

Taunton and Somerset NHS Foundation Trust

Musgrove Park Hospital

Quality Report

Taunton
Somerset
TA1 5DA
Tel: 01823 333444
www.tsft.nhs.uk

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

Ratings

Overall rating for this hospital

Accident and emergency	
Medical care	
Surgery	
Intensive/critical care	
Maternity and family planning	
Services for children & young people	
End of life care	
Outpatients	

Summary of findings

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Summary of findings

Overall summary

Musgrove Park Hospital is the largest general hospital in Somerset and is part of Taunton and Somerset NHS Foundation Trust. It has 700 beds, 30 wards, 15 operating theatres, an intensive care and high dependency unit, a medical admissions unit, a fully equipped diagnostic imaging department and a purpose-built cancer treatment centre. There is also a specialised children's department, including a paediatric high-dependency bay and a neonatal intensive care unit for all of Somerset. The trust has an annual budget of nearly £240 million and employs more than 4,000 staff.

We chose to inspect Musgrove Park as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. From the information in our 'Intelligent Monitoring' system, Taunton and Somerset NHS Foundation Trust was considered to be a low risk provider.

Our inspection team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers. The team spent two days visiting the hospital. They also visited out of hours and at the weekend over three nights and undertook a pharmacy inspection visit on one day. We held a public listening event in Taunton and heard directly from people about their experiences of care. We spoke with patients and staff at the hospital. We received valuable information from local bodies such as the clinical commissioning groups and Healthwatch.

Most patients received safe and effective care. Surgical procedures were safe and most patients were being treated according to best practice guidelines. Most staff had received the specialist training they needed, but improvements were required in some areas. We found that most areas of the hospital were clean and infection rates were low compared to other hospitals.

Patients were treated with dignity and respect and involved in their treatment and care. The patients we spoke to were very satisfied with the service they received and all patients praised the caring, helpful and compassionate attitude of staff.

Among staff there was a sense of collective responsibility for ensuring that good quality care was delivered at every level. Staff morale was generally good and many staff told us they were proud to work in the trust.

In A&E most people were seen within the four-hour national waiting time limit. Care was taken to manage safety concerns for medical patients, particularly those who were frail and elderly. Surgical procedures were safe and the Critical Care service performs better than most other similar units across the country. Women reported good experiences of child birth. Children's care was coordinated and services were being designed to make children comfortable in hospital. End of Life care was managed by a passionate and specialist team. Most outpatient clinics were managed efficiently and patients felt that communication was good. Many of the services we inspected were well-led and used performance information, comments and complaints to improve.

The trust was well-led, and the leadership team was focused on making sure it provides good quality, safe services. Clinical staff were involved in developing and improving services.

However, there were a number of areas for improvement in all of the services we inspected: A&E, medical care, surgery, intensive/critical care, maternity, children's care, end of life care and outpatients.

The trust had increased the number of senior doctors on duty at weekends over the last two to three years to improve the decisions made about treatment. However, staff told us there were still not enough senior doctors present at night and weekends in the A&E, medical care and surgical departments. This was affecting the quality of medical decisions and patient handovers. In addition, due to an increasing number of medical emergencies, people were not always transferred to the appropriate specialist ward and may not have been seen by a specialist. Some patients in surgery did wait for a senior surgical opinion.

Most patients were discharged appropriately. A few patients at our listening event expressed concerns about being discharged too early, including at night. We also found that discharge arrangements needed to improve

Summary of findings

over weekends, in maternity, and for people with complex needs. The number of emergency medical admissions was comparatively higher at night and weekends, yet there were fewer discharges at the weekend and this put the hospital under pressure.

Patients' care needs were being met. However, staff told us that sometimes, when it was busy, older people and people with dementia, may not receive the care and emotional support they need. Children in A&E were seen by specialist staff from the paediatric department but not enough staff in A&E were qualified in emergency care of children.

The theatre and wards in the older part of the hospital needed to be better maintained, for example, where water leaked through ceilings. Some of the wards, including ITU, were cramped, with equipment stored in corridors. Some parts of the maternity department were in need of refurbishment. Important equipment in maternity was not fit for purpose, and equipment in intensive care was not appropriately maintained.

Some patient records were not well-maintained. The hospital was not meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing planned spinal, colorectal, bariatric, ophthalmic and ear, nose and throat surgery. Some patients waited a long time for an outpatient appointment and some orthopaedic patients had long waits in clinics.

In some departments 'do not attempt resuscitation' (DNAR) forms were not always fully completed. This meant there was a risk of inappropriate decisions being taken about their treatment. Many of the forms did not show that decisions had been discussed with patients or their families which could mean that patients' rights and wishes were not respected. End of life care needed to improve on medical and surgical wards.

While there was good signage and other patient information available for people who speak English, there was none available for people whose first language is not English and for people with learning disabilities. The translation service was not always used when it was required.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The A&E department provided effective care and staff were caring and responsive. Most patients were seen and treated within the national waiting time limit of four hours and plans were put in place for discharge or transfers for further care and treatment. However, there were not always enough senior doctors present at night and weekends. Children were seen by appropriate child care specialists but there were concerns that not enough staff in the A&E department had up-to-date qualifications in emergency child care.

Medical care (including older people's care)

Patients on medical wards received safe, caring and responsive care. Staff had appropriate skills and training, there were enough nursing staff, and the service was caring, compassionate and well-led. Infection rates were low. There were not always enough senior doctors present at night and weekends. An increasing number of patients were being admitted as medical emergencies and were not always transferred to the appropriate specialist ward. Some patients were moved several times between wards, which could lead to inconsistent care and treatment.

Surgery

Patients received safe surgical care. There were good safety checks for patients having surgery and infection rates were low. Patients with hip fractures generally have surgery quickly. However, there were not always enough senior doctors present at night and at weekends, and clinical staff told that patients' health could deteriorate while they were waiting to see a doctor, and patients often stayed in hospital when they were fit to return home. Some staff did not have appropriate training to meet people's specialist needs, for example, physiotherapists to meet the needs of people who had undergone hip surgery. Staff told us that at busy times it was difficult to always meet people's care needs, particularly older people and people with dementia.

The theatre and wards in the older part of the hospital needed to be better maintained and some of the wards were cramped, with equipment stored in corridors. Patient records were not well-maintained, and it was difficult to follow the treatment path of patients who had moved wards several times.

The hospital was not meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing planned spinal, colorectal, bariatric, ophthalmic and ear, nose and throat surgery. It was working to address this.

Summary of findings

Intensive/critical care

Patients received safe, effective and responsive critical care services, There were enough specialist staff to meet people's needs and ensure that they had appropriate 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate. The Critical Care service performs better than most other similar units across the country.

However, there were sometimes inappropriate referrals of patients to critical care out of hours because senior doctors were not available to make the decision that a patient was too ill to benefit from clinical intervention. Once patients were better, staff needed to improve the coordination of their care with the general wards. The department was cramped, with a lack of storage facilities, and there was a water leak in the ceiling. Some equipment was not maintained appropriately and was not always available.

Maternity and family planning

Women spoke highly of the staff and said they felt involved in developing their birth plans and had sufficient information to make choices during labour. There was a home birth service available and the home birth rate was higher than the national average. However, some areas of maternity were in need of refurbishment and some equipment was not fit for purpose. Services were stretched during busy times, which meant some women could be discharged too early because of a lack of postnatal beds. There was no resident anaesthetist in the maternity unit and there was sometimes a delay in finding an anaesthetist for women in need of an emergency procedure during labour. Staff said that maternity was not well-led and problems had existed for a number of years, which had 'stunted' the development of the service.

Services for children & young people

Children received effective care from specially trained staff. Staff engaged well with children of different ages and the facilities were good, particularly on the day surgery ward. The environment was well maintained and there were toys and activities available for children. However, there were sometimes not enough nurses and junior doctors on the inpatient wards. Parents also told us they wanted the service to be more coordinated. For example they suggested having one point of contact between themselves and doctors from different specialties, as doctors didn't always communicate among themselves. This could lead to frustration and confusion among parents and staff.

End of life care

Staff working in the service had expertise in palliative and end of life care. They were passionate about providing good care. People had

Summary of findings

support to make decisions about their care and were discharged with the right care and support. People were fast-tracked to get immediate funding for the right home care or nursing home. A specialist team provided advice, support and guidance to children and family members, including bereavement counselling. However, end of life care on medical and surgical wards needs to improve. There have been a number of formal complaints about end of life care relating to the care, compassion and support from nursing staff. Resuscitation decisions on medical and surgical wards were not properly documented.

Outpatients

Patients received safe and effective care and staff were caring. Patients received treatment and follow-up in private consultation rooms, and had time to ask questions to help understand their treatment plans. Most clinics were managed efficiently and patients said the department communicated with them well. Patients who needed to be seen urgently were given appointments according to national standards. However, some patients waited a long time to be seen. The orthopaedic clinics were particularly busy: some patients had been waiting for three hours because they needed x-rays. The number of patients who failed to attend and the number of cancelled clinics was above the national average. The views of patients were not actively sought to help the service improve. The consultation, assessment and treatment process was not monitored for effectiveness. The service needs to be better led to bring about improvements.

Summary of findings

What people who use the trust's services say

The trust was rated about the same as other trusts in the 2012 Adult Inpatient Survey, while exceeding the national average performance in the 'doctors' area of questions. It has performed well on the Friends and Family Test. It also

ranked in the top 20% of all trusts for 20 of the 64 questions in the Cancer Patient Experience Survey – including the overall proportion of patients rating their cancer care as “excellent” or “very good”.

Areas for improvement

Action the trust **MUST** take to improve

- Ensure there are sufficient senior doctors present at night and at the weekend.
- Reduce the number of patients transferred to the wrong specialist ward and improve patient discharge to alleviate service pressures.
- Ensure that staff have appropriate training to enable them to deliver care and treatment safely and to an appropriate standard.
- Ensure that patient records are appropriately maintained and available, including Do Not Attempt Resuscitation forms.
- Ensure that equipment is appropriately maintained and is available for use.

- Improve leadership of the maternity unit.

Action the trust **SHOULD** take to improve

None

Action the trust **COULD** take to improve

- Improve the quality of medical handovers, particularly at weekends.
- Improve the environment in theatres, ITU and ward areas.
- Provide information that is readily accessible for people that do not speak English as a first language.
- Review staffing at busy times to ensure patients' care needs are always met.

Good practice

Our inspection team highlighted the following areas of good practice:

- All the patients we talked to in the hospital told us that staff were caring, helpful and compassionate and that they were treated with dignity and respect.
- There was good well-coordinated multi-disciplinary care in children's day surgery and neonatal care and for patients who have had a stroke.
- Sedgemoor Ward has been specially designed to enhance the hospital experience for older people, and especially for people who have dementia.
- The Beacon Centre for cancer care has won a number of awards for providing high quality patient-centred care. These include the Customer Service Excellence Award, the Insight for Better Healthcare International Award and the Macmillan Quality Environmental Mark.
- COMPASS is a specialist multi-disciplinary team that supports families as they cope with the emotional and physical effects of living with a child with a serious,

life-limiting illness. The team consists of paediatricians, community children's nurses, clinical psychologists, a play specialist and an administrator. Additional support is given to children and their families to include end of life care and bereavement.

- The trust holds monthly one-hour sessions for all staff (called Schwartz rounds) to look at emotional and social dilemmas that arise when caring for patients. This is accredited support that gives staff the space to reflect on the challenges of providing care to patients and their families, and to learn from other experiences. They have been shown to improve outcomes for patients.
- A national survey by the Intensive Care National Audit & Research Centre (ICNARC) highlighted the good work carried out by the intensive care unit. ICNARC has released figures comparative figures which demonstrate that fewer people died in ITU when compared to other hospitals.

Summary of findings

- The trust showed that it has one of the best call to treatment times in the country for appropriate emergency intervention following a heart attack.

Musgrove Park Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair:

Dr Chris Gordon, Programme Director, NHS Leadership Academy and Consultant Physician, Hampshire Hospitals Foundation Trust

Team Leader:

Joyce Frederick, Care Quality Commission

The team included CQC inspectors and analysts, doctors, nurses, a midwife, a specialist paramedic, patient 'experts by experience' and senior NHS managers.

Why we carried out this inspection

We chose to inspect Musgrove Park as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. From the information in our 'Intelligent Monitoring' system, Taunton and Somerset NHS Foundation Trust was considered to be a low risk provider.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection.

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting the inspection team looked at lots of information held by CQC about the trust and asked other organisations to share what they knew about it. This information was used to guide the work of the inspection team during the announced visit on 24 and 25 September 2013.

Detailed findings

During the announced visit the team:

- Held six focus groups with different staff members from all areas of the trust and the trust governors;
- Looked at the personal care or treatment records of a sample of patients;
- Observed how staff were caring for people;
- Talked with patients, carers, family members and staff;
- Interviewed staff members;
- Reviewed comment cards in the comment card boxes placed around the trust during the inspection from staff and people who used the service;
- Reviewed information that we asked the trust to provide; and

- Held a listening event on the evening of 24 September where patients and members of the public shared their views and experiences of the trust.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the hospital.

A subset of the inspection team carried out unannounced visits on the evening of 27 September and the weekend of 28 and 29 September 2013. An inspection was also carried out on 3 October 2013 by a pharmacy inspector.

Are services safe?

Summary of findings

Patients received safe care and were protected from risks. Infection rates were low and the hospital was clean. However, risks to people's safety increased during busy times. Medical patients were transferred to surgical wards and some patients moved several times between wards and did not always see a specialist appropriately. Some equipment needed to be better maintained and some areas were in need of refurbishment. Patient records needed to include accurate and appropriate information.

Our findings

Patient safety

Patients told us that they felt safe in hospital and had experienced good care. Comments included: "I had an orthopaedic procedure in A&E, I had to choose between a tourniquet or local anaesthetic. My options were explained and I felt comfortable choosing a local anaesthetic even though there could be more pain, I knew I would recover quicker." In obstetrics a patient told us, "I had a c-section and my baby was breech... they talked me through the procedure and all the side effects ... I felt fully informed and in good hands."

The trust was focussed on safety and there was an open culture of reporting when things went wrong. Staff were reporting incidents and, in many cases, were being encouraged to do so by senior staff. Staff received feedback on incidents, although some staff said that they did not always receive feedback on incidents they had reported. Incidents were analysed and used to improve the quality and safety of services. The majority of the trust's incidents were near misses, low or no harm incidents. Serious safety issues and avoidable harm were reported to the National Reporting and Learning Service. In the NHS Staff Survey (2012) staff were reporting errors, incidents, near misses in line with national expectations although they had witnessed more potentially harmful errors, near misses or incidents than expected. The trust was aware that they needed to improve their reporting so that an accurate

picture of incidents is available for national comparison. The trust intends to develop an electronic reporting system and some staff said that this change would increase their reporting.

The trust had had one Never Event in the last 12 months. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. This event the, removal of a wrong tooth, was appropriately investigated to identify the cause of error. The trust had also taken action to improve the safety of surgical procedures in all theatres.

The increasing number of emergency admissions put patients at risk. Patients, for example, were assessed appropriately on admission but if the hospital was under pressure, medical patients were transferred to surgical wards and some patients moved several times between wards. This increased the risks to patients as they did not always receive appropriate specialist care. The quality of medical communication to handover patients between different shifts of doctors also varied, particularly in the evenings and at the weekend. We observed, for example, a medical handover where patient safety and escalation issues were not fully discussed. The trust had plans to improve its procedures for managing emergency admissions over the winter months. The Trust is reconfiguring its wards in order to provide additional medical beds to reduce the numbers of medical patients treated on surgical wards, and maintain surgical activity.

Patients who became critically ill were managed effectively by the critical care team. Staff used early warning scores to assess patients at risk, and patients received timely specialist support. Some delays to treatment did occur when patients moved between wards and the trust was implementing an electronic system in November 2013 to track patients more effectively. A General Medical Council (GMC) survey in 2013 also identified delays in escalating patients in trauma and orthopaedics to the critical care team. Action was being taken by the trust to review this.

Staffing

Staff reported that they were significantly stretched and under pressure at busy times. In the NHS Staff Survey (2012/13) staff felt supported to manage safety issues, but 75% of staff said they were satisfied with the quality of their work which was worse than expected when compared nationally but more staff would recommend the trust as a place to work or receive treatment. Junior doctors said they

Are services safe?

were supported to learn new skills and were supervised to cope with new clinical problems. Nursing staff said they were supported to request more staff for the wards to manage dependency needs. We observed this to be case during the inspection but nurses also said they were stretched when the trust was busy.

