emergency department. There was a lack of clarity for some staff around bed management and how these decisions had been made. There were also times when the lack of side rooms, due to infection isolation issues, had meant that people had received their end of life care on the ward. Staff said they were aware that the high levels of bed occupancy in the hospital presented challenges to bed management and put pressure on the staff at times to move patients when ideally they should remain where they were.

Learning from complaints and concerns

- We evidence from the minutes of the specialist palliative care multidisciplinary team meetings and the monthly operational meetings of learning from complaints being discussed and disseminated to the team.

Are end of life care services well-led?

Good

There was good local leadership of the palliative care team and end of life services were represented at board level by the trust medical director.

The specialist palliative care multidisciplinary team had clear policies, procedures and guidance and a strategy to develop and improve the service at a trust wide level. The team were self-critical, committed to development and aware of where the challenges were for the service.

Vision and strategy for this service

- The specialist palliative care team produced an annual report. We were shown the latest version which covered up until the end of March 2015. This was a detailed document that covered previous achievements and challenges, a range of audited information and statistics and also a clear message about the values of the team. Information was provided about operational policy, service delivery and the planned work for the coming year. Details were also given about specific future work streams both for the team and for individuals. The size of the specialist palliative care multidisciplinary team had been increased by one full time nurse during the two years prior to out inspection. This had enabled the team to develop their work and role within the hospital.

End of life care

- The medical director was the lead for end of life care on the board. The palliative care consultants had undertaken a presentation to the board on an end of life improvement plan. This covered all aspects of their work and the team's strategy. They told us that they felt their work, including issues or concerns, were well represented at board level.
- There were effective links with the local community and the work being done by the palliative care team on advanced care planning was being promoted. One of the palliative care consultants had visited and met with all the local GP surgeries to discuss and promote understanding around palliative care. Part of this involved promoting the use and knowledge of an electronic communication system between the hospital and the GP practices. A format for advance care planning was also promoted.

Governance, risk management and quality measurement

- There was a clear governance structure for the specialist palliative care services. Monthly meetings were structured and minuted.
- There were four current entries on the end of life risk register. Action plans were in place and review dates had been set. Two of these plans included improved training for staff: one on the use of syringe driver equipment on the ward and another in relation to medication administration. The third risk register entry related to communication with patients following multidisciplinary team meetings. Discharge planning had been on the register since November 2014 the action plans identified that work needed to be done with outside partners as well as improvements internally to improve the opportunities for patients to be rapidly discharged. This was rated as a high risk. Ongoing action to resolve this was being led by the specialist palliative care team.
- The trust did not monitor the timescales for rapid discharge for patients at the end of their life or the number of patients achieving their preferred place of dying. Although the reasons for delays in rapid discharge were known by the trust, the lack of data regarding this meant that the trust was not aware of the numbers of patients affected.
- There were was an operational policy in place for the palliative care multi-disciplinary team. This stated that the aim of the policy was to have standards and process in place that provided patient focused care. The policy provided clear statements about the role of the different professionals on the team. The policy document stated that it had been written in accordance with national guidance and aimed to "encourage best practice in the management of patients with life threatening illnesses". The team met weekly and also had monthly policy review meetings.
- The level of engagement with patients was monitored by the specialist palliative care team, for example the monthly level of referrals and also the breakdown of cancer and non-cancer patients receiving input from the team.

Leadership of service

- There was evidence of strong local leadership of the end of life care services in the trust. Staff working in the specialist palliative care team were provided with clarity about objectives and values by the lead nurse and the specialist consultants.
- Clinical and healthcare staff we spoke to on the wards were very positive about the input from the team and the advice and support that was provided. Two ward managers we spoke with said the team provided leadership to the staff on all aspects of end of life care. All the staff we spoke to working on the wards were aware of who the team members were and their role.
- Staff we spoke with said their line managers and the specialist consultants were approachable and supportive.

Culture within the service

- Staff we spoke with in the specialist palliative care team, the Macmillan advice centre and the end of life champions on the wards all demonstrated a positive and proactive approach to providing care and support for people receiving end of life care. Staff expressed their understanding of the importance of the work and the improvements they were committed to making.
- Staff we spoke with said they were proud to work at Weston hospital.

Public engagement

- A survey had been conducted of bereaved relatives titled "Voices" and second round of this was being undertaken at the time of our inspection visit. The

results were better than the national average and showed relatives were satisfied and impressed with the service they received. Staff we spoke with were proud of the feedback they had received from the surveys.

Innovation, improvement and sustainability

- One of the palliative consultants had linked with the local "compassionate community" project. This was one of five national projects based on a world-wide Compassionate Community initiative. Part of the aim of the project is to develop a community that supports people during the end of their life by involving professional such as doctors and care workers as well as members of local organisations or faith groups and family members. It promotes the idea that palliative care is a community responsibility and aims to improve the support for people's final wishes to be realised and respected.

Outpatients and diagnostic imaging

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

Information about the service

Weston General Hospital saw 196,417 patients in outpatients (OPD) and diagnostic imaging last year (2014). Outpatients were seen in three separate areas, Main Outpatients, Orthopaedics and the newer Quantock Outpatients Unit. New appointments were made by a centrally located "Access team". As well as X-ray rooms and ultrasound scanning the diagnostic imaging department also has a magnetic resonance imaging (MRI) scanner and a computerised tomography (CT) scanner.

We visited the outpatient clinics for general surgery, orthopaedics, haematology, phlebotomy, breast surgery, diabetes, gastroenterology, ophthalmology, cardiology, rheumatology, respiratory and general medicine. We spent time in the diagnostic imaging department and spoke with 22 patients and 29 staff, including medical and nursing staff, healthcare assistants, receptionists, medical secretaries, managers and administrators. We received comments from our listening events, staff focus groups and from people who contacted us about their experiences. We also reviewed the hospital's performance data.

Summary of findings

We rated outpatient and diagnostic imaging services as good in the safety, caring and well led domains. We rated the responsive domain as requiring improvement. We have reported on the effectiveness of outpatients and diagnostic imaging services. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients department.