The trust had increased the numbers of senior doctors present in A&E and the medical admissions unit, but staff reported that there remained insufficient senior doctors present at night and at the weekends. Cover was provided, in most cases by junior doctors that were qualified for two years. Consultants were on call, but their responsiveness could vary. The Junior doctor rota was compliant with the European working time directive and national New Deal guidelines, but junior doctors reported that they worked long hours because of the intensity of the work. The trust was reviewing staffing levels, but these did not meet some national recommendations, for example, junior doctor cover in paediatrics. The impact on patient care was identified for frail and elderly patients, children, and women in labour who also needed anaesthetic care. The trust was reviewing its staffing requirements and was developing plans for seven-day working.

Managing risks

The trust was managing patient safety risks. The NHS Safety Thermometer measures people who fall, develop pressure sores, a blood clot in the veins, or a catheter urinary tract infection. The trust was similar to the national average on these measures although there were occasions in the last year when numbers were higher. The number of people who fall, especially those who are frail and elderly was increasing. The trust had introduced measures to manage falls but these were not being consistently applied. There was on-going monitoring to improve safety and action plans to focus on the quality of care on wards, which included steering groups to act on each safety issue, nurse monitoring measures, a dementia care programme, and an enhanced recovery programme for elective surgical patients.

Medicines management

Medicines were prescribed, administered and stored correctly. The hospital used a formulary list of approved medicines for prescriptions and this was monitored and followed. Medicines not on the formulary were only given if there was a clinical need or if the person was already stabilised on another drug. We observed medicines being

given to patients as prescribed and administered safely. We did see two incidents where medicines were not administered correctly (one patient without identification another with the wrong (lower) drug dose given incorrectly by syringe driver). Medicines were stored in locked areas, cupboards and trolleys, and were kept at the right temperature. We observed two incidents where medicines were stored incorrectly (an incorrect fridge temperature and one intravenous drug not locked). None of these incidents resulted in harm and the trust took swift action to correct these issues. Medical staff told us that safer medicines prescribing could be improved by electronic processes. The current procedures though were legal, safe and effective.

Cleanliness and hospital infections

Patients were protected from the risk of infection. The trust infection control rates for *Clostridium difficile* (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) were much lower than expected. There had only been two patients with MRSA in the last two years. The trust had investigated why this had occurred and found that one case was potentially avoidable. All the wards we visited were clean and cleaners used appropriate and precise cleaning schedules. Patients and visitors were provided with information on how to prevent infections and there was hand hygiene gel in all ward areas for patients, staff and visitors to use. We observed staff wearing gloves, and aprons, and washing their hands between seeing patients. Patients were screened for infection on admission and patients with spreadable infections were treated in isolation or side rooms. The trust monitors infection prevention and control and action was taken on safety concerns. The Chief Executive described an example where action was taken by the Medical Director to ensure medical staff on elderly care wards were following appropriate procedures.

Safeguarding patients

Staff had knowledge and understanding of how to protect patients from abuse and restrictive practices. The majority of staff in the trust had had safeguarding training at the appropriate level. Procedures were safe and effective, particularly in maternity and paediatrics and patients with dementia were kept safe but were not unduly restricted. The trust had a whistleblowing policy which staff were

Are services safe?

aware of. The policy was being used, for example, a performance issue was raised in Spinal surgery. The trust had acted appropriately to address the concerns and ensure the safety of the service.

Patient records

Patient records did not always have accurate or appropriate information. Care plans on surgical wards were difficult to follow as records were loose and temporary files were in use for long periods of time. Across the trust, 'do not attempt resuscitation' (DNAR) forms were not always fully completed. It was not always recorded how, or if a decision had been reached. This put patients at risk of inappropriate and unsafe care. Regulation 20 (1) (a). The trust is developing a new process to record resuscitation and treatment escalation intervention decisions.

Medical equipment

Equipment was not always serviced and maintained appropriately and some essential equipment was not available for use. The trust's medical devices department had a backlog of equipment that requires maintenance and this includes equipment that is used in high-risk areas. Most departments had equipment that was serviced and maintained but there was a risk that patients requiring

life-sustaining equipment may not have the appropriate equipment available to them. Equipment in the maternity unit was also not fit for purpose. The call bell system did not work on the postnatal ward and ventilation needed to improve to decrease the level of gas from the use of gas and air equipment. These were on the trust's risk register but progress was not detailed. Regulation 16 (1) (a) and (2).

Buildings and environments

Buildings in the hospital were safe but there were areas identified as not fit for purpose. The trust is a mixture of old buildings, built in the 1940s and new buildings, such as its purpose-built Beacon Centre for the treatment of cancer patients. The trust had a number of new building and refurbishment projects underway, for example, a new surgical unit and A&E had new resuscitation facilities and cubicle areas for seriously ill and injured patients. Theatres and orthopaedic wards were not fit for purpose, for example, the roof in theatres sometimes leaked. Some areas, such as intensive therapy unit (ITU) and maternity, had insufficient space and were cluttered. The trust was assessing the safety of these buildings and had improvement plans and secured funding to improve these environments.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patient care and treatment was effective and guidelines for best practice were monitored. However, these guidelines were not always consistently followed. There were not enough senior doctors present at night and weekends in the A&E, medical care and surgical departments. This was affecting the quality of medical decisions and handovers in those areas. Some staff did not have appropriate training to provide specialist care to patients.

Our findings

Clinical management and guidelines

Patients received care according to national guidance, although this did vary. The trust was using National Institute for Health and Clinical Excellence (NICE) and professional guidelines, and most services had a lead to ensure these were implemented and monitored. The trust was similar to or better than other similar trusts in how patients with chest pain, stroke, hip surgery, and critically ill patients in intensive care, were treated. The trust's plans for clinical audit demonstrated guidelines were being monitored, although some programmed audits had yet to start. The trust participated in national and regional audits. Some areas required improvement, such as pain relief in A&E, and staffing at night and during the weekend did impact on the effectiveness of some services. Patients with hip surgery, for example, did not have access to physiotherapy on the weekend to help them recover their mobility. There were also fewer therapists in A&E to support treatment, on medical wards to support patients recover from stroke, and to support discharge. The trust was developing an enhanced recovery model to ensure trained staff would be available at the weekends. We observed good multi-disciplinary team working, for example, in stroke services, day surgery paediatrics and end of life care.

Patient mortality

Patient mortality was similar to other trusts and was within the expected range. The trust had reviewed mortality over the weekends from September to November 2012. There were 69 deaths and they identified issues with delayed diagnosis, care delivery and problems in the escalation and supervision of patients. Care was found to have been suboptimal to some degree in one-third of patients but was not felt to have contributed to their deaths. One patient death may have been avoided. The trust has increased the number of senior doctors on duty over the last two to three years to improve the decisions taken on treatment. The trust had noted that the mortality at the weekend was raised in five of the last eight months and had taken quick action to review this. They are reviewing admissions, the management of medical outliers and mortality for patients with pneumonia, urinary tract infections and heart attacks.

Staff levels and skills

Staff did have appropriate skills and training but there were concerns in some areas. The trust supports staff to have appropriate skills, knowledge and training and this is monitored and prompted when staff training is out of date. The trust scored better than other trusts in the NHS Staff Survey (2012) for staff receiving relevant job training. There were only a few areas of mandatory training from the staff survey that were worse than expected, for example, in health and safety and equality and diversity. Staff told us, however, that they did not always have appropriate specialist training on time. Staff in A&E did not have appropriate paediatric training and nursing staff in surgery did not have training to deliver intravenous drugs. Junior doctors told us that induction and department training varied, for example, some were shown round their departments and received basic life support training but others did not. Junior doctors reported that they had not had IT training to use the trust computer system, and this had increased the amount of their time spent on administration. The trust acknowledged that access to training should be more flexible to respond more quickly to service changes and staff needs. There should be suitable arrangements in place for appropriate training. Regulation 23 (1) (a).

Are services caring?

Summary of findings

Patients told us that staff were caring and compassionate and that they were treated with dignity and respect. People at our listening event identified times when basic personal care had not always been provided and some staff told us that when they were busy, it was difficult to always meet patient's emotional needs.

Our findings

Patient feedback

Overwhelmingly all the patients we talked to in the hospital told us that staff were very caring and helpful and that they were treated with dignity and respect. One patient on a medical ward said, "The staff are very caring...they come quickly when I call". A patient in maternity said, "I have had a brilliant experience 10 out of 10" and a patient on the surgical ward said, "They really care for me ...and ask if I am in pain." One patient on a surgical ward told us "All is good here, I've been well looked after". Only one person told us that their friend had not received "appropriate end of life care".

People from our listening event commented that they had received good care. They gave us examples of "caring" and "kind" staff for patients who had breast care treatment, caring for their relative with dementia, end of life care and when they had an emergency operation. Some people expressed concerns about the services they or their relatives or friends had received. They were concerned about the attitude of staff, the care of people who fall, poor end of life care, and the lack of help and support for basic personal care, such as eating, going to the toilet and pain relief. Comments included, "The nursing staff did not help to clean my mother", "I was left without help to eat my food...", "The staff never talked to my daughter because of her disability...".

Most information on the NHS Choices website and on the trust's own Patient Opinion website included positive comments. There were comments about staffing, in particular ward staff being professional, approachable, communicative and focused on meeting patients' needs. Comments also praised hospital cleanliness and the quality of food. We also had people who contacted us using

our Share Your Experience forms. The majority of comments were positive and highlighted that staff were caring and helpful. Negative comments highlighted poor nursing care and pain management.

Patient treatment

Patients were supported to ensure their fundamental care needs were met, although there were times when this did not occur. We observed that patients had food and drink when they needed it, and were supported with their personal care and to manage their pain. This was particularly important for patients that were frail and elderly and staff took time to ensure that patients received the right care. The trust had introduced intentional rounding (which is where nurses check patients every two hours for pain, nutrition, hydration, skin, falls and anxieties) although this was not being applied consistently. Ward inpatient quality surveys also demonstrated that some wards had lower scores for supporting people to eat and for giving pain relief. Staff were observed to be kind, compassionate and caring and were honest about when the quality of care did not match their standards.

Nursing staff told us that sometimes there were not enough staff to appropriately care for elderly patients and patients with dementia, and sometimes patients were not supported to eat and drink appropriately. Pain management in A&E needed to improve. For adults, for example following hip fracture and for renal colic and to adequately assess pain scores for children. The trust was taking action to address these concerns by using monitoring information to improve quality, developing plans to deal with increasing numbers of patients, and training nurses in A&E to manage illness in children.

End of life care

Patients at the end of life were being managed according to the Department of Health interim guidelines and the Liverpool Care Pathway was no longer being used. This was done in response to the national independent review *More Care, Less Pathway: A Review of the Liverpool Care Pathway* published in July 2013.

Patient privacy and rights

Staff respected patients' privacy and dignity and their right to be involved in decisions and make choices about their care and treatment. The CQC adult inpatient survey (2012) asked patients questions about their care and treatment, if staff treated them with dignity and respect and if they were involved in decisions about their care. The trust's score was

Are services caring?

similar to or better than other trusts. The Cancer Patient Experience Survey was done in 2011/12 and the trust was rated in the top 20% of trusts for its services. Patients reported, for example, that they had time to discuss their treatment and felt supported. In the National Bereavement Survey (VOICES) 2011, patients at the end of life reported good experience of care but needed more spiritual support and the support to die where they wished. We found that the trust had improved its end of life care services to be able to support patients in this way.

Food and drink

Patients were given a choice of suitable food and drink to meet their nutritional needs. Patients were given help to

order meals from the hospital menu and the majority of patients told us that the food in the hospital was good and they had a choice of drinks throughout the day. They told us they had been asked if they needed support to eat and drink. We observed staff helping patients to eat and that patients had water within easy reach which they told us was replenished regularly. Patients with special diets (including vegetarian, vegan, diabetic, gluten free and soft or puréed diet) had a choice, although this could be limited for patients with very specific diets.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Patients told us that the hospital responded to their needs and the trust was working to improve its care for vulnerable patients, for example patients with a learning disability or dementia. However, we had concerns about discharge arrangements and waiting times for some surgical procedures and outpatient appointments. Information for the public was available in English but not in a format that all patients could understand.

Our findings

Patient feedback

Patients we talked to in the hospital told us that services responded to their needs. Patients told us they were seen very quickly. Comments included, for example, "They have been very efficient... I was seen by the doctor very quickly".

At our listening event some people told us they had received very good services, for example, in breast care, from physiotherapists in orthopaedics, for end of life care, and for the care of a relative with dementia. However, we received some comments of concern about cancelled operations. A few patients at our listening event expressed concerns about being discharged too early, including at night, when they felt they still needed care.

Most information on the NHS Choices website and on the trust's own Patient Opinion website included positive comments. We also had people who contacted us using our Share Your Experience forms. Positive comments highlighted that people had had a good experience of care including staff who were compassionate during end of life care. Negative comments highlighted a lack of information on patient discharge, that doctors did not always have relevant information so some outpatient appointments were wasted, and staff not being responsive to people's needs.

Discharge of patients

Most patients were discharged appropriately. The CQC's national inpatient survey conducted in 2012 demonstrated that patients' views on discharge were similar to other trusts. Patients said that they were given enough notice on discharge and did not wait longer than four hours for medicines or an ambulance. Readmissions are used as an

indicator of quality and effectiveness because it could show that patients may have been discharged too early or there may have been problems with their care and treatment. The trust had lower numbers compared to the national average of patients who were readmitted as an emergency within 30 days of discharge – though numbers were higher in musculoskeletal, dermatology and stroke services. We observed that some discharge arrangements were problematic. Some discharge decisions did not happen over the weekend because of a lack of staff, including senior doctors and therapists; in the maternity unit some women were asked to go home sooner than they may have wished or planned to because of the lack of postnatal beds, and some discharges, for example, were delayed for people with complex needs.

Waiting times

Patients were seen quickly (within one and three hours) in the A&E department compared to national average. The trust is also better than the national target for seeing 95% of patients in A&E within four hours. There were times this year when the trust fell below this target and the availability of beds on the wards had caused delays and ambulances have queued outside of the hospital. Like many hospitals, the trust is expecting an increasing number of patient admissions over the winter months and is developing its plan to increase its capacity of medical beds to manage this workload.

Some patients we talked to told us that they came to the A&E service as they could not access a GP out of hours. The out-of-hours GP service is run by South Western Ambulance Service NHS Foundation Trust and the service has three GPs to cover the county of Somerset. The trust was engaging with partners on the Urgent Care Project group to look at ways of reducing attendances in A&E and ensure effective discharge to its community hospital beds or other arrangements.

Some patients were waiting a long time for surgery. The trust is similar to other hospitals in terms of the number of cancelled operations but was not meeting the national 18-week referral to treatment times in general surgery, orthopaedic and spinal surgery, ear, nose and throat (ENT) and bariatric (weight loss) surgery. Planned surgery was affected because of an increase in the number of emergency admissions in March and April 2013. The trust was working with commissioners and Monitor to identify how they manage these waiting lists. There was a focus on

Are services responsive to people's needs?

(for example, to feedback?)

improving efficiency but the trust had made it clear that patients would be seen on the basis of clinical need and not management targets. The trust understood that they may fail to reach targets this year.

Outpatient care

Some outpatients waited a long time to be seen. There were pressures on some outpatient clinics because of a lack of capacity, and some patients in Orthopaedics and Ophthalmology can wait a long time for followup treatment. A few patients we talked to told us that outpatient services were often not joined-up and they came to outpatient clinics only to be told that they needed to have tests done and another appointment. One patient said, "I am not sure why my GP could not order these tests ... as I have waited some weeks to be seen by a specialist".

Support for vulnerable patients

Specific support was given to people who were caring for vulnerable patients. We observed, for example, that relatives had facilities in critical care, and there was spiritual and coordinated support for adults and children receiving end of life care. We observed that care was taken to ensure that a patient with learning disabilities could consent appropriately in critical care but A&E did not have tools to enable someone with a learning disability to assess their pain. The local authority learning disability service had also identified considerable problems with the hospital's ability to make reasonable adjustments for people with a learning disability. They had developed hospital passports in response to the Mencap Six Lives report (2009). The trust has improved in its use of reasonable adjustments and the passports to support needs for people with learning disabilities are being used.