Patients found staff to be friendly, professional and caring and were happy with the outpatients and imaging services provided by the hospital. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was learning from incidents and this led to improvements in patient safety.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking and service accreditation. Information about effectiveness was shared and was understood by staff. It was used to improve care and treatment and people's outcomes. Staff had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.

We observed people being treated with dignity, respect and kindness throughout our inspection. Staff anticipated people's needs and addressed them in a

Outpatients and diagnostic imaging

compassionate manner. People's privacy and confidentiality was respected at all times. Waiting times and delays were kept to a minimum and managed appropriately.

Appointment cancellations were high but the department did not monitor this and as such the reasons for this were not understood.

Most services ran on time and patients were kept informed of any disruption to their appointments. The leadership of the outpatients and imaging departments promoted safe, high quality, compassionate care. They encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.

Are outpatient and diagnostic imaging services safe?

Good

We rated the outpatient and diagnostic imaging services as good. Outpatient and imaging staff reported incidents and risks and received feedback when these had been investigated. Learning was shared and used to improve safety. Outpatient staff had a working knowledge about the duty of candour (where serious incidents needed to be discussed with the patient and recorded). The outpatient clinics were visibly clean and staff followed infection control practices. Records were available when needed, comprehensive and stored securely.

An increase in activity had not been reflected in an increase in nursing staff and there were some radiographer vacancies. However, action was being taken to address this. A small number of consultant radiologist posts were filled with long-term locums but the locums were familiar with the working practices of the department and were mentored by experienced consultants. Safeguarding and mandatory training was up-to-date.

Incidents

- During the year prior to our inspection there had been one never event in diagnostic imaging, but no serious incidents. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Senior staff undertook an investigation immediately and we were given the route cause analysis that resulted. A major contributing factor was that initial patient investigations had been undertaken by another healthcare provider. Although this could not be prevented in the future, mitigating action had been taken to prevent a repeat of this type of incident. Protocols had been changed and staff were aware of the reasons for these changes.
- We looked at other incidents that had taken place in outpatients and diagnostic imaging. These had been logged on the hospital incident reporting system. The incidents were clearly described and appropriate remedial action taken when necessary.

- Reportable incidents regarding ionising radiation medical exposure need to be reported to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The trust had reported five incidents between 1 January 2014 and 15 May 2015. These had been reported to the Care Quality Commission. Action on reportable incidents was taken and there was evidence of root cause analysis investigations and learning as a result. The number of reported incidents was similar to other trusts with comparable levels of activity.
- Learning from incidents and near-misses was displayed on noticeboards in the staff area in outpatients and we saw that there were regular discussions at staff meetings.
- The outpatients' manager also responded and developed improvements as a result of incidents that originated outside the outpatients department. For example, problems had been caused by plaster casts that had been applied in other wards and departments. In response, the senior plaster technician in the orthopaedic clinic had devised a teaching programme to improve the skills of other clinical staff. This had been rolled out across the hospital and no further problems had occurred.
- Learning from diagnostic imaging incidents was not always well recorded. Although we saw that radiography staff had regular safety updates at monthly meetings, minutes from medical staff meetings had few records of learning. However, doctors could verbally describe changes in practice following incidents.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients with information and support when a reportable incident has, or may have occurred.
- We discussed the duty of candour with the staff that had been involved in the Never Event described above. They described the discussions that had taken place with the patient concerned and it was clear that they had fulfilled the requirements of the legislation and had implemented the duty of candour.
- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. Senior staff demonstrated detailed knowledge of the practical application of this new responsibility

Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic areas were visibly clean and tidy. 'I am clean' stickers were present and in date on each piece of equipment checked. Disposable curtains were used and changed every 6 months (or sooner if they had been contaminated). There were labels on all curtains stating when they had last been changed.
- Mandatory infection control training had been completed by 97% of staff across outpatients and diagnostic imaging.
- Hand gel was available in all communal areas, as well as in clinical rooms. All clinical areas had appropriate hand washing facilities and we observed staff complying with the hospital policies and guidance on the use of personal protective equipment (PPE) and that they were bare below the elbows. We observed staff in outpatients washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- Recent hand hygiene audits showed 100% compliance with hospital policies.
- Monthly cleaning audits carried out by departmental managers consistently showed compliance with national standards of between 96% and 100%.
- There were posters in waiting areas and other communal areas advising patients to use hand gels.
- We noticed that the mattress on one of the OPD patient trolleys was worn and had a small split at one end. This can be a focus for infection. We brought this to the attention of the manager who took immediate action to replace the mattress.

Outpatients and diagnostic imaging

- During our inspection we observed correct systems for waste disposal and clinical waste bins being emptied before they became overfull.
- The imaging department ensured that patients with infectious diseases were seen at the end of each session and that the imaging room was disinfected afterwards. This helped to prevent the spread of infection to other patients.

Environment and equipment

- In the outpatient departments the environment was clean and well maintained. Most areas were spacious, well lit and well ventilated. There was sufficient room for patients to sit and wait for appointments. The majority of consulting rooms and waiting areas were wheelchair accessible. However, waiting areas in the orthopaedic clinic were cramped and it was difficult to move wheelchairs into some of the consulting rooms.
- The eye clinic had large signs with a yellow background so that people with poor vision could see them more easily.
- In the imaging department, the environment was well maintained and was wheelchair accessible. There was signage to alert patients to potential radiation hazards in relevant areas. There was adequate room for patients to sit and wait for appointments.
- There was a good range of resuscitation, imaging and medical equipment. Resuscitation equipment was checked weekly in line with hospital policy. This was clean, well maintained, regularly checked and ready for use. Imaging staff worked with the radiation protection adviser to ensure safe radiation levels.
- Each imaging room had a warning light above the door instructing people not to enter. This lit up automatically when imaging equipment was being used.
- Metal objects should not be taken into MRI rooms for safety reasons. We saw that all patients about to have an MRI scan were asked to complete a checklist and sign a declaration to prevent them doing this. Despite these precautions a metal object had been taken into the room during an MRI scan, causing minor damage. As a result, a hand-held metal detector was now used to check people before they entered the scanning room.

Medicines

- Medicines used in the departments, including controlled drugs, were stored securely and recorded accurately and appropriately.
- Medication refrigerator temperature checks were being completed by staff in line with hospital policies. Records that we looked at were completed daily and ensured that medication was stored at the correct temperature.
- In the outpatient department prescription pads were checked out at the beginning of each day and recorded as checked back into a secure cupboard at the end of each day. This process was in place to provide assurance that all used prescriptions could be accounted for at the end of each clinic and nursing staff told us that to date no prescriptions had been unaccounted for.
- Prescriptions from out-patients could only be used at the hospital pharmacy. Patients that we spoke with said that this provided a good service and they rarely had to wait long for their medication.
- We observed the waiting area for the outpatient pharmacy on a number of occasions and noted that there was rarely more than one person waiting for their medicines.

Records

- In all outpatient and imaging areas we observed that patient records were kept in secure areas so the information they contained remained confidential.
- We looked at 12 sets of patient records and found them to be accurate, complete and up-to-date. Some handwriting was difficult to read but, after each out-patient visit, a clearly typed letter had been sent to a GP or referring clinician.
- We visited the medical records department and found that the doors were secured with a digital lock. The passcode was changed every six months to ensure that no unauthorised person could gain entry.
- Before records were sent to clinics they were checked to ensure that they contained the correct documents.
- We were told by medical records staff that, if existing records were not available when a patient attended, a temporary file was made up. Medical records staff when to great efforts to retrieve letters and clinical summaries held on the hospital's computer system so that the

clinicians had as much information as possible available to them. The hospital monitored the number of temporary records used and currently this only occurs in 0.4% of patient attendances.

Safeguarding

- Training records showed that 100% of outpatients and imaging staff had completed level two safeguarding training for adults and children. Children were sometimes seen in the ENT clinic and plaster room and so level three children's safeguarding training had been arranged for staff who worked there.
- All staff that we spoke with knew how to report a safeguarding concern and who to speak to within the hospital for further advice if required.
- We were shown safeguarding folders to support staff with reporting a safeguarding concern.
- The trust had a whistleblowing policy that was known to staff that we spoke with. They told us that the policy was easy to follow and that they would be confident that they would be listened to if they raised concerns.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control and manual handling. Most training took place on-line and uptake was good.
- Completion rates varied from 95% to 100% which complied with targets set by the hospital.
- Following manual handling training in 2014/15 medical records staff had become concerned about the weight of boxes of records that they needed to lift. As a result, scales have been installed throughout the hospital to ensure that no boxes heavier than 11kg are lifted by staff**.**

Assessing and responding to patient risk

- Staff had received mandatory training in patient resuscitation and demonstrated a good knowledge of dealing with clinical emergencies.
- In outpatients a new emergency alert system had been installed. This ensured that each clinical room had an emergency call bell. When this was activated display units throughout the department indicated the location of the emergency so that staff could assist rapidly.
- There were notices for pregnant women in reception and the waiting area of the imaging department, warning of the risks of radiation. They were asked to inform a member of staff if there was a possibility of pregnancy. In addition, staff checked the date of the last menstrual period before undertaking procedures that involved radiation.
- Risk assessments were in place to prevent contrast induced nephropathy (kidney damage). These were in line with national guidelines.

Nursing and radiography staffing

- There were 32 staff working in outpatients but only seven registered nurses available to take charge of the clinics. Staff told us this used to be sufficient but, since January 2015, more complex procedures were being undertaken and these required more nursing time.
- The outpatient manager told us that a staffing review had recently taken place and she was waiting to hear if additional posts would be funded.
- On one morning during our inspection the main outpatient department did not have a registered nurse in charge. Although this did not have an immediate impact on patient safety it did make it difficult to access medication. Only registered nurses can hold the keys for medication stores and on this occasion, they were with the nurse in Quantock outpatients. If medication was needed in the main outpatient department the nurse from Quantock had to be called to assist. This caused occasional delays to patients in both departments.
- HR records showed a 7% radiographer vacancy rate in the imaging department. The manager told us that rotas were adjusted to cover the vacancy and that temporary staff were rarely used.

Medical staffing

- The vacancy rate for doctors in the imaging department (radiologists) was 25%. Locum doctors were employed until the vacancies could be filled. We were told that these were long-term locum doctors who were familiar with the policies and procedures of the department. Locums were allocated a mentor who monitored their practice and who could give advice if necessary.
- Other doctors in the hospital told us that the radiologists were helpful and professional.

Outpatients and diagnostic imaging

- Hospital policy stated that medical staff must give eight weeks' notice of any leave in order that clinics could be adjusted in a timely manner. Various staff told us that medical staff leave was one of the causes of clinics being cancelled at short notice. The hospital did not monitor clinic cancellations or the causes of them and so it was not possible to assess the scale of non-compliance.

Major incident awareness and training

- The hospital had a major incident plan which was available to staff on the hospital intranet.
- Although managers were aware of their role in the event of a major incident most staff were not. This had already been identified as a weakness and an audit of awareness was taking place so that the issue could be addressed.
- We saw that there was an internal procedure for dealing with radiation incidents and that it followed national guidance.

Are outpatient and diagnostic imaging services effective?

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients department.

Outpatient and imaging departments adhered to national and local guidelines in order to ensure up-to-date practice. Patient outcomes were monitored and used to inform multi-disciplinary working. Staff had access to training and were able to use these opportunities to develop professionally.

Outpatient clinics were mainly held from Monday to Friday but, in order to minimise waiting times, some clinics took place on Saturdays or during the evening. Diagnostic imaging was provided 24 hours, seven days a week. Staff had access to appropriate information and this was shared with other healthcare professionals.

Evidence-based care and treatment

- Outpatient services adhered to the relevant NICE guidelines to treat patients. We looked at the clinical guidance for diabetes and respiratory services and both referred to NICE guidance.
- We saw that the imaging department followed Royal College of Radiology standards by assessing kidney function before administering intravenous contrast solution.

Nutrition and hydration

- Staff arranged for sandwiches to be delivered from the hospital kitchen for patients with diabetes who had to wait in the department during the lunch period (for example, when waiting for blood test results).
- If a clinic was delayed by more than an hour (staff told us this happened rarely) a tea trolley was brought to the waiting room so that people could be offered drinks and snacks.