The trust is aiming for a 'dementia friendly' hospital and its strategy was developed to ensure that staff awareness improved, patients receive appropriate care, and their carers were involved. We observed that some of the medical wards specialised in caring for patients who had dementia but also that patients with dementia should have flower signs on their beds to remind staff, but these were not always used.

Accessible information

Information was readily available in ward areas but was only in English. Information could be produced in different formats or languages but this would result in a delay. In A&E, for example, signs for emergency treatment for patients with chest pain were only in English. The trust had

an interpreter service which staff were aware of. We observed, however, patients from Polish and Portuguese communities being treated in the hospital; some could not speak English, but interpreters were not used. A few patients also told us that staff whose first language was not English needed to ensure that they were properly understood.

Patient consent

Patient consent was obtained appropriately. The trust has a policy on consent and records showed that staff were following this guidance. Consent forms were signed appropriately by patients and or their relatives.

Patient records and end of life decisions

Some 'do not attempt resuscitation' (DNAR) forms were not always fully completed. Some forms were not signed to indicate if the decision had been discussed with the patient or their family. There was not an accurate record. Regulation 20 (1) (a).

Patients' complaints

Information was available for patients on how to make complaint. Some people at our listening event told us that complaints were not handled appropriately. In the Patient Advice and Liaison Service (PALS) they pointed out delays in managing their informal complaints, and that some medical staff were defensive when they received a complaint. One person said, "The doctor told me I had no grounds to complain about my treatment". Some people said that it would be good for the trust to have a system to give compliments as well as complaints. One person said "It would be good to tell the trust about the good care".

The trust had used the Patients Association survey to improve how they handle complaints. The main issues were for a more personalised approach and informing complainants of lessons learned. Staff told us that complaints were taken very seriously, even if a small complaint was raised. The trust carried out investigations for all complaints and offered face-to-face meetings. The trust was also working effectively with commissioners to deal with two complaints where the patients had requested that these be independently investigated. There were 247 formal written complaints in 2012/13 and this number was decreasing compared to previous years, and more Complaints were being managed informally but the PALS team. Most complaints were about clinical treatment and nursing care, the attitude of staff and failures in communication. The trust had had nine complaints

Are services responsive to people's needs?

(for example, to feedback?)

referred to the Parliamentary and Health Services Ombudsman and of those investigated, none were upheld. The trust's complaints were analysed and the trust produced a quarterly report, which included action taken and lessons learned for staff.

Patients' feedback

The trust had arrangements to actively obtain feedback from patients about their care and treatment. For example, from comments, inpatient surveys, volunteer supported interviews, patient stories, and online feedback. Inpatient surveys were displayed in ward areas to improve the quality of care on the wards. There was a patient experience committee where information was monitored and lesson learned were fed back to staff.

The NHS Family and Friends test was introduced in April 2013 to allow patients to give feedback on the quality of care. The trust scored above the national average for inpatient stays indicating that the majority of patients (in June 97.7%) were 'extremely likely' or 'likely' to recommend the ward where they stayed to family and friends. The trust scored below average in A&E but the numbers of patients reporting were very low so the results should be

interpreted with caution. The trust was developing ways to improve patient feedback and use electronic and paper surveys. The trust scored similar to or significantly better than average in the A&E survey (2012)

Patient-led assessments of the care environment (known as PLACE) were introduced in April 2013. These are patient-led assessments of cleanliness, food and hydration, privacy, dignity and wellbeing and the condition, appearance and maintenance of the environment. The trust scored above average (over 90%) in each area, with over 95% for cleanliness.

Car parking

Most people at our listening event told us about their concerns with car park charges. They told us that the charges were very high and weighted so you had to pay more if you stayed for the duration of visiting time. Some people told us that patients with chronic conditions who need to visit the hospital frequently do not have special parking facilities and the cost of parking was proving difficult to manage. Also with the hospital refurbishment, some wards had moved and the disabled car parking bays were now further away. The trust had put in place a buggy service during the major building works but most people were not aware of this.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust has a clear clinical strategy and governance arrangements. It is focused on making sure it provides good quality, safe services and clinical staff were involved in making improvements to services. Staff told us they were proud to work in the trust. Staff had a sense of collective responsibility to deliver quality care and a 'duty of candour' was developing to ensure staff were open about performance issues, even if they happen to be about colleagues. The leadership team were monitoring the right areas and were listening to staff and patients about their concerns and experiences. Staff wanted the leadership team to improve the pace and implementation of change and champion services that needed resources and support. The leadership in some services needed to improve, especially in maternity.

Our findings

Leadership

The trust was well-led. The trust board was fairly stable; the only changes in 2013 were the appointment of two new non-executive directors, the Director of Nursing and Acting Director of Finance. The Director of Change, a position which includes workforce development, was an interim post. The leadership team worked well together and were a strong and cohesive group. There was a clear understanding of the priorities for the trust and there was a clear and coordinated approach to strategic and operational risks. The trust had clear lines of accountability and staff in the trust could articulate the governance processes. Staff were engaged with the trust leadership and this was important to ensure that leadership decisions were followed. There was a sense, from many staff, of collective responsibility to ensure that quality care was delivered at every level.

The trust recognised its clinical priorities as modernising the hospital's facilities, working towards a seven-day working week, developing services and valuing people. The trust was also clear about balancing the need to deliver quality services while managing the cost savings that are expected in the NHS. The trust had reorganised its committees to manage the trust strategy and operational

issues separately and there were committees to focus on audit, governance and the patient experience. This was beginning to work well to enable the leadership to focus on priorities and there was a good level of monitoring of operational performance and clinical effectiveness. The level of independence and challenge by non-executive directors and also by governors needed to develop to ensure issues identified were addressed by the trust. The leadership team performed patient safety walkabouts around the trust to talk to staff and review quality and safety.

Managing quality and performance

The trust had changed its clinical management structure and there were nine directorates. Each had a clinical director, directorate manager and matron. The lead doctors, nurses and managers in the directorates have attended, or are attending the Leadership Matters Programme. Staff told us that this had improved relationships and team working, although a few staff still felt unable to get things done quickly through the management structures. Most of the clinical directors were new to their roles and were appointed because of their leadership capabilities. Some clinical directors led areas that they did not specialise in. Staff did not identify this as a problem but felt that their director should be more visible, for example, to tackle performance issues and to champion services where resources were needed. The Medical Director of the trust was managing behavioural issues with clinical staff. The trust was developing staff understanding and working under a 'duty of candour'. This was identified in Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report) so that all staff working in the NHS had a responsibility to report and whistle-blow on performance of colleagues. This had started to happen but, in some areas, some staff still needed to be assured that they were safe to raise concerns.

The trust leadership team was looking at the right areas and most concerns of staff and patients were escalated appropriately. The board and leadership team regularly received performance information on risk and quality, including patient complaints and experiences of care. The trust board heard patient stories, which is an initiative for patients to tell their individual stories of both good and poor care. This had a greater impact on the trust board understanding what it is like to receive care in their hospital. Information on risk and quality was used to improve services and there were a number of patient safety

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

and patient experience initiatives. For example, surveys and nurse monitoring demonstrated that the quality of care is reduced when more agency staff are used. The trust was focusing on developing overtime for staff (bank staff) instead. The trust had acknowledged there were some delays in the pace and implementation of change and this required stronger management.

Service improvement plans

Clinical staff were involved in and leading plans to improve services. The trust understands that the NHS requires them to be competitive and to innovate to meet savings targets. In this environment they want to sustain good quality and safe services. They had taken the right financial steps and they operate at a level of efficiency that was better than other similar trusts. Service cost improvements plans had delivered £12m of savings and were approved on the basis of quality, clinical effectiveness as well as cost. New plans were being better coordinated so that the impact was understood across the trust rather than in service isolation. In planning ahead, however, the trust was aware that services would require radical change and they were looking to integrate services with partners across Somerset and bring services closer to patients, for example, in the community hospitals. The trust Improvement Network has been running for a few years and started with a number of small-scale projects, such as the enhanced recovery pathway in colorectal surgery and the management of acute sepsis (serious infection) had demonstrated that quality and efficiency savings can be achieved. Clinicians involved in the Improvement Network were extremely positive about the benefits of changing services in this way. About 18 months ago the trust started what they called “Big Conversations” with staff to find out how they want services to change and improve for patients. They are using these ideas in their Improvement Network to reorganise services across the trust.

Valuing staff

Most staff felt valued in the trust. The trust people strategy was to recruit staff based on values, such as compassion

and caring and they had a values-based appraisal system. The trust promoted its values through its communication and the behaviour of the leadership team. The NHS Staff Survey (2012) demonstrated that and the trust scored better than other trusts for its communication with staff. The trust was looking to have a more flexible pay and reward structure to retain good, high-quality staff and remain competitive with finances. The staff we talked to felt engaged with the trust, particularly in the Improvement Network, and as part of their clinical teams being accountable for monitoring and owning information about their own performance. They identified where leadership could be more active, for example, in making decisions about staffing, improving efficiency, championing services and dealing with the difficult behaviours in some clinical teams. The NHS Staff Survey (2012/13) showed that the trust had more staff than in similar trusts saying they would recommend the hospital as a place to work or receive treatment. Many staff told us they were “proud” to work in the trust.

Openness and transparency

The trust was open and transparent when working with partners to improve services in the Somerset area. The trust, was working with commissioners to coordinate how emergency admissions can be managed across Somerset and how access to planned surgery can improve to meet targets. The environment is complex, as commissioners can choose other providers to manage some planned services and the trust has been open and honest about where they underperform and how they intend to improve, and how patient care is based on quality and clinical need. The trust also works with external networks to improve services. For example, many patients may come into hospital with a pressure sore from their home or care home and some develop pressure sores in hospital. The trust works with the Somerset Pressure Ulcer Collaborative, a peer review group which aims to reduce pressure sores in hospital and in other care services.

Accident and emergency

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The accident and emergency (A&E) department is open 24 hours a day, seven days a week. The department sees about 56,000 patients (adults and children) each year. A&E includes Jowett Ward, a short-stay, clinical decision ward used to observe patients assessed as low risk but who need further tests. It is also used by patients awaiting transfer home or to other services. We talked to 35 patients, six relatives and 20 staff, including nurses, doctors, consultants, senior managers, therapists, support staff and an ambulance driver. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The A&E department provided effective care and staff were caring and responsive. Most patients were seen and treated within the national waiting time limit of four hours and plans were put in place for discharge or transfers for further care and treatment. However, there were not always enough senior doctors present at night and weekends. Children were seen by appropriate child care specialists but there were concerns that not enough staff in the A&E department had up-to-date qualifications in emergency child care.

Accident and emergency

Are accident and emergency services safe?

Patient safety

Patients told us staff were competent and they felt safe with those who had treated them. Comments included: “The doctor did my procedure and explained everything that would happen. I felt happy and assured.” Staff felt supported to deliver safe care to patients. All new nurses, for example, worked supervised alongside more experienced staff until they were competent to work alone to provide a safe level of care and treatment. A new member of staff confirmed that they had been able to ‘shadow’ someone more experienced. Staff felt they received training appropriate to their role and level of responsibility. All staff we talked to said there was excellent support and communication within the team.

Caring for children

Staff working in the A&E department did not have appropriate qualifications to care for children. The nurse practitioner was trained in paediatric life support but medical and other nursing staff did not have an up-to-date qualification. Staff raised this concern with us, but told us risks were reduced by using staff from the paediatric wards for children who needed specialist care. We observed that children were seen by an appropriately qualified member of staff. Training for nursing staff on identifying serious illness in children was being planned, but this and further paediatric training needs to be in place. Regulation 23 (1) (a).

Safeguarding

Staff had training and understood safeguarding and reporting procedures. A lead nurse supported best practice and provided information. Staff told us that all under ones were always stripped and visually inspected for bruises and weighed. Other children were appropriately checked if there were concerns. We observed that children’s case file did not record if a child was subject to a child protection plan. There were however, guidelines to share information with partner agencies. These had recently been reviewed by the local authority who identified the trust as a good example of whole organisational approach to safeguarding.

Staffing

Patients could potentially be placed at risk of receiving unsafe medical care by the lack of senior doctor presence

at nights and weekends, when cover was provided by junior doctors with an on-call consultant. Staff told us this reduction in senior doctor presence happened at the busiest time for the department. The clinical lead and staff in the department expressed concerns about this. The department also had nursing vacancies, though bank staff (staff who work in the trust as overtime) were being used to provide cover. Patients assessed as low risk were admitted to Jowett Ward for clinical decisions and observation but, for large parts of the day, this ward was staffed by one healthcare assistant. A trained nurse was allocated but not based in the ward all the time. We talked to four healthcare assistants who were all concerned about the safety of patients on Jowett Ward at busy times. They said they were never asked to undertake any tasks that they were not trained to do and could call the trained nurse for assistance, but at busy times it was difficult to make sure patients were kept safe. The ward closed at 10pm but when busy could stay open longer and staff stayed on to care for patients in their own time. Staff expressed particular concerns about the care of older people with mobility difficulties and dementia.

Managing risks

When the department gets busy it was acknowledged by nurses that basic nursing care such as pressure area care and hydration is difficult to deliver. One nurse in charge was looking to introduce intentional rounding (which is where nurses check patients every two hours for pain, nutrition, hydration, skin, falls and anxieties) once the new layout of the A&E department had been finished in November 2013.

Medical equipment

The equipment in the department was well maintained and it had been regularly checked and serviced to ensure that it continued to be safe to use.

The environment

The treatment spaces in the department were inadequate but were being improved. The department was divided into two main areas: one for minor injuries; the other for major injuries and serious conditions with staff allocated at the beginning of each shift. At busy times the fracture clinic was sometimes used to provide extra space. Additional treatment cubicles for major needs and improved resuscitation facilities were being built at the time of this inspection. Staff told us, however, that the trust had not identified the nursing staff for the new areas.

Accident and emergency

Are accident and emergency services effective?

(for example, treatment is effective)

Clinical management and guidelines

Patients were seen and treated effectively by appropriate staff. They received diagnostic tests relatively promptly, treatment was not delayed, and plans were put in place for discharge or transfer for further care and treatment. One person told us, "I've been really impressed. My relative is being admitted but they have already gone for a scan which we didn't think would happen this quickly." One patient said, "They have done blood tests and I'm just waiting for the results. The nurse has explained everything to me." Staff told us there were delays at busy times. Another patient said, "The doctor explained my procedure and told me everything that would happen."

Patients received care according to national guidelines. The department monitored the quality and safety of care to ensure on-going improvements and participated in national audits used by the College of Emergency Medicine (CEM). The trust, for example, demonstrated improvements in how they managed patients with renal colic and a fractured hip. Although patients did not always have adequate pain relief this was in line with national figures and there is a national trend to improve pain management. The report CEM Clinical Audits 2012–13: Feverish Children demonstrated that the trust had improved its management of children with fever but needed to ensure that vital signs were taken within 20 minutes of arrival in A&E. Clinical audit plans included monitoring of National Institute for Health and Care Excellence (NICE) and other professional guidelines.

The department worked in partnership with other professionals to make sure patients received appropriate care and support. There was a joint emergency therapy team which consisted of physiotherapists and occupational therapists. The team used referrals by pager to see patients quickly. One team member told us, "It means we can get people home quickly and safely." However, this team only worked on weekdays, so evening or weekend patients would not receive the benefit. GPs also worked in the department during the week to manage patients with minor injuries and conditions normally treated in primary care.

Staff skills

Staff have access to training. Some nursing staff, however, that had been with the department for a long time stated that a lot of their A&E specific courses and education such as advanced life support (ALS), paediatric life support or trauma care courses had expired some years ago and they had not been supported to revalidate. Regulation 23 (1) (a).

Are accident and emergency services caring?

Patient feedback

All patients we talked with at the hospital were complimentary about staff in A&E. One patient said, "The staff are always courteous and polite. They keep you informed about what is going on and are all friendly." Another person said, "The doctors and nurses have been excellent. They are all so kind and caring".

During our listening event a few people raised concerns about the attitude of staff in A&E, particularly about care and discharge of older patients. Two people told us that they had not been informed when their older relatives had been discharged and so could not be there to support them.

Pain relief

Adult patients received pain relief when required and those we talked with said their needs had been met. A few patients told us they were still in pain after triage. We observed adult patients being asked about pain and pain relief was dispensed in a safe manner. However, there were no resources or tools to support staff to assess pain for people with learning disabilities or dementia and those whose first language was not English.