Pain relief

- Patients we spoke with told us that their pain was being managed effectively by staff in the departments.

Patient outcomes

- Responses from the NHS Friends and family test were generally positive for the trust. People found staff friendly and approachable.
- The outpatient manager organised a patient experience survey within the department. The results of this had been presented to the hospital patient council who had praised the outpatient department for the effectiveness of service that it was providing.
- At the beginning of 2015 the imaging department had gained full accreditation with the Imaging Services Accreditation Scheme (ISAS). This is a patient-focussed assessment that is designed to ensure that patients consistently receive high quality services. The ISAS website states that, as of May 2015, only 20 hospitals in the UK had achieved this accreditation.

Competent staff

- We were provided with documentation to confirm that all clinical and support staff had received an annual appraisal.

Outpatients and diagnostic imaging

- Nursing staff, radiographers, healthcare assistants and administrators from each speciality were offered training opportunities to develop professionally and gain the latest skills and knowledge relevant to their post.
- Clinical nurse specialists in the outpatient department had been encouraged to develop their skills and gain qualifications in nurse prescribing.
- Some nurses were aware of revalidation, which had yet to be introduced nationally for nursing staff but was being planned. The nursing staff were aware of their responsibilities. Most said that they hadn't received any formal updates from the trust, but used their own initiative to ensure that they met the requirements.

Multidisciplinary working

- The outpatient department offered one stop breast clinics which also ran a family history clinic where family members could be screened for breast cancer. During the clinic, patients could receive an ultrasound, mammogram, and cell aspiration dependant on clinical need. The clinic was staffed by a specialist nurse alongside a consultant. Specialist nurses offered a counselling service for patients.
- Staff were able to access dietician and pharmacist support in clinics where needed.
- The imaging department monitored the length of time it took to send diagnostic reports to the referring clinician. We were shown recent results for reports of CT scans which met the requirements of national clinical guidance. Clinical staff throughout the hospital expressed satisfaction with the quality of service they received.

Seven-day services

- The imaging department provided an emergency service 24 hours a day, seven days a week. It provided some elective services on Saturdays.
- Some outpatient clinics were provided on a Saturday in order to prevent delays in arranging initial appointments.

Access to information

- All clinics and wards had access to the electronic imaging system and this was password protected. This meant that X-rays and scans could be viewed on computer screens throughout the hospital.
- There was no official procedure for sending patient information to GPs but we were told that the aim was to send this within 10 working days of an outpatient appointment, X-ray or scan. Information was sent electronically to local GPs and posted to GPs from further afield. We looked at 25 GP letters and 20 imaging results chosen at random. All had been typed and sent within 10 working days and most within three days.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff had an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Some staff had received training and could explain in detail how it affected their patients and what staff responsibilities were.
- All staff we spoke with knew whom to contact for any guidance in relation to the MCA and DoLS

Are outpatient and diagnostic imaging services caring?

Good

We rated caring in outpatient and diagnostic imaging services as good. Patients were very happy with the care they had received in outpatients and diagnostic imaging. They consistently told us that they had been treated with kindness and respect and that their care had exceeded expectations. We saw caring and compassionate care delivered by all grades and disciplines of staff. They often offered assistance without waiting to be asked.

Staff worked hard to ensure patients understood what would be involved during their tests and treatment and dealing with bad news was given a particular priority.

Compassionate care

- During our inspection we saw many examples of patients being treated with compassion, dignity and respect. Staff introduced themselves by name and explained what was going to happen next. Receptionists were smiling and helpful and greeting people with a cheerful "How can I help?"
- Without exception, people that we spoke with praised the staff for their kindness. One patient said "They are so

kind here. They should be used as a benchmark for the rest of the NHS". Results from the last outpatient survey showed that 98% of patients thought that reception and nursing staff were friendly and welcoming.

- Another patient told us that she had forgotten her purse and so was not able to use the vending machine to get a drink. A member of staff saw this and made her a cup of tea herself.
- We often observed staff approaching people who looked lost and asking if they needed help. Information was given slowly and carefully so that it was easy to follow.
- We saw a member of staff crouching down to speak to a patient in a wheelchair so that she was more easily understood.
- There were clear signs throughout the departments encouraging patients to ask for a chaperone. One nurse told us "My chaperone duties are a priority".

Understanding and involvement of patients and those close to them

- Patients that we spoke with felt well informed and included in the decision-making process in relation to their care and treatment. One patient told us "I can ask them anything and I know they will give me the right answer".
- Patients in the imaging department told us that they understood the reason for their investigations and what was involved in them.
- In the eye clinic we observed a healthcare assistant discussing an information leaflet with a patient with poor eyesight. There was an important telephone number on the leaflet. The healthcare assistant underlined this carefully so that the patient was able to see it when they got home.

Emotional support

- One of the patients attending the rheumatology clinic told us that he had been coming for several years. He said "I regard the people here almost as friends. They ask about my family as well as me. They seem to know when things are not going well and they help me through it".
- Clinical nurse specialists and Macmillan nurses form part of the team that helped to support people with the emotions caused by a cancer diagnosis. Patients told us that they relied on them. There was a "quiet room" available so that patients could stay longer than their appointment time if they wanted to talk about their feelings.
- Despite this the outpatient department manager told us that patients sometimes confided their feelings of grief to other members of staff who did not always feel fully prepared to respond. As a result, training in breaking bad news had been arranged for all members of staff so that they could help patients in a more meaningful fashion.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

We rated the responsiveness of outpatient and diagnostic imaging services as requiring improvement. Staff told us that clinics were sometimes cancelled at short notice. The trust rate of cancellations was high but the department did not monitor clinic cancellations and so it was not possible to establish the scale or causes of this problem.

Referral to treatment times were meeting national targets and were monitored on a regular basis. If delays for appointments increased extra clinics were arranged in the evenings and on Saturdays.

The needs of patients were a priority for staff in the imaging and outpatients departments. Facilities were good and patients were given information to help them understand outpatient processes. The departments learnt from complaints and concerns raised by patients.