Children with minor injuries did not always receive pain relief in a timely manner. The CEM's Pain in Children Audit 2011/2012 looked at the pain relief administered to children aged between 5 and 15 years in moderate or severe pain. The findings showed that less than 50% of children in A&E received pain relief in line with guidelines (the national average was 58%). We observed that children in the department were given pain relief. However, care records did not always document children's pain scores. The A&E department had a smiley faces tool but we did not see this used. There were no other resources or assessment tools specifically available to support staff in assessing pain in children.

Accident and emergency

Nurses needed to ask doctors to prescribe pain relief which could lead to delayed administration. One nurse stated that some nurses had not signed the patient group directive to allow them to prescribe simple pain relief such as paracetamol. This was because the process was “a rigmarole” and needed to be updated each year.

Patients’ privacy and rights

Staff respected patients’ privacy and dignity. One patient was being observed on Jowett Ward following a head injury. We saw that staff showed great patience and kindness when the person needed assistance.

Staff respected patients’ right to make choices about their care. We saw staff explaining treatment options to patients to make sure they fully understood the treatment and choices available. All patients we talked to said they had been informed of the procedures being undertaken. All reported seeing the same doctor or nurse throughout their stay in A&E and all felt involved in decisions about their care and treatment.

Food and drink

Patients received adequate nutrition and hydration if they had to wait a long time for admission to a ward or another service. Patients were offered drinks and snacks. However, one patient said they had been in A&E for around six hours and had not received anything to drink until they were transferred to a ward.

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

Waiting times

In the past 12 months the department had performed better than the national target of seeing 95% of patients within four hours of their arrival. There had been instances when this did not happen for example, in March 2013, and pressure on beds meant that ambulances sometimes queued outside the department. The trust was also performing better than the national average for waiting times from initial decision to hospital admission (between four to 12 hours), and for seeing patients quickly (within one to three hours).

Staff responded to patients in a timely manner. During our inspections we saw that patients did not wait longer than four hours (the national target) to be seen. Patients were

seen reasonably promptly when they arrived. Everyone we talked to who had arrived by ambulance said they had been seen within 10 minutes. One person told us, “I got the treatment I needed without any waiting around.” Another person said, “My relative was seen straight away. Everyone has been really kind and efficient.”

The department was under pressure at times. During one evening the department was full. We were told that beds were available on the wards but patients were not being moved in a timely manner. This led to some ambulance delays, with one waiting over 30 minutes to admit their patient. During the inspection we noted that A&E staff identified a situation with patient flow which meant that patients were not being admitted quickly. Managers were called to take action and the situation was alleviated.

Caring for children

Staff said they felt they responded quickly to the needs of children. Despite there being only one nurse trained as a children’s nurse in A&E, staff said there was support from the paediatricians and GPs in A&E. One parent said, “All the staff have been excellent, really kind and responsive to all [my child’s] symptoms.” We observed that children were prioritised in A&E. A child was seen by the triage team within 10 minutes, and then by a doctor within 30 minutes of their arrival. They were treated and admitted to the hospital in under two hours.

Children were treated alongside adults. There was a designated children’s waiting area and treatment room. However, staff stated that the treatment room was not used because its position made clinical supervision and oversight impossible with current staffing.

Accessible information

Information was not readily available in a format that all patients could understand. All literature and signs (including signs for emergency treatment) were only in English. Staff told us that English was the first language for most people who attended A&E but also said a significant number of Polish and Portuguese people used the service.

Are accident and emergency services well-led?

Leadership

The A&E service was well-led. The team was motivated, with excellent team working and good communication

Accident and emergency

between all grades of staff. Staff said they felt well supported by their colleagues and managers. Staff told us they had not yet met the clinical director who was recently appointed.

Managing quality and performance

The service monitored the safety and quality of care and action was taken to address concerns. Performance information was used to improve the service and the trust was actively working to ensure that A&E was able to meet the needs of the local community. The clinical lead for A&E informed us that medical cover, nursing vacancies and paediatric training were on the trust's risk register and they were working to address these issues, but arrangements for nursing staff for the new major cubicles in the department were not decided. The trust was also working with the

Somerset Clinical Commissioning Group as part of an Urgent Care Project Group to better co-ordinate how A&E attendances could be managed and work more effectively with the out-of-hours GP service for Somerset.

Information technology systems

There was widespread concern and complaints from staff about the department's three computer systems which were not fully integrated. This had an impact on the time doctors spent with patients, prolonging the administration time needed to discharge patients. At one time we noted that the computer showed that six patients had been in the department for over four hours. We saw that all six patients had left the department but doctors had not had time to complete the computer check-out.

Medical care (including older people's care)

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Musgrove Park Hospital has 10 acute medical inpatient wards with a total of 244 beds. Three of these wards (74 beds) specialise in providing a service to frail elderly patients. We talked to 33 patients, two relatives and 20 staff, including, nurses, doctors, consultants and senior managers, therapists and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patients on medical wards received safe, caring and responsive care. Staff had appropriate skills and training, there were enough nursing staff, and the service was caring, compassionate and well-led. Infection rates were low. There were not always enough senior doctors present at night and weekends. An increasing number of patients were being admitted as medical emergencies and were not always transferred to the appropriate specialist ward. Some patients were moved several times between wards, which could lead to inconsistent care and treatment.

Medical care (including older people's care)

Are medical care services safe?

Patient safety

The service was focused on safety. Staff reported most incidents and said they were encouraged to do so by senior staff. Staff said they did not always receive feedback and this could sometimes discourage their reporting, not knowing what action was taken. The paper reporting system was described as cumbersome and staff said that this may also reduce reporting. Incidents were analysed and improvements were made, for example, steering groups on falls and pressure sores were implementing changes. Patients told us that they felt safe. Comments included: "I know I am in good hands. They all know what they are doing," and "I feel very safe here. There is always someone there if you need them". Patients were complimentary about the care they received. Comments included: "They have been very efficient," and "I was seen by a doctor very quickly and they arranged a scan for me".

At our listening event, a few people expressed concerns about being discharged too early, including at night in their nightclothes. There were also poor multi-agency arrangements for people with complex needs. One person said, "I was discharged without any support at home ... I could not move or feed myself ... my neighbour had to help". Another person said, "My mother was discharged. She was in pain ... and could not move her arm".

Patients' medical needs were assessed appropriately on the medical admissions unit and this reduced the risk of unsafe or inappropriate care. Records were fully completed and risks clearly identified. These included risks relating to malnutrition, pressure damage to skin, falls, moving and handling, and use of equipment. Each patient had a plan of care to manage their risks.

Risk to patients increased if they were not transferred to an appropriate ward or were moved between wards. The hospital was coping with an increasing number of emergency medical admissions during our inspections and patients were not always transferred to an appropriate specialist ward. These patients, called medical outliers, meant that medical patients were being treated on surgical wards. During one day of our inspection, there were 40 medical outliers in the hospital.

The trust links its medical and surgical wards so that medical staff know where their outlying patients are. This

worked well in some areas but not in others and some surgical wards said it sometimes difficult to locate medical teams to review patients. We observed, for example, seven medical outliers on Blake Ward. One elderly patient had fallen in the evening and the team was awaiting additional staff to supervise a patient who was displaying aggressive behaviour. Staff on surgical wards expressed concerns about the management of medical patients, especially the elderly and people with dementia.

The risk of patients receiving suboptimal care due to ward transfers was on the trust's risk register. Some patients had moved several times between wards for clinical and non-clinical reasons that were not always documented. For example, one patient with a respiratory condition had moved to five different wards, without a documented reason. This could lead to inconsistent care and treatment.

Staffing

There were not enough senior doctors on duty at nights and weekends and this was affecting the quality of medical decisions. Junior doctors reported they were very stretched with the amount and intensity of work covering medical wards. We observed some formal, structured and safe medical handovers (where staff change shifts and communicate information about patient care). However, the quality and safety of handovers varied, particularly at the weekend. One handover, for example, did not have a detailed list of patients. The handover did not identify patient safety concerns, issues to escalate or the resuscitation status and discharge was delayed for some patients. The number of emergency medical admissions was comparatively higher at nights and weekends. There were fewer patient discharges at the weekend and this placed the hospital under pressure.

The trust had had a plan to deal with emergency pressures over the winter. This included increasing the number of medical wards and reducing surgical activity. The trust had an action plan to improve discharge arrangements.

There were sufficient numbers of nursing staff on the medical wards. The trust reviewed nursing staffing levels in acute medicine in February 2013 and levels were based on the patients' dependency needs. Nursing staff on medical wards told us there were enough staff on duty to enable them to deliver good and safe care. We observed examples where additional staff had been made available to provide one-to-one supervision for high-risk patients. We saw a

Medical care (including older people's care)

structured nursing handover meeting where each patient was discussed in detail, including discharge plans. Patient safety was taken seriously and any issues were openly discussed and addressed.

The wards worked in partnership with other professionals to make sure patients received appropriate care and support, including physiotherapists, dieticians and mental health professionals. Many of the wards confirmed that they did not experience difficulties in accessing clinicians out of hours or weekends. However, some wards said it was “more difficult” at weekends. Staff told us they did not feel that patient safety or wellbeing was compromised, but there were, for example, delays in discharge and therapeutic interventions for patients with complex needs.

Managing risks

The risks to patients identified by the NHS Safety Thermometer assessment tool were being managed. Patient records showed that the risk of patients developing blood clots, pressure sores, catheter and urinary tract infections and falls were managed. The trust monitored these indicators and information was displayed in ward areas and some wards had comparatively higher numbers of falls than others. The trust had introduced intentional rounding (which is where nurses check patients every two hours for pain, nutrition, hydration, skin, falls and anxieties). This had reduced the number of falls for example, but was not being consistently applied. We observed that additional staff had been provided to care for patients who had been assessed as high-risk on some wards. The trust was introducing nurse monitoring measures and a dementia care programme to decrease the number of people who fall. Staff told us they recorded and reported all untoward incidents such as falls and pressure sores. These were discussed and monitored at ward and senior management level.

Hospital infections

Patients were protected from the risk of infection. Medical wards were clean and safe. The trust infection control rates for *Clostridium difficile* (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) were much lower than expected. Patients and visitors were provided with information on how to prevent infections and there was hand hygiene gel in all ward areas for patients, staff and

visitors to use. We observed staff wearing gloves and washing their hands between attending to patients. Patients with spreadable infections were treated in side rooms.

Safeguarding procedures

Staff had a good understanding of how to protect patients from abuse and restrictive practices. Staff understood the types of abuse and knew how to report any safeguarding concerns. Staff said they were confident that concerns would be appropriately dealt with to ensure patients were protected. We observed that two medical wards (Mendip and Dunkery) had notices on the entrances warning of patients at risk of wandering and to keep the doors closed, or directed visitors to use an alternative door. These doors were never locked or obscured in a way that could have constituted restraint. Staffing levels had been increased on the wards to support patients who were wandering and confused.

Patient records and end of life decisions

We found inconsistencies in the recording of patients' right-to-life resuscitation decisions. It was not always recorded how, or if a decision had been reached. This put patients at risk of inappropriate and unsafe care. This is a breach of Regulation 20 (1) (a).

Medical equipment

Medical equipment was well maintained and had been regularly checked and serviced to ensure that it continued to be safe to use. Patients had been provided with the specialised equipment they needed. An example included the provision of air flow mattresses to reduce the risk of skin damage. A visitor told us their relative “had skin damage before they were admitted. The staff made sure a special mattress was in place straight away”.

Are medical care services effective?
(for example, treatment is effective)

Clinical management and guidelines

Patients received care according to national guidelines, although this could vary. The trust participated in national audits, for example, they had better-than-expected standards for the treatment of patients who have a heart attack, but had some worse-than-expected results in caring for older people who fall. The trust had not participated in the national stroke audit in past years, although was participating currently. We observed good multidisciplinary

Medical care (including older people's care)

care and treatment for stroke patients. There was a clinical lead to ensure the implementation and monitoring of guidelines. Clinical audit plans included monitoring of National Institute for Health and Care Excellence (NICE) and other professional guidelines. The trust demonstrated, for example, that it has one of the best 'call to treatment' times in the country for appropriate emergency intervention following a heart attack.

Patient mortality

Patient mortality was similar to other trusts and was within the expected range. The trust had reviewed mortality over the weekend from September to November 2012. There were 69 deaths and they identified issues with delayed diagnosis, care delivery and problems in the escalation and supervision of patients. Care was found to have been suboptimal to some degree in one-third of patients but was not felt to have contributed to their deaths. One patient death may have been avoided. The trust has increased the number of senior doctors on duty over the last two to three years to improve the decisions taken on treatment. The trust had noted that the mortality at the weekend was raised in five of the last eight months and had taken quick action to review this. They are reviewing admissions, the management of medical outliers and mortality for patients with pneumonia, urinary tract infections and heart attacks.

Patients with dementia

There were improvements for patients with dementia. Each medical ward had a dementia champion who received additional training in dementia care to share knowledge and best practice with ward staff. Sedgemoor Ward was a specialist dementia care ward. The décor and layout, and picture signs enhanced the hospital experience for older people, especially those with dementia.

Staff skills

Staff had appropriate skills and training and their competency was regularly monitored. On each of the wards we visited staff were professional and competent in their interactions with patients. Staff told us that training opportunities were "very good". They told us they were never asked to undertake a task they had not received training for, and confirmed that they received good levels of supervision and annual appraisals.

Are medical care services caring?

Patient feedback

All the patients and visitors we talked to commented on the kindness of all staff involved in their care. Comments included: "You cannot fault the staff. They have all been so very kind," and "I have nothing but praise for the staff here". Another patient said, "I'm proud of the service they provide here, and that we can rely on people like them in the NHS."

Patient treatment

Staff treated patients with dignity and respect. In their interactions with patients on the medical wards, staff were kind, professional and patient. Staff assisted patients in a discreet and dignified manner. Patients told us they were treated with respect and were never made to feel uncomfortable or embarrassed when assisted with personal care.

Care records contained evidence that patients had been involved in planning their care. Patients told us they had been able to discuss their care and preferences when they were admitted to the ward. Comments included: "The nurse and the doctor had a chat with me. They told me what would be happening and asked if I was happy with everything," and "They wrote everything up and asked me to check it. I feel that they keep me informed and they encourage you to tell them if you are worried about anything".

Food and drink

Patients had adequate nutrition and hydration. Patients were supported to eat meals. We observed lunch times on two wards where care was provided to older patients and patients with dementia. Patients were supported to choose their preferred meal and all had access to a drink. Patients who needed help to eat, or their intake monitored, had their meals served on a red tray. Discreet signage was used to alert staff to patients who had dementia so they could provide suitable support. Most patients thought the food was good. One patient who required a vegan and dairyfree diet did not have a meal delivered for several days as it could not be catered for. In the interim, nursing staff had to "find" suitable food for the patient to eat.

Are medical care services responsive to people's needs?

Medical care (including older people's care)

(for example, to feedback?)

Patients told us they felt well cared for and that staff responded to their needs and requests in a timely manner. One patient who had been admitted 36 hours ago told us they had been “speedily dealt with, which included a scan”. They were awaiting discharge and praised the care they received.

Ward environment

The ward environment was appropriate for patients. All wards had single-sex bays and side rooms so that patients with more complex needs could be appropriately cared for. Responding to concerns raised by patients in a shared bay about a patient who was noisy at night, staff moved the patient to a side room close to the nurses' station so they could be closely monitored.

Patient records and end of life decisions

Some ‘do not attempt resuscitation’ (DNAR) forms were not always fully completed and many were not signed to indicate if the decision had been discussed with the patient or their family. The was not an accurate record. Regulation 20 (1) (a).

Accessible information

Information was readily available in ward areas but only in English. Information could be produced in different formats or languages but would mean delays for people whose first language was not English.

Are medical care services well-led?

Leadership

Medical care was well-led. Senior managers and clinicians had a good understanding of the performance of their departments and teams worked well together. All staff were involved in monitoring quality and there was a willingness to respond to change. Monthly meetings demonstrated that staff openly discussed concerns about the service and clinical care, and how the service could improve. There were clear lines of accountability and less-experienced staff were supported by more senior staff. Staff morale was good and staff told us they were proud of the standards of care they provided and worked in good teams.

Managing quality and performance

Safety and quality of care was monitored and action taken to address concerns. Performance monitoring meetings were held every month with appropriate follow-up action. Concerns raised by staff were on the risk register and emergency admissions, medical outliers, falls and the mortality rate of weekend admissions were being monitored through action plans. Some risks, such as medical handover, or the workload of junior doctors, were not on the risk register and some actions did not have an indication of progress. Untoward incidents, complaints and concerns were monitored and discussed at ward and board level. The learning from these had been identified and implemented.