Service planning and delivery to meet the needs of local people

- The outpatient department had been extended in 2014 to better meet the needs of the people who used it. All outpatient departments were well signposted and easy to find. There were volunteers at main reception who could take people to the appropriate outpatient department if they had difficulty following signposts.

Outpatients and diagnostic imaging

- There was sufficient parking surrounding the hospital and there was always at least one empty disabled parking space available during our inspection. Payment was at the end of the parking session so that people did not have to worry that their parking ticket had expired if they spent longer in the hospital than anticipated.
- People we spoke with praised the hospital for allowing free parking for the first 30 minutes and also that there were always wheelchairs available at the front entrance.
- Patient transport vehicles were able to park near to outpatient areas so that patients could be taken directly to the appropriate area.
- All outpatient facilities had comfortable seating and magazines for people to read. Adult clinics had play areas available for patients who needed to bring their children with them to the hospital. Vending machines and toilets were available and clearly marked.
- There were signs at reception desks stating "Please observe other's privacy and wait here until called to the reception desk". This was respected by people who were waiting.
- Changing rooms in outpatient and imaging departments had been arranged so that patients in hospital gowns did not meet people of the opposite sex before or after their procedures.
- Each clinical area had patient information boards. These contained a variety of information including how to identify different staff, infection control and hand hygiene audit results and patient survey results.

Access and flow

- We were told by staff in the access team that most non-urgent appointments were made via the Choose and Book national electronic appointment system. Appointments for the two week wait clinics – such as the cancer clinics could not be arranged using choose and book as it would take too long. Instead GPs telephoned or sent an e-mail to the access team in order to make an urgent appointment.
- All new outpatient appointments were made by staff in the hospital access team. They also monitored waiting times for appointments. If appointments were beginning to be delayed, staff in the access team would try to arrange extra clinics.
- The imaging department had a separate appointments system managed by its own staff. We were told that no patients would wait longer than six weeks for an appointment. We looked at the monitoring figures compiled by imaging staff and saw that the longest wait for an appointment during our inspection was four weeks.
- In order to prevent delays to patients with a stroke, ambulance crews took them directly to the imaging department for a CT scan. The ambulance service contacted the department in advance so that the CT scanner was ready when the patient arrived. We observed this happening during our inspection.
- "Did not attend" rates (DNA) for all clinics was below the national average, at around five percent. The trust policy for patients who did not attend (DNA) clinic appointments was to discharge the patient. However, the patient's notes were first sent back to clinicians for the final decision to be made so patients with potentially serious illnesses were not discharged.
- The diabetic nurse specialist ran a "drop-in" clinic every week so that patients with urgent concerns could visit without making an appointment. This service was highly valued by people that we spoke with.
- Plaster technicians in the fracture clinic also told patients that they could return without an appointment if they were worried about their plaster cast.
- National waiting time targets are for 95% of new patients to be offered an appointment and treatment within 18 weeks of referral to the hospital. Weston hospital had achieved 95.1% by April 2015. This was better than most other hospitals in England although there was variation between specialities. For example, orthopaedics and general surgery achieved 85% between May 2014 and April 2015 whereas thoracic medicine and rheumatology achieved 100%. It should be noted that orthopaedics and general surgery had improved their performance and achieved 94% and 92% respectively in April 2015.
- The hospital was consistently meeting the two week wait standard for patients with urgent conditions such as cancer and heart disease. By the end of 2014, 98% of these patients were being seen in less than two weeks. This compared to 95% achieved by most hospitals in England.

Outpatients and diagnostic imaging

- Some staff told us that, on occasions, clinics were cancelled at short notice. However, nursing staff told us that this no longer happened. None of the patients that we spoke with reported it as a problem. We asked managers how frequently clinics were cancelled and for what reasons but they were not aware of the data collected. Data from the trust from May 2014 to April 2015 showed that 15% of appointments were cancelled by the trust within that period.
- Waiting times for patients upon arrival in the outpatient clinics varied. During our first morning patients waited between five and forty-five minutes for their appointment. However, they were informed of this when they arrived and a notice board was used to provide updates. During the remainder of our inspection delays were less than ten minutes. Delays in the imaging department were minimal.
- Patient experience surveys that took place at the end of 2014 showed that the average waiting time across all clinics was 16 minutes. Of the patients who took part in the survey, 89% thought that this was satisfactory. It was noted that, in November and December 2014, 94.5% of clinics ran on time. The best performers were orthopaedic clinics where 98% of clinics experienced no delays.

Meeting people's individual needs

- The hospital ratio for follow-up appointment to new appointment was better than most other hospitals in England. This meant that patients did not have to travel to the hospital more than was necessary.
- Staff that we spoke with demonstrated a good understanding of the needs of patients with additional support needs. For example, there were volunteers available in the eye clinic to guide and assist people who were visually impaired.
- Staff in the access team stated that there was currently no system in place to identify a new patient with a learning disability or living with dementia. Referrals from GPs rarely mentioned this and so it was not possible to prepare the clinic in making reasonable adjustments prior to the patients' arrival. However, plans to flag existing patients on the computer system were near to completion.
- The outpatient department had folders for staff which included information for assisting patients with a learning disability. The information included a variety of communication tools and information about specific needs of people with a learning disability. "Easy-read" booklets had been produced to explain procedures that take place in outpatients such as taking blood samples.
- Outpatient department reception staff told us that, when they knew someone was living with dementia, they would arrange an early appointment to reduce any waits in the unfamiliar surroundings of the hospital. Copies of the "This is me" document were kept in the department. This is a tool for people living with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes. Staff discussed the completion of this document with the people concerned and gave them help if necessary. There was a dementia link nurse who was active in supporting staff in caring for people living with dementia.
- Outpatient department and imaging staff were able to access telephone translation services for patients. This could be arranged without notice when patients who required the service presented themselves in clinic.

Learning from complaints and concerns

- Complaints were handled in line with the hospital policy. If a patient or relative wanted to make an informal complaint they were directed to the person in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, who would formally log their complaint and would attempt to resolve their issue within a set period of time. PALS information was available within the outpatient and imaging departments.
- Formal complaints were investigated by the departmental manager and, if necessary, the relevant consultant. Replies were sent to the complainant in an agreed timeframe. We saw that learning points from complaints were discussed at staff meetings. For example, new guidance was produced and implemented following difficulties encountered when admitting a patient to a ward from a clinic.
- We looked at two recent complaints and found the investigations that followed were proportionate and

sufficiently thorough. A detailed and courteous response was sent to the complainants in an appropriate and timely manner and in accordance with hospital policy. We saw that action had been taken to prevent a recurrence of the complaints.

Are outpatient and diagnostic imaging services well-led?

Good

We rated the leadership of the outpatient and diagnostic imaging services as good. Staff felt their line managers were approachable and supportive. We were told they had the skills, knowledge, experience and integrity required to carry out their roles. Staff identified with the values of the hospital and these values were incorporated into the way staff worked across all outpatient areas. Staff felt valued and respected, they enjoyed their work and identified with the core values of the hospital.

There were active governance and risk management processes which meant staff were able to identify and mitigate risks and identify areas for improvement.

Vision and strategy for this service

- Imaging and out-patient departments had operational policies for 2015, setting out what they planned to achieve. Managers explained that a longer term strategy was not possible as the hospital was due to merge with another NHS trust at the end of the year. We spoke with a variety of staff about the merger and they all told us that they felt well informed. The chief executive had held a number of meetings and staff had been encouraged to ask questions and find out what the merger meant for their individual roles.
- Staff identified with the hospital values of People, Reputation, Innovation, Dignity and Excellence (PRIDE). They told us that the hospital newsletter announced monthly PRIDE awards for departments "that went the extra mile" for its patients.

Governance, risk management and quality measurement

- The outpatient and imaging departments both had risk registers. Risks were clearly defined and reflected the concerns described to us by a variety of staff. Risk scores had been accurately calculated and appropriate action had been taken to reduce risks. For example, at the end of 2013, short-notice cancellation of ENT clinics had been entered on to the risk register. Action had been taken and recorded and at the time of inspection, the risk had been reduced.
- Safety and quality issues were regularly and conscientiously addressed at out-patient and imaging staff meetings. There was evidence of learning from incidents.
- The imaging department did not hold specific clinical governance meetings. Issues such as clinical effectiveness, quality and audit, patient safety and incidents were discussed at radiology consultants meetings and at the radiology management committee. We looked at minutes from these meetings between January 2015 and April 2015. They were well attended, discussions appeared to be meaningful and action was taken when necessary.
- Waiting lists for outpatient appointments, diagnostic imaging and treatment were closely monitored. A manager in the access team had created a new database so that waiting times could be monitored on a weekly basis. If patients were waiting too long the appropriate directorate manager would be contacted in order to solve any problems.
- Clinic cancellations were not monitored by the outpatient management team. One of the access team told us she used to compile this information but no-one had ever asked for it so the activity was discontinued.
- Quality was measured by survey, comments cards, audits and engaging patients in patient experience meetings, where outpatient representatives would listen to patients with a view to improving services

Leadership of service

- Many staff spoke highly of the outpatient department manager who had been in post for a year. Staff told us that they felt well supported, encouraged to develop and felt valued by their manager and the hospital as a whole.
- During our inspection the outpatient department manager was informed that she had been nominated and was a finalist for the annual chief executive's award for outstanding leadership.

Outpatients and diagnostic imaging

- Leadership of the imaging department was shared between the senior superintendent radiographer and the senior consultant. Imaging staff felt that this was a good partnership and were particularly proud of achieving ISAS accreditation. At the time of our inspection they were one of only 20 departments in the UK who had gained this accreditation.
- Staff told us that the chief executive and director of nursing had made real improvements to the hospital since they were appointed two years previously. They were said to be approachable, knew what was going on at grass roots level and visited the departments on a regular basis.

Culture within the service

- The culture within the departments was centred on the needs and experience of people who used the service
- There was a strong sense of teamwork which encouraged candour, openness and honesty. Staff told us that the support and respect that they received from their colleagues and immediate line managers increased their sense of wellbeing.
- One member of the nursing staff said "I love my job. I am really happy here".
- The outpatient department team had recently won a hospital award for their work. The judging panel said: "The team have been working extremely hard and have shown great commitment and determination to turn the outpatient department around. The department has been in the media spotlight and patient feedback to new ideas and processes, as implemented by the team, has been extremely positive."

Public engagement

- The outpatient department manager was involved with the patients' council and had recently presented the results of the latest patient survey. This had been well received by council members.

Staff engagement

- Regular staff meetings were well established in the imaging department and had been introduced by the new manager in outpatients. They were well attended and staff were able to raise issues of concern. There was feedback from issues raised at previous meetings. Praise was recorded for staff achievements
- Patients' comments from surveys were collated and disseminated to staff in the minutes of staff meetings.

Innovation, improvement and sustainability

- All medical records had been barcoded in the year prior to our inspection. They were scanned electronically when they arrived and left each location in the hospital. This had greatly reduced the number of mislaid records and helped to ensure that they were always available when needed.
- The medical records team had devised new software to link old and new records of children who had been adopted and people who had undergone transgender surgery. Legally these records had to be kept separately, but medically there had to be an awareness that they referred to the same person. This had sometimes caused safety issues in the past but now safety and legal requirements were both satisfied.