Outpatients

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Outpatient Services are in the Queen's Building of the hospital. The clinics run from Monday to Friday 9am to 5pm and 280,000 outpatients attend appointments each year. The trust offers outpatient appointments for all its specialties where assessment, treatment, monitoring and follow up are required. During our inspections there were 45 separate outpatient clinics for diabetes, ear, nose and throat (ENT), ophthalmology, stroke, chiropody, orthopaedic, urology, endocrinology, rheumatology, gastroenterology, breast and paediatric clinics.

We talked to 35 patients and 15 staff, including the patient services manager, outpatients ward manager, booking and clerking staff, healthcare assistants, doctors and consultant staff and a phlebotomist to take blood samples. We observed care and treatment. We received comments from our listening event, from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patients received safe and effective care and staff were caring. Patients received treatment and followup in private consultation rooms, and had time to ask questions to help understand their treatment plans. Most clinics were managed efficiently and patients said the department communicated with them well. Patients who needed to be seen urgently were given appointments according to national standards. However, some patients waited a long time to be seen. The orthopaedic clinics were particularly busy: some patients had been waiting for three hours because they needed x-rays. The number of patients who failed to attend and the number of cancelled clinics was above the national average. The views of patients were not actively sought to help the service improve. The consultation, assessment and treatment process was not monitored for effectiveness. The service needs to be better led to bring about improvements.

Outpatients

Are outpatients services safe?

Patient safety

Patients received safe and appropriate care. Patients had consultation, diagnostic tests and assessment and consultations with appropriately qualified staff and advice was sought from other healthcare professionals, where necessary. Staff knew what to do in the event of an emergency and the department had appropriate equipment, such as a defibrillator for patients who may have heart problems.

Safeguarding patients

Staff understood safeguarding processes and what to do if they needed to raise an alert. Staff we talked to said they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures.

Hygiene and the environment

The outpatient service was provided in a clean, safe and accessible environment. We observed hand hygiene gels were available and used throughout the department by staff and some patients. All clinics were on the ground floor, making access safe and easier for patients with mobility difficulties. There were wheelchairs at the front of the outpatient entrance for patients to use if needed. A porter or staff from outpatients would escort or use a wheelchair to assist frail or disabled patients who attended without support from family or friends.

Are outpatients services effective? (for example, treatment is effective)

Clinical management and monitoring

Patients were allocated sufficient time with staff when they attended clinics. The booking and administration clerks explained to us how clinics were organised. More time was allocated for new patients to allow them time to ask questions and have follow-up tests. Patients who were returning for follow-up treatment or management of symptoms for a chronic condition were allocated shorter times and seen by consultants or registrars, specialist nurses, or allied healthcare professionals such as dietitians.

Patients told us that the outpatient service was effective. For example, one patient told us, "For endocrinology, you

couldn't ask for better. The consultant really cares and he knows what he is doing. I feel I am in safe hands and my condition is slowly getting better." Another patient told us, "The doctor always checks I understand what they are doing, tests and follow-ups, everyone is so caring here. I never have a problem."

Outpatient services were not monitored for effectiveness. Some specialties were evaluating their outpatient services, for example, there were clinical audits of the nurse-led rapid access clinic and the gynaecological open referral clinic. However, the consultation, assessment and treatment process in outpatient clinics was not regularly monitored by the trust.

Staff skills

Staff received training, support and supervision to enable them to provide a caring environment in the outpatient department. Staff told us that they were given an induction when they started work which covered patient focus and customer service. Staff also attended clinic meetings and supervision sessions to review their learning and competencies in dealing with patients.

Are outpatients services caring?

Patient feedback

Patients considered the outpatient service to be caring and supportive and told us about positive experiences. Comments included: "The staff are always helpful and supportive."

The feedback was less positive from people at our listening event who had recently attended outpatient services. We heard two examples of patients attending the breast screening clinic where they said, "The service was efficient, but staff lacked any empathy or caring". We heard another example where a patient felt their consultant did not listen to their opinion or show any "compassion" for their concerns about having their eye operation under a local anaesthetic.

Patients' privacy

Staff respected patients' privacy and dignity. We observed patients had consultations in private rooms and clinic doors were closed during clinical examinations. Staff did not discuss patients in public places and reception areas were separate from waiting areas so that private conversations were possible.

Outpatients

Are outpatients services responsive to people's needs? (for example, to feedback?)

Patients' feedback

Patients told us that the outpatient department communicated well with patients. There were waiting time announcements and a good booking system and treatment choices.

Patients' views and experiences were not obtained to improve the quality of the service. There were comment cards available in waiting areas, but these were not displayed prominently and we did not hear patients being encouraged to complete them. The trust had used the volunteer service to gain patient opinion in other areas of the hospital, but not within outpatients. There was no information on how patient feedback was monitored.

Waiting times

At our listening event, people told us there can be long waiting times in outpatients. Patients who need to be seen urgently are seen quickly but some patients have to wait for a first appointment. Cancer patients referred by their GP have an outpatient appointment within the national standard of two weeks and patients requiring diagnostic tests have these within six weeks. The number of people waiting for a first outpatient appointment had increased and waiting times were longest in ophthalmology, neurology and urology. The trust was taking action to improve the service in these areas.

Most patients were followed up and monitored according to national guidelines. The trust had benchmarked its outpatient services according to national specialty guidelines in January 2013. Most services had appropriate following up for patients. Some specialties, however, were outside of service standards. The trust had taken action to improve this but the capacity to provide follow-up treatment in ophthalmology remains a concern.

Some patients waited a long time to be seen in clinic. The outpatient clinics were well organised but the orthopaedic outpatients clinic areas were crowded and busy. Some patients waiting for spinal consultations had waited for three hours. This was because they needed x-rays prior to, or following, their appointment so consultants could

determine their treatment plan. Patients were informed of this in advance, but did not know why tests could not be arranged beforehand. The trust did not record the number of patients who could not wait to be seen by a doctor.

One patient, for example, told us, "They always let us know if the clinic is running late, and will always change appointments to a more suitable time if you ask." Another patient told us, "I am here for a follow-up appointment and need to also have an injection. They time it so that I have very little wait. I have found the consultant excellent, as are all the staff who work in outpatients."

Meeting patients' needs

Outpatient services were responsive to patient's needs. Appointments were booked from a central office, but patients could change the date and time if notice was given. One patient told us, "They are always happy to accommodate any changes as I need to be home at certain times as I am the main carer."

Patients who have dementia-type illness were offered morning appointments or a time which suited them, and patients with mobility difficulties had transport to attend clinics. If an emergency appointment was needed, space and time was allocated to allow for this.

Patients' consent

Patients' consent was obtained appropriately for treatment and procedures. Consent forms were signed and verbal consent was obtained, for example, when blood was taken. Consent was also obtained appropriately for children. Parents with responsibility were identified for children who were unable to give consent and staff understood the need to respect confidentiality for children who could consent and were competent to make their own decisions.

Accessible information

Information leaflets were available in the outpatient area to help patients understand their condition and treatment options. There was also information about how to make a complaint. All literature, however, was only available in English. We observed that people from Polish and Portuguese communities were using hospital services. Staff told us they could arrange for telephone interpreters for patients whose first language was not English.

Outpatients

The trust was working with the Taunton Citizens Advice Bureau (CAB) to improve the responsiveness of the outpatient service. The Taunton CAB was offering advice and guidance to people undergoing different treatments to respond to patient's needs.

Are outpatients services well-led?

Leadership

The outpatient department was well managed by staff who showed a passion for making the patient journey a positive and effective one. The staff team understood the complexities of providing a vast array of clinics and were experienced in running clinics and organising teams to work together collaboratively. Staff enjoyed working in the outpatient department. Staff we talked to said, without exception, that outpatients was busy but an “enjoyable place to work”. Several staff members we talked to had worked in the outpatient areas for over 20 years. One staff member said, “This is a great place to work, it is well

managed and our views and opinions are listened to.” We heard how regular clinic meetings were held and staff given the opportunity to raise safety concerns and comment on how the service was run.

Managing quality and performance

The outpatient service needed to be better led to improve the service for patients. The number of patients who missed clinics and the number of cancelled clinics was higher than the national average. Patients now had automatic reminders to attend clinics and the trust had started to take action to reduce cancellations. The trust was aware that it needed to focus on the efficiency and the effectiveness of the service. Service action plans, for example, did not monitor the quality and safety of the service, if patients were being followed up effectively, how long patients wait for appointments, and how many patients could not wait to be seen if they had waited too long in a busy clinic.

End of life care

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The Beacon Centre at Musgrove Park Hospital was built in 2009. It provides inpatient and outpatient chemotherapy, radiotherapy, symptom and pain relief to people with cancer, and people who receive palliative and end of life (EOL) care. Patients in other wards such as frail elderly, medical, intensive care and cardiology also receive EOL care where appropriate. End of life care across the trust is led by the palliative care team, who are available Monday to Friday from 9am to 5pm.

We talked to 3 patients and 15 staff, including clinical nurse specialists, the EOL care coordinator, an occupational therapist, doctors, chaplains, the bereavement coordinator and senior managers. We observed care and treatment and looked at eight care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Staff working in the service had expertise in palliative and end of life care. They were passionate about providing good care. People had support to make decisions about their care and were discharged with the right care and support. People were fast-tracked to get immediate funding for the right home care or nursing home. A specialist team provided advice, support and guidance to children and family members, including bereavement counselling. However, end of life care on medical and surgical wards needs to improve. There have been a number of formal complaints about end of life care relating to the care, compassion and support from nursing staff. Resuscitation decisions on medical and surgical wards were not properly documented.

End of life care

Are end of life care services safe?

Patient safety

The service was focused on safety. Staff reported incidents and told us that they did receive feedback and shared the lessons learned from the findings.

Patients received safe EOL care service. The records of eight patients who were receiving palliative care or EOL care at the Beacon Centre, elderly care and medical wards, demonstrated that they were being appropriately treated for their condition. Pain relief, nutrition and hydration were provided according to their needs. Their wishes for their EOL care were also clearly documented.

Patients were discharged safely with the right care and support. We listened to a weekly multidisciplinary meeting where palliative care patients were discussed in-depth, including those receiving end of life care. This included making sure support services were in place so that patients who wished to return home or to another care setting could do so safely. Patients were also fast tracked to get immediate funding to facilitate the right home care package or nursing home depending on their wishes.

Patient records and end of life decisions

Important information around EOL care was fully documented. Information on resuscitation was not documented appropriately and this put patients at risk of inappropriate and unsafe care. We looked at a sample of 60 records on the medical and surgical wards. Only half had 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms and, of those, only two-thirds were fully documented. It was not always recorded how or if a decision had been reached. This meant that some patients did not have an accurate record and appropriate information in relation to their care. Regulation 20 (1)(a).

Are end of life care services effective? (for example, treatment is effective)

Clinical management and guidelines

Patients' EOL care was managed effectively. Patients received effective support from a multidisciplinary palliative care team. The palliative care team acted swiftly to referrals to ensure that patients received an effective service. The team included three nurse consultants who were led by a consultant who worked one day per week. An

EOL care coordinator provided support to all patients and staff across the trust. The service included four chaplains to provide spiritual support, volunteers and a bereavement coordinator who, following a patient death in hospital, made sure families received their personal belongings and essential documents as well as providing information and support about bereavement services. All the staff were trained to provide specialist care and expertise in palliative and EOL care.

The EOL care followed government guidelines. The Department of Health asked all acute hospital trusts to undertake an immediate clinical review of patients on EOL care pathways. This was done in response to the national independent review *More Care, Less Pathway: A Review of the Liverpool Care Pathway* published in July 2013. The trust had undertaken this review and had an interim policy on EOL care which replaced the Liverpool Care Pathway, which they had previously used.

Are end of life care services caring?

Patient feedback

Patients had mixed views about the EOL care service. We heard from a range of people at our listening event and also from people contacting us to describe their experiences of relatives having EOL care. We heard mixed views and some people told about their relative's really good experience of EOL care, but others told us that staff had lacked care, compassion and respect. One person told us "my wife had the most wonderful treatment in A&E and on the Ward.... They could not have been better or kinder". One person told us, "We did not feel our mother's needs had been very well met by the A&E department, but once she was admitted to the [end of life care] ward, we could not fault the care, compassion and attention she received. She died with dignity and we were kept fully consulted." One person said, "A good friend died there recently and was not given appropriate end of life care".

We talked to three patients in the Beacon Centre about their experiences of receiving treatment for progressive cancers. They all expressed a high level of satisfaction with the care and treatment they had received. The trust had a significant number of complaints, however, about EOL care. In the last year (September 2012 to August 2013), 6% (14) of the trust's complaints were about EOL care,

End of life care

specifically, about the lack of care, compassion and support from nursing staff. The majority of complaints were mainly about the care on the acute medical and acute surgical wards.

Support for patients

The trust obtained funding in June 2013 from Marie Curie Cancer Care to support volunteers to act as Musgrove Companions for patients who did not have friends or family to support them at the end of their life. The trust currently had 40 volunteers to support patients, but this funding was going to be used to recruit more volunteers and provide specialist training to provide this specific support. Patients' spiritual needs were met by a team of chaplains, volunteers and staff. We spoke with two chaplains who told us they were integrated into the multidisciplinary team and so were aware of all patients who required EOL care. They held contact numbers of main religious faiths and had information about other faiths, including bibles and prayer books in different languages.

Caring for children

Children with life-limiting conditions and EOL care needs had specialist support. The trust had a specialist team, called COMPASS, who provided advice, support and guidance to children and their family members, including bereavement counselling. The team was made up of paediatricians, community children's nurses, clinical psychologists, a play specialist and an administrator.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Patients who needed end of life care were seen by specialists quickly. The palliative care team responded to all urgent referrals within 24 hours and those less urgent within three days. The trust annual report (2012/13), reported that 95% of all patient referrals were seen the same day or next working day. Nurses on the wards told us said that the palliative care team were very responsive to referrals. They talked to patients and families to explain EOL care, options available, pain control. They also discussed and recorded people's preferences for where they spent their final days.

Patients' rights and wishes

In the National Bereavement Survey (VOICES) 2011, the NHS trusts in Somerset did not perform well for patients receiving appropriate spiritual support and ensuring patients stayed where they wished for final days of their life. The palliative care team had completed their own survey between April and July 2012. This showed that, for all patients who wished to die at home, this was achieved within a three-day period. The introduction of the EOL care coordinator post had proved to have a significant impact on ensuring patients were in their preferred place at the end of their lives.

Patients received flexible care and support and were able to make choices about their EOL care. Their needs and wishes were fully discussed at the palliative care multidisciplinary meeting. Staff showed compassion for ensuring patients' wishes were fully discussed and, where possible, discharges to either hospice care, home or nursing home was facilitated within 24 hours. One patient, for example, whose first language was not English, wished to return home to die. The team had used an interpreter to provide a flexible care package to ensure that the patient's family and friends had 24-hour support.

Patient records and end of life decisions

In a sample of 60 records reviewed on the medical and surgical ward, it was not always recorded if the EOL decision had been discussed with the patient or their family. This meant that some patients did not have an accurate record and appropriate information in relation to their care. Regulation 20 (1)(a).

Support on the wards.

Patients received good support and information on wards with EOL care. The palliative care service is from Monday to Friday, 9am to 5pm. One of the lead specialist nurses had overall responsibility for ensuring the principles of good EOL pathways were being followed across the trust. This included providing training and support to all staff across all wards to ensure they understood effective pain relief. It also ensured decisions about EOL were fully discussed and documented with the patient where possible and their family. We heard how folders were being produced for each ward area with key information about EOL care, including contact details of support agencies.

End of life care

Are end of life care services well-led?

Leadership

The palliative care team were well-led by specialists who understood their role and were passionate about ensuring good care outcomes for patients at the end of their life. The team was not fully staffed and there were consultant vacancies. The service had one consultant lead for one day a week, but had excellent links with a consultant at the local hospice who also worked in the trust one day a week. Recruitment of palliative care consultants is managed by Somerset Partnership NHS Foundation Trust. The EOL care coordinator's post was only funded until June 2014 and the team had collated evidence to show this post had worked well for ensuring good quality outcomes for patients. The team felt they lacked a champion at board level to push for this post to be made permanent.