Outstanding practice and areas for improvement

Outstanding practice

- There was an outstanding example of caring shown to a patient with a learning disability who was coming into the day-surgery unit for a procedure. One of the staff had contacted the patient's care home and discussed the best way to manage the appointment for the patient. The arrangements were then made to reduce the anxieties of the patient, and allow one of the main carers to be with the patient as much as possible during the procedure. An 'easy read' booklet about coming into hospital was send to the care home to go through with the patient in advance of their visit. This showed a good depth of knowledge and sensitivity for people with different needs.
- There was an outstanding staff newsletter produced each month. It included 'celebration of success awards' which were running for their second year. There were messages from public bodies, such as Public Health England, awards and recognition for staff and wards, updates on new staff, messages from patients, training and policy updates, and charity news and updates.
- The patient safety midwife demonstrated a thorough understanding of risk and clinical governance processes. This person maintained clear audit and investigative trails which supported safe and current midwifery care in practice.
- There was outstanding care for children, young people and their families.
- The outpatients' manager responded and developed improvements as a result of incidents that originated outside the outpatients department. For example, problems had been caused by plaster casts that had been applied in other wards and departments. In response, the senior plaster technician in the orthopaedic clinic had devised a teaching programme to improve the skills of other clinical staff. This had been rolled out across the hospital and no further problems had occurred.
- Following manual handling training in 2014/15 medical records staff had become concerned about the weight of boxes of records that they needed to lift. As a result, scales had been installed throughout the hospital to ensure that no boxes heavier than 11kg are lifted by staff. One of the medical records managers told us there had been a decrease in musculo-skeletal injuries since this change.
- At the beginning of 2015 the imaging department had gained full accreditation with the Imaging Services Accreditation Scheme (ISAS). This is a patient-focussed assessment that is designed to ensure that patients consistently receive high quality services. The ISAS website states that ,as of May 2015, only 20 departments in the UK had achieved this accreditation.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Take action to improve medical staffing levels and skill mix in the emergency division (particularly within medical services) to ensure that people receive safe care and treatment at all times.
- Ensure that junior medical staff in the emergency division (particularly within medical services) are appropriately supported, supervised and trained to ensure that they are competent to fulfil their role.
- Ensure that the ambulatory emergency care unit and medical day case unit are appropriately staffed and equipped at all times.
- Ensure that patients who attend the ambulatory emergency care and medical day case units are accommodated in areas which are fit for purpose and ensure their comfort, privacy and dignity.
- Continue to take steps to reduce the incidence of avoidable harm as result of pressure ulcers, falls and medication incidents.

Outstanding practice and areas for improvement

- Ensure that patients arriving by ambulance are fully monitored and assessed for priority when in the corridor awaiting admission to the department.
- All patients receive timely assessment in line with College of Emergency Medicine guidance to ensure that they receive suitable and timely treatment.
- Ensure that all staff are aware of and work to standard operating procedures relating to the safer management of controlled drugs.
- Ensure that there are suitable numbers of staff with the qualifications, skills and experience to meet the needs of patients within the high care unit.
- The audit and use of the whole range of the World Health Organisation surgical safety checklists must be improved and evidence provided to show it is being followed at all times. The hospital must ensure there is approval at board level for how the checklist is being used and audited.
- Competency tests around the use of equipment in operating theatres must be improved to demonstrate it is vigorous. Considering there had been a high rate of medicine incidents, competency training must be introduced for medicines' management. There must be an approved protocol for how competency is assessed.
- The main operating theatres must ensure the management of all used surgical instruments is such to be assured the risk of cross-contamination is eliminated.
- The hospital must ensure the medical cover in surgery services, out-of-hours, and specifically at night, is safe and the staff on duty meet the requirements of the out-of-hours policy.
- The number of discrepancies in prescriptions in surgery services must be addressed and errors eliminated.
- The hospital must ensure patient confidential records are secured and stored in such a way as they cannot be seen or removed by unauthorised people.
- Staff in surgery services must get up-to-date with their mandatory and statutory training and meet trust targets.
- The hospital IT systems must be improved to enable staff to extract and be able to use data about all aspects of theatre and surgery services.
- As with most NHS hospitals, the hospital must improve the access and flow of patients in order to reduce delays from theatre for patients being admitted to wards, enable patients to be admitted when they needed to be, and improve outcomes for patients.
- The governance of the surgery service must improve so there is a clear process for assessing and monitoring the safety, effectiveness and responsiveness of the service. The governance team must be able to demonstrate continuous learning, improvements and changes to practice from reviews of incidents, appropriate use of the risk register, mortality and morbidity reviews, formal clinical audits, complaints, formal feedback to staff, and using reliable data and information.
- As with most NHS hospitals, the hospital must improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards; reduce the unacceptable number of discharges at night; enable patients to be admitted when they needed to be; ensure patients were not discharged too early in their care; and improve outcomes for patients. The full consideration of critical care must be taken into account in hospital escalation plans and staff in the unit closely involved with day-to-day strategic planning.
- The governance of the critical care service must improve so there is a clear process for assessing and monitoring the safety, effectiveness and responsiveness of the service. The governance team must be able to demonstrate continuous learning, improvements and changes to practice from reviews of incidents, appropriate use and review of the risk register, mortality and morbidity reviews (including overarching mortality ratios), formal structured clinical audits, complaints, formal feedback to and from staff, and useful feedback from people who use the service.
- Staff in the critical care service must get up-to-date with their mandatory and statutory training and meet trust targets.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure it follows the Duty of Candour regulations at all times.