Managing quality and performance

The palliative care team monitored the quality and safety of the EOL care service. Performance information was

regularly fed to the trust Board to demonstrate that the service was well-led and a valuable resource for patients. Steering groups for palliative care were developing ways and taking action to improve the service although the issues identified with EOL care across the trust was not on the trust risk register. The team undertook clinical audits to check on quality and safety and held multidisciplinary team meetings to share good practice ideas. Information from incidents and patient experiences, was used to plan care for patients.

The Beacon Centre has won a number of awards that demonstrate they provide high-quality, patient-centred care. These include the Customer Service Excellence Award (from the Centre for Assessment Ltd in September 2013), Insight for Better Healthcare International Award (CHKS in 2012) and the Macmillan Quality Environmental Mark (June 2010).

Services for children & young people

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Musgrove Park Hospital paediatric service has a dedicated day surgery ward, two inpatient wards for children, a high dependency unit (HDU), a neonatal unit and an outpatient service.

We talked to 11 parents (or relatives) and their children and 15 staff including nurses, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at nine care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Children received effective care from specially trained staff. Staff engaged well with children of different ages and the facilities were good, particularly on the day surgery ward. The environment was well maintained and there were toys and activities available for children. However, there were sometimes not enough nurses and junior doctors on the inpatient wards. Parents also told us they wanted the service to be more coordinated. For example they suggested having one point of contact between themselves and doctors from different specialties, as doctors didn't always communicate among themselves. This could lead to frustration and confusion among parents and staff.

Services for children & young people

Are services for children & young people safe?

Children's safety

The children's service was focused on safety. The parents and children we talked to were very complimentary about the service they received at the hospital. Parents told us they were confident in the care provided by staff. Parents with children who had complex needs felt their children were particularly well looked after.

Managing risks

Children who were admitted to the inpatient wards were risk assessed on admission and care was planned accordingly. Ward nurses attended medical handovers to ensure there was good communication between doctors and nurses about each child's care.

The service used a paediatric dashboard (a reporting system measuring performance against quality and safety indicators) to show potential risks. Incidents were reported and monitored. Nurses could tell us when they would report an issue as an incident and could describe the necessary process. They also explained how they learned from incidents. For example, the trust identified a high number of medication errors in the children's unit. In response, two nurses are now required to double check medication and dosage before it is given to a child. We observed staff on the inpatient wards checking medicines in this way. We also saw staff explain to parents what the medications were and why they were being given. Findings from incidents were also referenced in the service's audit plan and provisions were made to audit changes to staff practice.

Staff on both the inpatient and day surgery wards told us they had access to the equipment they needed. Fire doors needed to be replaced as they did not comply with current fire safety standards. This was on the trust's risk register.

Communication

Parents wanted the service to be more coordinated. One area where parents felt the service could improve was in having one point of contact to liaise between themselves and the doctors from different specialties. They told us that when children were being cared for by more than one doctor, the doctors did not always communicate among themselves. This sometimes led to confusion and frustration among parents and staff.

Staffing

There were not always sufficient numbers of staff to meet the needs of children on the inpatient wards. Wards were generally well staffed but there were times when additional nurses were needed but not provided. Additional staff cover was not provided when nurses leave the general children's ward to care for high-dependency children or to transfer a child to another hospital. Staff also felt there was inadequate access to junior doctors out of hours. They said this was because the "paediatric junior doctors were stretched" between the children's wards, the neonatal unit, and A&E. An internal audit, measuring the service's performance against standards set by the Royal College of Paediatrics and Child Health, showed the children's service did not have enough paediatric doctors when wards were busy. Junior doctors told us that consultant paediatricians were on call out of hours to provide additional medical cover when the service was busy. They said consultants were accessible and supportive.

Safeguarding children

A trust report showed that 96% of staff on the children's inpatient wards and 100% of staff on the day surgery unit had safeguarding training.

Hygiene and the environment

All areas in the children's unit were visibly clean. We saw staff cleaning equipment, although labels were not used to mark the equipment as cleaned. Hand hygiene gel was available and used by staff, parents and visitors on the ward. The children's unit environment was well maintained. There were toys and activities available for children. They were clean and in good condition.

Are services for children & young people effective?

(for example, treatment is effective)

Clinical management and guidelines

The parents and children we talked to said they received prompt care and attention. They praised staff for their expertise, with one parent describing the staff as "brilliant". Parents told us their children had prompt and adequate pain relief.

Children received care according to professional best practice clinical guidelines. We observed, for example, that children were given pain relief according to national

Services for children & young people

guidelines. Where clinical practice fell short of professional standards, action was taken in response. For example, the Royal College of Paediatrics and Child Health National Neonatal Audit Programme Annual Report 2012 (published August 2013), found the trust performed significantly worse than the national average (13% against a national average of 79%) in ensuring premature babies had eyesight screening checks. The trust investigated why and a plan is in place to improve performance.

Children's care and treatment was monitored. There were clinical audit plans which outlined the audit arrangements for ensuring the National Institute for Health and Care Excellence (NICE) and other professional guidelines were implemented by an assigned clinical lead. Action was taken when standards were not met and this was monitored. Staff told us, for example, that the unit's last decontamination audit achieved 91% compliance and explained where they needed to improve.

Staff skills

Children were cared for by staff specially trained to care for and treat children. Day surgery services were provided by nurses, surgeons, and anaesthetists who specialised in paediatrics. Nurses in the HDU and neonatal unit had specialist training in children's care. When needed, specialist paediatric doctors provided support to staff in A&E who were not specifically trained to care for and treat children. There were good arrangements for children on the neonatal unit to transfer to another NHS trust and staff had expertise in caring for exceptionally sick children.

Are services for children & young people caring?

Patient feedback

Parents and children said staff were very caring and kind, and responded well to their needs. Parents told us their children's treatment and care were explained to them in a way they could understand and they felt comfortable discussing concerns with staff. They said they felt well supported and could get help from staff when they needed it. Parents said their children received pain medication quickly when they arrived on the children's wards and they were given information about their child's medication. Parents of children who had surgery were given

information about any risks involved with the procedure, how to prepare for their child's operation, and what to expect after discharge. The children we talked to said they enjoyed the food.

Support for children and their families

There were arrangements to ensure children felt secure and comfortable, and less anxious about being in hospital. Parents were able to stay with their children overnight on the Acorn and Oak wards. Toys, books, and other forms of entertainment were available for children of all ages. The bedding used on the inpatient and day case wards was specially designed for children. There were regular 'open days' on the day surgery unit so that children and their parents could familiarise themselves with the ward. Parents were given information about any risks, how to prepare for their child's operation, and what to expect after discharge. Women who wished to breastfeed were given support to do so and were provided with three meals a day to ensure they received adequate nutrition. Women on the Acorn and Oak wards who had chosen to breastfeed all said the arrangements worked well and staff were very encouraging.

Are services for children & young people responsive to people's needs? (for example, to feedback?)

Patients' feedback

Parents expressed concerns about high car parking charges and the inaccessibility of eating facilities, especially in the evenings and on weekends. They noted it was a "long walk" from the children's wards to the hospital restaurant. Moreover, the Beacon Centre is closed on weekends and the hospital restaurant closes at 7pm which left no other means for obtaining meals. This was a particular problem for breastfeeding mothers in the neonatal unit who told us they were given toast for breakfast but meals were not provided. Parents also felt that more thought should be given to providing easier access from the car park to the children's inpatient unit. They told us the current route was circuitous and involved a long walk. Parents were not aware of the trust buggy which is being used to transport patients.

Services for children & young people

Parents' and children's experiences of care was used to improve the service. Parents were encouraged to complete feedback questionnaires and we saw a sample of these. Ward matrons could describe how they responded to feedback from parents and children.

Accessible information

Information about care and treatment was available on the wards. There were leaflets about various topics including explanations of clinical procedures, breastfeeding, and other sources of support. There was also information about how to make a complaint. All literature, however, was only in English. During our visits on the wards, we found a small number of parents and patients who did not speak English and for whom an interpreter was not provided. Despite its importance for communication, the need for an interpreter was not always documented in children's care plans. Staff told us they were able to use telephone interpreters when children and their families were not fluent in English but they did not often contact them.

Are services for children & young people well-led?

Leadership

Children's care services were well-led. There was a new Clinical Director and leadership structures were still under development. The Clinical Director for Women and Children's Services had been in post for three weeks. There was good operational leadership on the wards and day case surgery and the neonatal unit were well-led. Staff on the day case surgery ward showed a high level of

enthusiasm for their work and the service was clearly developed around the needs of children. Staff worked together as a team and there was good communication between the surgical and ward staff.

Senior managers within the paediatric service had a clear vision for developing the service in the future. For example, they talked us through their plans for changing the way in which medical assessments were carried out for children identified by social services as being at risk of harm. The anticipated changes were in response to concerns that the current system was slow and sometimes caused children and their families' unnecessary anxiety. The concerns were documented in the trust's risk register.

Managing quality and performance

Safety and quality of care was monitored and action taken to respond to concerns. This included reporting on performance indicators through the paediatric dashboard and monitoring risks through the risk register. The paediatric dashboard was reviewed monthly by the operations board and concerns were escalated to the trust Board. Incidents, complaints and patient feedback were monitored at both board and directorate level. Where concerns about clinical care were identified, action was taken to address them and learn from them. The risk register did not identify some key risks, including that senior managers were not aware of concerns about the availability of paediatric doctors out of hours. The potential need for additional nursing cover on the children's inpatient wards during peak times was also not identified as a risk.

Maternity and family planning

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Musgrove Park Hospital maternity service delivers over 3,000 babies annually. The maternity unit includes an early pregnancy assessment clinic (EPAC), antenatal clinics, a labour ward with nine delivery rooms, an antenatal ward (Fern Ward) and a postnatal ward (Willow Ward). It also includes the Bracken Birthing Centre and a home birth service for women with low-risk pregnancies. There are two dedicated operating theatres on the labour ward and there is a special care baby unit on site. We talked to 22 women and 32 staff, including midwives, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at nine care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Women spoke highly of the staff and said they felt involved in developing their birth plans and had sufficient information to make choices during labour. There was a home birth service available and the home birth rate was higher than the national average. However, some areas of maternity were in need of refurbishment and some vital pieces of equipment were not fit for purpose. Services were stretched during busy times, which meant some women could be discharged too early because of a lack of postnatal beds. There was no resident anaesthetist in the maternity unit and there was sometimes a delay in finding an anaesthetist for women in need of an emergency procedure during labour. Staff said that maternity was not well-led and problems had existed for a number of years, which had 'stunted' the development of the service.

Maternity and family planning

Are maternity and family planning services safe?

Patient safety

The service was focused on safety. Incidents were reported and staff said that they received feedback and learned lessons. The maternity unit had seven severe harm incidents in the last 12 months. The trust's investigation reports found staff responded well to emergencies on the labour ward and that there was good interdisciplinary team working. Staff were able to discuss lessons learned with us and improvements to care had been audited. The trust also commissioned an external report on stillbirths which was published in July 2013. This found the service was compliant with National Institute for Health and Care Excellence (NICE) guidelines for antenatal care and stated that "the level of antenatal care ... meets the required standards and there are no cases of poor conduct". Midwives could tell us when they would report an issue as an incident and could describe the required process.

During our listening event, one woman told us her experience of maternity was very good but one woman commented on being discharged too early: "I had a c-section and felt pressured into leaving too early... by the next day. I had not learned to breastfeed and subsequently had two infections, including on the surgery site."

Managing risks

Expectant women were risk assessed and there were plans of care for identified risks. Women were reviewed at antenatal appointments and at the onset of labour. There was good communication between staff of different disciplines regarding women's care. We observed a staff handover on the labour ward. It was well attended and well organised. The handover was multidisciplinary and included representation from consultants, anaesthetists, junior doctors, night and day shift staff, the midwife coordinator, and a senior midwife. There was good discussion about maternity care and clear action plans to address concerns. The handover concluded with a safety briefing, including examples of information related to concerns raised by audits and identified risks.

The maternity service monitored the quality and safety of care. The service used a maternity dashboard (a performance reporting and tracking system using a number of quality and safety indicators) to identify and

monitor potential risks to patients. The dashboard was reviewed monthly by the operations board with concerns escalated to the trust Board. However, there were no arrangements for the trust Board to directly review the findings. This is contrary to guidance in Safe Births: Everybody's Business – an independent inquiry into the safety of maternity services in England (2008).

Safeguarding patients

Records showed that almost 100% of staff were trained to safeguard women and children. Staff told us about a child protection case that happened during our inspection. The mother's story had triggered a concern and staff correctly instigated child protection procedures, coordinating action with the police and social services.

The environment and equipment

All areas in the maternity unit were visibly clean. Hand hygiene gel was available and used throughout the maternity unit. Some areas in the maternity unit were in need of refurbishment and upgrade. For example, the Fern Ward was used as a day assessment unit, a triage and induction area, and as an antenatal inpatient ward. It was busy and cramped. The labour ward environment was outdated, cluttered and had only two toilets for women who were in labour. Staff told us that a refurbishment of the labour ward was due to begin in October 2013.

Some of the equipment on the maternity unit was not fit for purpose. The call bell system on the Willow Ward could not be heard on the ward and there were no call bells in the bathrooms. There were contingency arrangements but staff told us there could be delays in responding to women who may need urgent assistance. On the labour ward, ventilation needed to improve to decrease level of gas from the use of gas and air equipment. This meant that midwives working in the early stage of their own pregnancy have had to disclose this information in order to work safely in other areas of the unit. These issues were on the maternity risk register but there were no details on progress. That the equipment is not properly maintained or suitable for its purpose. Regulation 16 (1) (a) and (2).

Staffing levels

There were sufficient numbers of staff to meet the needs of women on the unit but there were concerns about capacity to cope at busy times. Consultants were available on the labour ward for 46 hours rather than the 60 hours a week recommended by the Royal College of Obstetricians and Gynaecologists. Consultants were on call during nights and

Maternity and family planning

at weekends and staff told us this arrangement worked well. The trust had a Birthrate Plus national report which identified the number of midwives required based on clinical activity and risk. This demonstrated that they had sufficient midwives.

There was no resident anaesthetist in the maternity unit; they were based on the other side of the hospital. Staff told us there were sometimes delays accessing an anaesthetist for women who needed an emergency procedure in labour. This potentially increased the risks to the woman because of the need for a general anaesthetic. The delays were not recorded as a potential risk on the trust's risk register. Women saw an anaesthetist where possible, and on an ad hoc basis, for their antenatal care if they had high risks. There was no high-risk anaesthetic clinic but patients that require review are referred to an anaesthetist and seen appropriately. Staff, however, told us they were frustrated by the lack of space and funding for organising such a clinic.

Ward capacity

Staff told us that, when the unit gets busy, there were not enough postnatal beds. They said the lack of capacity had a knock-on effect throughout the unit and an adverse impact on patients. Staff told us they were particularly worried about women being discharged too early to free up postnatal beds. This was so commonplace that staff no longer completed incident forms. The trust was awarded £600,000 by the Department of Health to make improvements to the maternity unit.

Are maternity and family planning services effective?

(for example, treatment is effective)

Clinical management and guidelines

Women told us they were pleased with the continuity of service. Many of the women we spoke with praised the breastfeeding support they received and said this gave them the confidence to breastfeed. One of the women had an emergency caesarean section and she described her experience as "fantastic". Another woman had an elective caesarean section; she told us her "care was good and everything went as planned".

Women received care according to professional best practice clinical guidelines. We observed that maternity

was managed in accordance with the principles in Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour published by the Royal College of Obstetricians and Gynaecologists in conjunction with other professional bodies (in 2007). Women who needed planned caesarean sections were treated according to national guidelines and were first assessed for potential surgical risks. The World Health Organisation's (WHO) checklist was used as part of surgical checks and documentation for caesarean sections. The Local Supervising Authority Annual Report to the Nursing and Midwifery Council 2012/2013 found that the maternity service performed about the same as other maternity services in the region.

Clinical audits were undertaken to ensure that National Institute for Health and Care Excellence (NICE) and other professional guidelines were implemented, monitored by an assigned clinical lead. The service had a monthly audit newsletter which informed staff about the outcomes, recommendations, and improvements to services.

Staff skills

Midwives had statutory supervision of their practice and access to a supervisor of midwives at all times for advice and support. The supervisors ran drop-in sessions for women needing specialist support. Midwives told us they were supported to attend mandatory training and access professional development opportunities. They also had an annual meeting with their supervisor to discuss their practice and raise any concerns. Midwives, however, were attached to specific clinical areas within the maternity unit for long periods of time, preventing them from developing their skills, in a flexible way, which could be used across the maternity pathway.