Outstanding practice and areas for improvement

- Take steps to increase staffing levels in physiotherapy, occupational therapy, speech and language therapy and pharmacy so that patients' care and treatment and discharge are not delayed.
- Ensure root cause analysis reports in surgery services identify, acknowledge and act upon all causal factors identified in the investigation of the incident.
- Improve the utilisation and organisation of the operating theatres to make the services more efficient for patients, staff and hospital revenue.
- Ensure that surgical-site infection data is captured internally and provided in governance reports.
- Address the security of operating theatre areas to avoid unauthorised people getting access to areas that otherwise should be secure.
- Ensure that trolleys for resuscitation equipment in surgery areas are secured in such a way to highlight to staff if they had been opened or used between daily checks.
- Ensure there is an appropriate and safe level of equipment in main theatre operating areas, including the recovery room.
- Take steps to improve record keeping. In particular, particular nursing staff on Uphill Ward should ensure that they consistently document when they re-position patients and check cannula sites. Medical staff in medical services should ensure that DNACPR records clearly indicate the timeframe for the decision documented. The medical staff in critical care should review their entry to patients' notes and ensure they provide a comprehensive, contemporaneous record to both records used on the unit and those used for patient discharge to the wards.
- Ensure that patients' notes are filed securely so that they do not become lost or put in the wrong place.
- Ensure that patients on surgery wards should have all their repositioning in beds or chairs attended to when it is required so that pressure ulcer damage reduced and safely managed.
- Establish a dedicated pain team in accordance with the Royal College of Anaesthetist standards.
- Review staffing levels and the use of bank and agency staff and look for ways to reduce the impact this is having on patients and substantive staff.
- Review ward round arrangements on surgery wards to reduce this to a manageable and safe level.
- Review the operational policy for theatre to ensure that it follows the latest Royal College or other relevant guidance.
- Review hip-fracture surgery for patients to increase the number of procedures meeting the best-practice tariffs.
- Improve the provision of in-house training and development for surgery staff, particularly in theatres.
- Review the risk register in surgery services so it is a true and current reflection of specific risks within the service. The document should be proactive and discussed as a standing agenda item in governance meetings so all staff are aware of the risks within it and their responsibilities for reducing or mitigating them.
- Review local management arrangements on the critical care unit. The unit should be run by all staff in a collective approach, so each can contribute to the management of the service and support one another. There should be a multidisciplinary approach to the running of the unit in the same way as there is to the care and treatment of the patient.
- Ensure the rota for the critical care consultants is sustainable in the longer term and review the cover by trainee doctors against the guidance of the Faculty of Intensive Care Medicine Core Standards.
- Review the critical care services risk register so it is a true and current reflection of specific risks within the service. This should include entries to describe where the unit does not meet the Faculty of Intensive Care Medicine Core Standards and the Department of Health building standards for critical care. The document should be proactive and discussed as a standing agenda item in governance meetings so all staff are aware of the risks within it and their responsibilities for reducing or mitigating them.
- Ensure that trolleys for resuscitation equipment in critical care should be secured in such a way to highlight to staff if they had been opened or used between daily checks.
- Review the provision of technical support for equipment cleaning, set-up and maintenance in critical care.
- Review the process for critical care obtaining non-stock items from the pharmacy in order that the patient's prescription drug chart does not need to leave the unit.

Outstanding practice and areas for improvement

- Improve pion of in-house training and development for critical care and ensure the guidelines of the Faculty of Intensive Care Medicine Core Standards around use of a clinical nurse educator are met.
- Review staffing skill mix to ensure there is supernumerary cover by senior staff on duty at all times, including weekends.
- Ensure the protocol used for applying Deprivation of Liberty Safeguards in critical care follows the provisions of the Mental Capacity Act (2005) and any deprivations would be applied with in line with the legal requirements of the Safeguards.
- Review the use of some of the more recent developments in critical care support, such as the patient diary, follow-up clinic, and professional psychological for patients and their relatives.
- Improve the provision for visitors to critical care and look at ways to improve the experience for families and friends.
- Review the ratio of supervisor to midwives to ensure compliance with the recommended ratio of 1:15.
- Ensure are be compliant with the trust's mandatory training targets of 85%.
- Ensure that midwives are compliant with the trust's annual appraisal target of 85%.
- Improve the uptake of the Friends and Family Test in all maternity areas to give more consistent and reliable data.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 The Health and Social Care Act 2008 (Regulated Activities)** **Regulations 2010 Person-centred care** **The provider had not ensured the care and treatment of service users was** **(a) appropriate, and** **(b) met their needs.** **Patients in the critical care service were not discharged in a timely way from the unit onto wards when they were ready to leave. Patients were also discharged too often at night.**

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 The Health and Social Care Act 2008 (Regulated Activities)** **Regulations 2010 Safe care and treatment** **The provider had not ensured care and treatment was provided in a safe way for service users by:**

This section is primarily information for the provider

Requirement notices

(b) doing all that is reasonably practicable to mitigate any such risks;

(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely, and

(g) the proper and safe management of medicines.

Staff did not always follow plans and pathways identified to mitigate the risks of patients acquiring pressure ulcers and the risk of falling.

Not all staff in surgery services had vigorous equipment or medicines management competency tests. Staff were not meeting the provider's targets for updating their mandatory training.

There was an unacceptable level of discrepancies in prescriptions in surgery services.

At times, morphine was prescribed as a variable dose within the emergency department. Records did not should how much was administered or what happened to any unused drug in accordance with safer management of controlled drugs legislation.

Medicines were not always administered accurately in accordance with the prescriber's instructions and at suitable times to make sure that people who used the service were not placed at risk.

Not all staff in the critical care service were meeting the provider's targets for updating their mandatory training.

This section is primarily information for the provider

Requirement notices

Junior medical staff were not always adequately supported and supervised and were frequently asked to undertake tasks which they were not trained or prepared for.

Patients on the high care unit on Harptree Ward did not always receive care from appropriately qualified, competent or experienced staff.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Premises and equipment The provider was not ensuring all premises and equipment used by the service provider was: (a) clean. Used surgical instruments were not transported from two of the main operating theatres to protect people and other equipment from the risks of cross-contamination.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Good governance

This section is primarily information for the provider

Requirement notices

The provider had not operated systems or processes to:

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, and

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risks which arise from the carrying on of the regulated activity, and

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and the decisions taken in relation to the care and treatment provided.

The surgery services were not able to demonstrate incidents, clinical audits, and mortality and morbidity reviews were learned from to improve patient care. Staff were not able to extract sufficient information from the database to provide good governance information.

The audit of the surgical safety checklist in main theatres was inadequate. There was no policy for how the audit should be performed and how the results should be used.

The surgery wards were not ensuring patient notes were secure at all times.

The critical care service was not able to demonstrate continuous learning, improvements and changes to practice from reviews of incidents, appropriate use of the risk register, mortality and morbidity reviews (including overarching mortality ratios), formal structured clinical audits, complaints, formal feedback to and from staff, and useful feedback from people who use the service.

This section is primarily information for the provider

Requirement notices

Staff who reported incidents which affected the health, safety and welfare of people using services, or had the potential to cause harm, did not always receive feedback or assurance that appropriate action had been taken to remedy the situation.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Staffing The provider had not taken appropriate steps to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed for the purposes of carrying on the regulated activity. There were not always sufficient numbers of medical staff on duty in the surgery division out of normal working hours. There was an acute shortage of consultant physicians. This meant that they were not able to provide adequate training, support and supervision to junior medical staff and the medical day case unit and ambulatory emergency care unit were not always fully staffed with appropriately trained nursing staff. This meant there was a risk that people who used the service may not receive adequate support in the event of a medical emergency.