Are maternity and family planning services caring?

Patient feedback

Women spoke very highly of staff in the maternity services and almost all of them stressed the positive experiences they had. Women felt involved in developing their birth plans and had sufficient information to enable them to make choices about their care and treatment during labour. Every woman we talked to said they had one-to-one

Maternity and family planning

care from a named midwife throughout their labour. They felt well supported and cared for by staff, that personal care was given with professionalism, and that their choices were respected.

Patient involvement

Women felt involved in developing their birthing plans and were given sufficient information to enable them to make choices about giving birth. They had adequate pain relief and were given information about pain relief choices, including the use of the birthing pool. Women were offered time and support to discuss their care. The maternity unit offered a 'time to listen' clinic which was run by the supervisors of midwives as a forum for women to discuss their experiences.

Patients' privacy

Women could maintain their privacy, dignity and independence. On the antenatal and postnatal wards, curtains could be drawn around their beds for privacy. We observed staff speaking respectfully to women and their families and acting with compassion and kindness. Despite cramped conditions on the antenatal ward, staff made an effort to make women and their partners as comfortable as possible. For example, there was a small kitchen with microwave cookers and refrigerators for women and their families to use.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Some midwives had specialist areas of expertise to meet the diverse needs of patients, including mental health, substance misuse, infant feeding, safeguarding and smoking cessation. Some obstetricians also had specialist areas, for example, in high-risk pregnancies and diabetes.

Home births

There was a home birth service available and the trust home birth rate was higher than national average. Staff told us there were few community midwives to provide the service and the service was suspended on two occasions in August 2013 due to staff sickness. No woman had to go into hospital to give birth when she did not wish to, but there were no contingency plans to minimise the impact of unplanned absence on the service, and this issue was not documented on the risk register.

Patients' feedback and complaints

Women's experiences of care were used to improve the service through patient surveys, complaints and comments. For example, staff on Fern Ward told us about changes to triage arrangements to improve waiting times for assessments. Staff in the Bracken Birthing Centre told us the hospital purchased 10 wireless cardiotocography (CTG) machines (used to monitor fetal heartbeat) so women using the birthing pool would not have to leave the pool to be monitored.

Accessible information

Information leaflets about various topics, including tests and screening, breastfeeding, and other sources of support, and how to make a complaint were available in clinical areas. Information could be produced in different formats or languages but this would result in a delay. All literature, however, was only in English. Staff told us they were able to use telephone interpreters when women were not fluent in English but they did not often contact them. We observed that people from Polish and Portuguese communities were using hospital services and did not have a translator. Access to an interpreting service is important to ensure women understand the results of diagnostic tests and scans. A trust-commissioned report, published in July 2013, found that staff used women's family members as interpreters. It recommended the use of formal interpreters instead.

Are maternity and family planning services well-led?

Leadership

The maternity unit had a new Clinical Director and leadership structures were still under development. The Clinical Director for Women and Children's Directorate had been in post for three weeks and the Head of Midwifery had been in post on secondment for six months. There was a clinical lead for obstetrics and gynaecology and two risk leads. Senior managers told us that a strategy was not yet in place to determine the direction and future development of the maternity unit.

Service culture and development

Clinical and managerial staff at all levels of the maternity service described a dysfunctional culture in the maternity unit. Staff talked to us about a "disconnect" between the trust and the Maternity unit and between the manager and

Maternity and family planning

clinical staff in the directorate. They attributed the tensions to what they felt was the uncooperative behaviour of the consultant staff who did not work well together and were also difficult to access for advice. The trust had invested in a number of external reviews and service improvements to focus on culture. However, staff expressed frustration that problems had existed for a number of years but had not been resolved. The trust management indicated that the Clinical Director was beginning to address the conflict.

Staff indicated the dysfunctional culture in the unit had “stunted” service development and improvement but did not currently affect clinical outcomes for women in obstetrics. Performance indicators supported this view but there has been no review of the culture to ensure the unit could continue to provide safe, high-quality care in the future.

We also received information of concern about a variation in clinical practice standards in obstetrics and gynaecology. We have therefore asked the trust to undertake an independent review of the consultant clinical practice in this directorate.

Managing quality and performance

The service monitored the quality and safety of care and action was taken in response to identified concerns. This included reporting on performance indicators through the maternity dashboard and monitoring of incidents, complaints and patient feedback. Concerns were monitored at both board and directorate level and action was taken to address these and lessons learned. The risk register for the maternity service was not always up to date. We found instances where the ‘dates for action’ had passed without a review of progress or resolution. The risk register did not identify concerns in the unit such as the capacity issues, delays in anaesthetic cover and the need for contingency plans to support the home births service.

Intensive/critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The critical care service at Musgrove Park Hospital has 12 beds in the Critical Care unit. There are six intensive therapy unit (ITU) beds delivering care to patients of all ages with serious life-threatening illness, and six high dependency unit (HDU) beds, for patients who are too ill to be cared for on a general ward. A critical care outreach team assists in the management of critically ill patients on wards across the hospital.

We talked to two patients, one relative and eight staff including nurses, doctors, consultants and senior managers. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patients received safe, effective and responsive critical care services. There were enough specialist staff to meet people's needs and ensure that they had appropriate 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate. The Critical Care service performs better than most other similar units across the country.

However, there were sometimes inappropriate referrals of patients to critical care out of hours because senior doctors were not available to make the decision that a patient was too ill to benefit from clinical intervention. Once patients were better, staff needed to improve the coordination of their care with the general wards. The department was cramped, with a lack of storage facilities, and there was a water leak in the ceiling. Some equipment was not maintained appropriately and was not always available.

Intensive/critical care

Are intensive/critical services safe?

Patient safety

The service was focused on safety. Staff reported incidents and received feedback. A senior nurse confirmed that incidents were analysed and appropriate specialists recommended improvements. For example, information on pressure ulcers was routinely analysed to make prevention and treatment more effective. Trends in facial pressure points because of oxygen mask straps were identified and staff were working with the tissue viability nurses (who work on wound management and preservation of skin tissue) to address the problem.

Most patients who became critically ill while in hospital received immediate treatment. Ward staff confirmed that the patients at risk of deteriorating were identified and assessed using the Patient at Risk (PAR) early warning score, which triggers contacting the on-call outreach nurse for advice and attention if needed.

Hospital infections and hygiene

Patients were cared for in a clean environment with clean equipment. We saw that the ITU was visibly clean. There were cleaners on the ward throughout the day and patients told us the ITU ward was always clean.

Patients were protected against the risk of infection. Hand hygiene gel was available at the entrance and exit of the units. Staff wore gloves and aprons and washed their hands before leaving the units and between seeing patients. Pedal bins were available for waste disposal. One patient told us, "There are basins everywhere and signs telling you to wash your hands. The nurses never leave my room without washing their hands."

Critical Care outreach team

We received a mixed response from staff on other wards regarding the responsiveness of the outreach team. Most said the outreach team responded promptly to requests for telephone support and attended wards when requested. However, some said there could be delays. The outreach nurses confirmed that assessment was sometimes delayed when patients moved wards after a referral with time spent searching for patients. The trust was implementing a new information system by November 2013 to improve the information received by the outreach team.

A General Medical Council (GMC) survey in 2013 identified a patient safety concern. Patients in the Trauma and Orthopaedics department needed to be escalated more promptly to the critical care team. Action was being taken by the trust to ensure this.

Staffing

There were enough appropriately trained staff to meet patients' specialist needs. The critical care unit only recruited nurses with a minimum of six months acute nursing experience and patients were allocated nurses in line with their assessed needs.

Patients had either one-to-one nursing, or one nurse to two patients. If these ratios could not be maintained then the unit had a policy to bring in staff from other wards to ensure that emergency patients could be admitted. The unit did not admit any more patients if a safe level of nursing care could not be assured. Patients told us that the ITU ward ran well. One patient said, "Everyone knows what they are doing." Another said, "Staff seem confident. They all know how to use the equipment. There was an emergency case last night but everyone just worked together and carried on as usual".

Medical equipment

Equipment was not maintained appropriately and was not always available. Incident records showed there had been two equipment failures on the unit in the past month. Some of the equipment used was not serviced on time and, if it failed, a replacement was not always available. One patient told us their monitor did not work and had to be replaced. Spare equipment was available in the unit's equipment store. There were some portable ventilators, but on the days of our announced inspection, there was a shortage of tubing stock which meant that these could not be used. Older models would only be adequate for 12 to 24 hours. Consequently, there was a risk that patients may not have the life-sustaining equipment available to them when needed. Regulation 16 (1) (a) and 16 (2).

The environment

The environment in ITU did not ensure the safety of patients. For example, the ITU was cramped. There was a lack of storage facilities which meant furniture was stored in corridors, creating a trip hazard. Staff confirmed that there was insufficient space to store the new patient transit

Intensive/critical care

trolley which needed to be easily accessible. There were also problems with water leaks through the ceiling. A building assessment was currently being undertaken and work was planned to maintain a safe building.

Are intensive/critical services effective? (for example, treatment is effective)

Clinical management and guidelines

Patients received care and treatment according to national guidelines and this was monitored. An effective critical care service ensures prompt, appropriate admissions. Units had clear criteria for patient selection and senior staff said the system was effective. The unit was reviewing if admissions and surgery were prompt and appropriate.

A senior nurse told us there are sometimes inappropriate referrals out of hours because senior doctors were not available to make the difficult decision that a patient is too ill to benefit from clinical intervention. The service has just started to analyse information to see how patient assessment and referral could be improved.

Patient mortality

The critical care service performs better than other similar hospitals. A national independent survey by the Intensive Care National Audit & Research Centre (ICNARC) highlighted the good work carried out by the intensive care unit. ICNARC has released comparative figures showing that the Musgrove Park Hospital unit was busier than most similar units across the country. Fewer people died in ITU than would have been expected given the area, age and health of the population the hospital serves. Recently introduced monthly mortality meetings with a consultant took place to monitor and understand why people might die on the ward so improvements could be made.

Communication

Staff communication needs to improve when critically ill patients recover. The outreach team are responsible for ensuring that recovered patients are effectively managed by ward staff. Outreach nurses told us they could not always hand patient information on because ward rounds for different teams took place at the same time. The critical care directorate manager told us they were introducing electronic data collection to analyse activity across the wards to help improve clinical outcomes for patients.

Staff skills

Staff had appropriate training to provide effective care and confirmed that training and skills development opportunities were available. The outreach nurses also worked for four weeks on the ITU every year to update their knowledge and practical skills. The trust training plan was similar to national guidance for training and mentorship but was under review to ensure compliance.

Treatment research

The service's research ensured that the trust remained involved in the development of new treatments to improve clinical outcomes for patients. The unit's small research team coordinated research studies and shared learning with the service. The service was currently involved in several projects – for example, examining the effects of new drugs on reducing death and disability in patients with traumatic brain injury.

Are intensive/critical services caring?

Patient feedback

Patients told us they were treated with care, consideration and compassion. One patient said, "I was getting a bit anxious with the oxygen mask on. The nurse noticed it, took it off and spoke with me for a bit to reassure me that it was all fine. But the way he did it really touched me. He wiped my face and was kind and tender. It made me feel very reassured." A relative told us that she was "happy with the way staff were treating her son". We observed staff treating patients in a kind, calm and friendly manner.

Patients' privacy and rights

Patients were treated with dignity and respect. We observed that staff greeted patients every time they entered a room. They engaged with patients to make sure they were comfortable. Bed curtains were drawn to ensure patients had privacy. Nursing staff explained procedures to patients and reassured them. One patient told us, "They never do anything without telling you why, every time."

Staff respected people's rights to make choices about their care. Patients told us that they were kept informed about their treatment and that doctors provided them with updates during ward rounds. One Polish patient told us that, although they understood English, the doctor had

Intensive/critical care

helpfully used pictures and the monitor screen to ensure that they understood their treatment. Another patient did not have their glasses with them so staff read the GP transfer letter for them.

Relatives were involved in patients' care. The ITU had a room where families could relax and have some refreshments. Relatives told us the facilities were good. One patient told us his parents and wife were there when the doctor explained his treatment. He said, "We were squashed into this small room and I was expecting him to ask if someone could leave but he didn't and answered everyone's questions in detail."

Food and drink

Patients received adequate nutrition and hydration in the ITU. Food trolleys on each ward meant that food could be served warm. Staff told us that meal times were flexible. Records were kept of the amount of fluids patients drank to ensure that they remained hydrated. Patients told us the food was good and choice was offered. One said, "I wasn't very hungry. I just felt like some biscuits, so they got me some".

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Patients' feedback and complaints

Patients told us staff were responsive to their needs. One person said, "When I came back from my surgery they asked me if I was hungry because I had not eaten the night before". Another patient confirmed that pain medication was given in a timely manner.

Patients' experiences and complaints were used to improve the service. The ITU and HDU wards could not always gain feedback from patients when they were critically ill but held a relatives' meeting to gain families' feedback. One staff member told us that one of the concerns relatives raised was the sudden loss of support when people recovered. In response, they had informed relatives of the different levels of support provided at each stage of the patient's recovery. This meant relatives could prepare for changes. A recent complaint had highlighted the need to have detailed records of all conversations held with relatives about a patient's treatment. The ward was improving the recording of all discussions.

Patients' welfare

Patients' welfare was regularly monitored to ensure that changes were responded to in a timely manner. There were sufficient senior doctors at night to ensure that patients' health did not deteriorate out of hours. We saw that patients were checked by a nurse every hour, more often if required. Patients told us, "They check on you the whole time" and "If you call them, they are right there". Patients said senior doctors saw them every day and monitored their condition. One said, "My anaesthetist came to see me as well as my doctor. When I was transferred to the unit my doctor came down with me to ensure that he handed me over to the nurses." The unit had 24-hour cover by specialty junior doctors. The senior nurse told us, "We have no problem getting a doctor to the ward at night. The consultant will come in at a drop of a hat to attend to patients if we have concerns".

The unit responded to changes required to keep people safe. When current trolleys were identified as having insufficient space to attach and transport patients' equipment safely, new trolleys were purchased.

Patients' consent

Where patients could not fully understand or be involved in decisions about their care, the unit ensured that treatment decisions were made in their best interest, and their relatives and support network were involved. Records showed that consent for a person with learning disabilities on the ward had been obtained appropriately. The patient's carer remained involved and engaged in their day-to-day care.

Accessible information

Patients were given comprehensive information on how to manage their condition or respond to concerns. One patient said, "The doctor and nurse spent a long time talking to me to explain what I need to do to recover ... as well as what to do if I had any concerns." General information leaflets on the wards were, however, only available in English and information in other formats or languages had to be requested.

Are intensive/critical services well-led?

Leadership

The critical care unit was well-led. Senior managers and clinicians had a good understanding of the performance of their department and staff were a strong and cohesive

Intensive/critical care

team. All staff were involved in monitoring quality of the units and there was a willingness to respond to change. Monthly meetings demonstrated that staff openly discussed concerns about the service and clinical care, and discussed how the service could improve.

Managing quality and performance

The service monitored the safety and quality of care and action was taken to address identified concerns.

Performance monitoring meetings were held every month and action was taken. Concerns raised by staff were on the risk register and the suitability of the building and equipment was monitored through action plans. These actions did not have a completion date, which made it difficult to judge what progress had been made or what interim measures had been taken to patient safety.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Surgery at Musgrove Park Hospital consists of seven surgical wards (112 beds) and 15 theatres. The hospital has bariatric, colorectal, head and neck, interventional cardiology, orthopaedic, thyroid and endocrine urology, gynaecology, vascular and general surgical specialties.

We talked to nine patients and 19 staff, including nurses, doctors, consultants, senior managers, therapists and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patients received safe surgical care. There were good safety checks for patients having surgery and infection rates were low. Patients with hip fractures generally have surgery quickly. However, there were not always enough senior doctors present at night and at weekends, and clinical staff told that patients' health could deteriorate while they were waiting to see a doctor, and patients often stayed in hospital when they were fit to return home. Some staff did not have appropriate training to meet people's specialist needs, for example, physiotherapists to meet the needs of people who had undergone hip surgery. Staff told us that at busy times it was difficult to always meet people's care needs, particularly older people and people with dementia.

The theatre and wards in the older part of the hospital needed to be better maintained and some of the wards were cramped, with equipment stored in corridors. Patient records were not well-maintained, and it was difficult to follow the treatment path of patients who had moved wards several times.

The hospital was not meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing planned spinal, colorectal, bariatric, ophthalmic and ear, nose and throat surgery. It was working to address this.

Surgery

Are surgery services safe?

Patient safety

The service was focused on safety. Staff reported incidents as normal theatre practice. Incidents were analysed and appropriate specialists made recommendations for improvements. (For example, we saw that the department's pressure ulcer steering group and the matron monitored all pressure sores. The causes had been analysed and a process agreed to manage the risk of skin damage.)

Patients were protected from avoidable harm during surgery. We observed a theatre team undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The nine theatre staff completed safety checks before, during and after surgery. When several changes were made to the patient list, we saw that the written and computerised lists did not correspond. These changes increased the risk of potential mistakes but there was a thorough safety briefing that ensured all staff were informed of the final surgical list.

The trust had worked with another hospital to share learning and improve its understanding of surgical safety procedures. The use of the WHO surgical safety checklist had improved in all theatres and this was monitored and discussed at weekly safety meetings.

Managing risks

The trust had learned from mistakes. The hospital had a serious patient safety incident in June 2013 called a Never Event. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. This event resulted in the removal of the wrong tooth during a patient's surgery. The dental surgeon and theatre lead told us that safety checking procedures had changed and dental surgery was now safer, with photographs and other marking methods being trialled.

Risks to patients identified by the NHS Safety Thermometer were being managed. Records showed that national safety guidance was followed on the prevention and management of pressure sores, blood clots, falls and catheter urinary tract infections on the surgical wards. Staff reported skin concerns on admission, reducing the risk of patients developing pressure sores. Each ward had a nurse

who acted as a champion to prevent falls, pressure sores and blood clots. They supported the staff to implement the guidance consistently. Pressure sores at grade 2 or higher and falls resulting in harm were investigated by the matron.

The hospital also monitored its hip surgery performance on a monthly basis and had recommended that all hip fracture patients should have a bed with pressure mattress on admission to prevent the development of pressure sores.

Hospital infections and hygiene

Patients were protected from the risk of infection. The trust infection control rates for *Clostridium difficile* (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) were much lower than expected. Patients and visitors were provided with information on how to prevent infections and there was hand hygiene gel in all ward areas for patients, staff and visitors to use. Staff wore gloves and washed their hands between seeing patients. Patients with spreadable infections were treated in side rooms.

Patients were cared for in a clean environment. Patients told us that the ward was clean and we observed cleaners using a detailed cleaning list and recording tasks as they were completed.

Staffing

There were concerns that there were not enough senior doctors present at nights and weekends. Patients were regularly monitored and any changes in their condition responded to in a timely manner but there were delays in seeing a doctor in the evenings and weekends. We observed senior doctors and specialist nurses completing daily ward rounds. Patients were checked every two hours by a nurse and records showed that changes, for example, pain levels, were responded to quickly. However, clinical staff told us there could be long delays seeing a doctor at nights and weekends as there were not always sufficient senior doctors on call out of hours. Staff told us that patients' health could deteriorate while waiting for a doctor, and some patients often stayed in hospital when they were fit to return home.

Patient records

Patient records were not well maintained. We observed on one surgical ward that patient records were loose and could easily be misplaced. Temporary emergency files were used for long periods and did not follow a consistent format. It was difficult to follow the treatment path of patients who had moved wards several times. This meant

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that each patient's full medical and treatment history were not readily available to inform decisions. We found inconsistencies in the recording of patients' resuscitation decisions. Patients' resuscitation wishes were not always clearly recorded or easily accessible. It was not always recorded how, or if a decision had been reached. This put patients at risk of inappropriate and unsafe care. Regulation 20 (1) (a).

Buildings and environments

The theatres' in the older part of the hospital needed to be better maintained for patient safety. The older theatre areas were run-down and staff told us that the roof leaked when it rained. Some of the wards were cramped as they lacked storage facilities which meant equipment was stored in corridors, creating a trip hazard. Staff confirmed that elderly patients should be encouraged to walk independently to aid their recovery, but they were always supported to walk because there was not enough space on the ward. They also told us that striped flooring in one of the orthopaedic wards did disorientate elderly patients and those with dementia. The ward sister told us the patients think the strips are steps so they take big steps and then become unsteady on their feet. The trust was awarded £150,000 from the national Dementia Challenge Fund to make improvements. Improvement plans for the older theatres were under development and the trust was completing the new Jubilee Building to provide new surgical wards, scheduled for March 2014.

Are surgery services effective? (for example, treatment is effective)

Clinical management and guidelines

Patients with hip fractures had surgery quickly but their recovery was delayed at the weekends. The hospital meets the national guidance for hip fracture surgery to be performed within two days from admission. This increases the chances of patients making a full recovery. The directorate manager confirmed that the hospital consistently met this guideline for 80% of patients (above the national average of 74%). Some patients having hip surgery had a delayed recovery plan. Patients recovering from hip surgery were not always supported by a physiotherapist to get up within 18 hours of their surgery. Ward sisters told us that physiotherapists were not always available, especially over weekends.

Patients received care according to national guidelines, although these were not consistently applied. There was participation in national audits such as the National Bowel Cancer Audit. The trust had taken some actions to improve the service where indicators were lower than the national average, for example, they had improved their recording to demonstrate that patients were managed by a multidisciplinary team and saw a clinical nurse specialist. There was a clinical lead to ensure the implementation and monitoring of guidelines. Clinical audit plans included monitoring of National Institute for Health and Care Excellence (NICE) and other professional guidelines.

Staffing skills

There were not enough appropriately trained staff to meet patients' specialist needs. One ward sister, for example, was concerned that not enough staff had spinal training to undertake a neck hold safely. Another told us that, at times, there were only one or two qualified nurses available to administer intravenous medication. Many patients on the surgical wards required intravenous antibiotics and the ward was managing this risk by planning shifts around the availability of trained nurses. At busy times, however, this meant that staff were stretched. In the evening we saw that it was sometimes necessary for experienced surgery nurses to move to medical wards to support emergencies. This further reduced the amount of experienced staff available. There were not enough physiotherapists to safely meet the needs of patients who had undergone hip surgery. Instead, ward sisters told us, patients were helped to walk by nurses who did not have the specialist training to do this safely. The trust was developing an enhanced recovery programme with physiotherapists, including suitable nurse training. Staff did not always have appropriate training. Regulation 23 (1)(a).

Are surgery services caring?

Patient feedback

Patients were treated with dignity and respect. We observed staff speaking with patients in a kind, calm, friendly and patient manner. The patients we talked to were complimentary about the staffs' attitude and engagement. Comments included: staff were "caring, very attentive, brilliant," and "They had a great attitude, very compassionate and always took the time to have a little chat".

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Patient treatment

Patients' emotional needs were not always met because there was not enough staff. Some staff told us that they did not always have the time to reassure and comfort patients. One staff member told us, "Patients with dementia are often scared and distressed on the ward. We all feel that we do not have the time to sit with them and reassure them in a kind manner that everything is OK." Another said, "We meet people's physical and clinical needs but I do not always feel that we get the time to be compassionate."

Patients' privacy and rights

Patients' privacy and dignity were maintained. We observed patients being cared for at bath time and saw that patients' bed curtains were drawn and staff were talking to patients in private.

Staff respected people's right to make choices about their care. Patients said they were kept informed about their treatment. Staff provided patients with information, doctors provided updates during ward rounds and we observed a specialist spinal nurse speaking to patients to explain their recovery plan and answer questions in detail.

Food and drink

Patients had adequate nutrition and hydration but some patients did not receive appropriate help to eat and drink. Staff told us, and we saw evidence on ward nutritional performance assessments, that there was not always enough staff to ensure that patients with dementia were supported to eat with sensitivity and respect for their ability.

Meal times were generally flexible and food trolleys on each ward meant that food could be served warm. Most patients thought the food was good. One patient with diabetes told us that they were not always appropriately supported to ensure their nutritional needs were met.

Are surgery services responsive to people's needs?
(for example, to feedback?)

Patients' feedback and complaints

Patients' experiences and complaints were used to improve the service and the effectiveness of treatment. For example, a complaint about a delayed diagnosis identified

the importance of a daily senior doctor review for surgical patients. This resulted in a review of working practices with surgical teams, with senior doctors completing ward rounds more often.

Emergency medical patients

The hospital was responding to the increased demand for emergency treatment and emergency medical patients were transferred to surgical wards. This did not always happen in a planned or coordinated manner and patients did not always have an appropriate allocated member of staff. Also, staff on the surgical ward did not always have the specialist skills to support patients' medical needs and nurses told us they had difficulty locating medical teams to review the medical patients. Some patients and relatives who had contacted us identified similar concerns. Theatre time and beds were appropriately prioritised for emergency patients but this meant that planned surgery was sometimes cancelled.

Discharge of patients

Some patients, particularly those with complex needs, were not discharged on time. Nursing staff reported real difficulty locating or requesting medical teams to review medical outliers on their ward. They report several patients who are fit for discharge but who are unable to be transferred because of inadequate social services availability out of hours and at weekends. This meant that patients were at risk of developing hospital infections and their recovery could be delayed. This also limited the availability of surgical beds.

Waiting times

Some patients were waiting longer for elective surgery. The hospital was not meeting the national waiting time of 18 weeks from referral to treatment for patients undergoing planned spinal, colorectal, bariatric (weight loss), ophthalmic and ear, nose and throat (ENT) surgery. The directorate manager told us the trust was taking action to improve waiting times. A project group was working on improving access to surgery and the efficient use of theatres. Action taken included working innovatively with other hospitals to increase response to spinal trauma surgery. The trust was clear that patients would have surgery on the basis of clinical need, so that the most urgent patients were seen first. This meant that they may

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fail on targets for waiting times this year. Records showed the hospital had written to patients whose surgery was cancelled as a result of increased emergency activity to keep them informed.

Patient records and end of life decisions

Some 'do not attempt resuscitation' (DNAR) forms were not always fully completed and many were not signed to indicate if the decision had been discussed with the patient or their family. There was not an accurate record. Regulation 20 (1) (a).

Accessible information

Information was readily available in ward areas but only in English. Information could be produced in different formats or languages but would mean delays for people receiving information if English was not their first language.

Are surgery services well-led?

Leadership

Services in surgery were well-led. Senior managers and lead clinicians had a good understanding of the performance of their department. All staff were held accountable for maintaining the quality of the department and there was a willingness to respond to change and ensure safety procedures were consistent. The trust was working with clinicians to ensure that teams worked well

together and there was shared responsibility to implement change. There was a lack of cohesiveness in some surgical teams but transparency over performance and behavioural issues was in evidence. Individual performances that fell under the acceptable level was addressed and staff held accountable for raising concerns about colleagues (something not previously done in a timely manner).

Managing quality and performance

Safety and quality of care was monitored and action taken in response to concerns. Ward sisters, for example, monitored their performance against department standards. Staff were informed of the outcome of quality monitoring to improve performance. For example, monitoring staff compliance with hand washing and the impact of inexperienced junior nurses on the safe delivery of care. Performance monitoring meetings were held every month in each department, and information was available on safety, mortality and morbidity, and how Surgery was meeting standards and service development. Concerns raised on the wards – such as the shortage of physiotherapists, delayed planned surgery, the state of the theatre building, and improving care for dementia patients – were on the risk register, with monitored action plans in place. Some actions did not always state the date for completion, making it difficult to judge whether these were completed within agreed timescales.

Good practice and areas for improvement

Introduction

Musgrove Park Hospital is providing patients with safe and effective care but the hospital is dealing with a high number of patients requiring care and treatment. The quality of care and the effectiveness of treatment was affected at busy times and some patients were waiting longer for surgery and outpatient appointments. The majority of patients said that the staff were caring and kind. Some people, and their complaints, identified areas where treatment, the attitude of some staff and communication needed to improve. The trust had areas of outstanding practice, including its staff and the support they received, the speed of treatment given to heart patients, and the care given to patients with cancer and children with life-limiting illnesses.

Areas of good practice

- All the patients we talked to in the hospital told us that staff were caring, helpful and compassionate and that they were treated with dignity and respect
- There was good multi-disciplinary coordinated care in children's day surgery and neonatal care and for patients who had had a stroke
- Sedgemoor Ward has been specially designed to enhance the hospital experience for older people, and especially for people who have dementia.
- The Beacon Centre for cancer care has won a number of awards for providing high quality patientcentred care. These include the Customer Service Excellence Award, the Insight for Better Healthcare International Award and the Macmillan Quality Environmental Mark.
- COMPASS is a specialist multi-disciplinary team that supports families as they cope with the emotional and physical effects of living with a child with a serious, life-limiting illness. The team consists of paediatricians, community children's nurses, clinical psychologists, a play specialist and an administrator. Additional support is given to children and their families to include end of life care and bereavement.
- The trust holds monthly one-hour sessions for all staff (called Schwartz rounds) to look at emotional and social

dilemmas that arise when caring for patients. This is accredited support that gives staff the space to reflect on the challenges of providing care to patients and their families, and to learn from other experiences. They have been shown to improve outcomes for patients.

- A national survey by the Intensive Care National Audit & Research Centre (ICNARC) highlighted the good work carried out by the intensive care unit. ICNARC has released figures comparative figures which demonstrate that fewer people died in ITU when compared to other hospitals.
- The trust showed that it has one of the best call to treatment times in the country for appropriate emergency intervention following a heart attack.

Areas in need of improvement

Action the hospital **MUST** take to improve

- Ensure there are sufficient senior doctors present at night and at the weekend.
- Reduce the number of patients transferred to the wrong specialist ward and improve patient discharge to alleviate service pressures.
- Ensure that staff have appropriate training to deliver care and treatment safely and to an appropriate standard.
- Ensure that patient records are appropriately maintained and available, including Do Not Attempt Resuscitation forms.
- Ensure that equipment is appropriately maintained and is available for use.
- Improve leadership of the maternity unit.

Action the hospital **COULD** take to improve

- Improve the quality of medical handovers, particularly at weekends.
- Improve the environment in theatres, ITU and ward areas.
- Provide information that is readily accessible for people that do not speak English as a first language.
- Review staffing at busy times to ensure patients' care needs are always met.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Patient records were not well maintained on surgical wards. Records were loose and temporary files were in use for long periods of time. The care plan for a patient who had moved between wards was difficult to follow.</p> <p>‘Do not attempt resuscitation’ (DNAR) forms were not always fully completed. It was not always recorded how, or if a decision had been reached, and some forms were not signed to indicate if the decision had been discussed with the patient or their family.</p> <p>How the regulation was not being met: People who used services were not protected against the risks of unsafe and inappropriate care and treatment by the maintenance of an accurate record. This is a breach of Regulation 20 (1) (a).</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Equipment was not maintained appropriately and it was not always available. There was risk that patients requiring life-sustaining equipment may not have the appropriate equipment available to them. Equipment in the maternity unit was not fit for purpose: The call bell system did not work on the postnatal ward and ventilation needed to improve to decrease level of gas from the use of gas and air equipment on the labour ward.</p> <p>How the regulation was not being met: There should be suitable arrangements to protect people from the risk of unsafe equipment. Equipment should be properly maintained and suitable for its purpose; equipment should be available in sufficient quantities. Regulation 16 (1) (a) and (2).</p>

Compliance actions

Regulated activity

Treatment of disease, disorder or injury

Regulation

There were a only few areas of mandatory training that were worse than expected compared to other trusts, for example, in health and safety and equality and diversity.

Staff told us, however, that they did not always have appropriate specialist training on time. Staff in A&E did not have appropriate paediatric training or training to prescribe paracetamol under a patient group directive. Some nursing staff that had been with the department for a long time stated that a lot of their A&E specific courses and education such as advanced life support (ALS), paediatric life support or trauma care courses had expired some years ago and they had not been supported to revalidate.

Nursing staff in surgery did not have training to deliver intravenous drugs or appropriate spinal treatment. Junior doctors told us that induction and department training varied, for example, some were shown round their departments and received basic life support training but others did not. Junior doctors reported that they had not had IT training to use the new computer system, and this had increased the amount of their time spent on administration. The trust acknowledged that access to training should be more flexible to respond more quickly to service changes and staff needs.

How the regulation was not being met: There should be suitable arrangements to ensure that persons employed area appropriately supported to enable them to deliver care and treatment safely and to an appropriate standard, including by receiving appropriate training. Regulation 23 (1) (a).