Great Western Hospitals NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Great Western Hospitals NHS Foundation Trust consists of one acute hospital (Great Western Hospital) and four community hospitals, of which three provide inpatient services. There are a total of 450 acute beds (including 12 critical care beds and 38 maternity beds) at the Great Western Hospital. Chippenham hospital as 37 beds spread over two wards, one ward of 25 beds at Warminster hospital and one ward of 26 beds at Savernake hospital. The trust provides acute and community healthcare services to a population of around 480,000 people from Wiltshire and the surrounding areas.

Overall, Great Western Hospitals NHS Foundation Trust was rated as requiring improvement. We rated it as good for caring and as requiring improvements in safety, effectiveness, being responsive to patients' needs and being well-led. Maternity and Gynaecology services and End of Life care were rated as good overall with all other core services rated as requiring improvement. We rated safety within the Urgent and Emergency care services as inadequate. Within the community services, we rated services to children and young people as outstanding. All other community service was judged as good.

Our key findings were as follows:

- The trust was open and generally had a good culture for incident reporting. Safeguarding processes and practices were good.
- There was information available for patients and visitors on how to make a complaint. Clear processes were in place for the management of complaints and concerns. Investigations occurred, and lessons were shared.
- Patients were treated with compassion, kindness, dignity and respect. Staff within the Children and Young Peoples community teams were focused on the needs of the children and young people, putting them at the heart of everything they did. Care was delivered with empathy and honesty.
- There were concerns with staffing and how this impacted upon patient safety. Within the Emergency Department the design and layout meant that waiting patients, including children, were not adequately observed. The physical isolation of the observation unit and lack of environmental safeguards, posed unacceptable risks to patient and staff safety. Staffing levels did not always meet patient need. Staffing levels in the Emergency department (ED) did not take into account the requirement to care for patients who queued in the corridor or the sub-waiting room. There were also concerns about the level of staffing within the children's ED and the ED observation unit. The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not achieved 100% of the time.
- Some accommodation in the ED and minor injury units (MIUs) was cramped and not conducive to the exchange of private conversations or the protection of patients' privacy and dignity.
- Compliance with level three safeguarding training within the maternity and gynaecology services was significantly below the trust standard.
- Not all staff were consistently adhering to good hand hygiene practices or using protective personal clothing.
- There was good multidisciplinary working to promote quality care. Patient outcomes, mortality and morbidity were generally monitored though action plans to address shortfalls were frequently incomplete so progress could not be assured.
- Whilst practice in some areas was good, consent to care was not consistently obtained in line with legislation and guidance including the Mental Health Act. Deprivation of Liberty Safeguards were not monitored and had expired without staff being aware.
- The ED was not consistently meeting the national standard for 95% of patients to be discharged, admitted or transferred within four hours of arrival at A&E or for consultant-led referral to treatment time (RTT) targets in five of the six surgical specialties. Bed occupancy rates were higher than the England average. Both the acute and community hospitals faced a high number of patients who were fit for discharge, but without transfer of care packages.
- Whilst not designed for that purpose, the day surgery unit (DSU) was frequently used to accommodate patients overnight.

Summary of findings

- As a result of the second class post imposed due to financial pressures some patients missed appointments whilst others did not receive MRSA washes or preparations for endoscopy procedures in time.
- At the time of the inspection, the trust was in breach of its licence from Monitor following a significant departure from the financial plan in late 2014 resulting in a deficit of £9 million against a planned surplus of £1million. The consequent actions, including independent reviews of governance arrangements, identified significant shortfalls that are in the process of being addressed. Governance processes within some divisions was found to be weak.
- The trust were committed to maintaining the quality of care whist also striving to manage demands for services and the flow of patients into, through and out of hospital. At the time of the inspection the necessary improvements had not been made and sustained.
- The trust was open about the issues faced and took feedback well. The significant scrutiny from regulators and commissioners was adding to the challenges for the leadership team.

We saw several areas of outstanding practice including:

- The diagnostic imaging team had some areas of outstanding practice, one of which, the palliative ascites drainage, was highly commended by the British Medical Journal (BMJ) in 2015. Innovative practice was seen with the introduction of the intra operative breast radiotherapy project.
- In the critical care unit we were given examples of staff 'going the extra mile' for their patients, including a patient attending a family wedding in London, with transport being arranged by the unit and staff escorting the patient for the day.
- The consultants provided specialist pre and post pregnancy counselling and support service to women. This and other specialist clinics developed to manage high risk pregnancies had been recognised as best practice. The lead consultant had won an All-Party Parliamentary Group Maternity Services Award during 2011. This service style had since been adopted by other Maternity Services across the country and show-cased at Harvard, USA.
- The midwives successful audit and interdepartmental training to prevent cerebral palsy in pre- term babies born at the hospital
- Children were treated with respect and their ability to give consent for their own treatment was taken seriously.
- The multi-disciplinary working within the community. For example the neurology community team worked with a patient, their carers, social services, housing authorities and other clinicians including the palliative care team to arrange the adaptation of accommodation for a patient with motor neurone disease.
- The wheelchair service who committed to providing wheelchairs for patients diagnosed with motor neurone disease within two weeks by prioritising the adaptations that were required to be completed. They also provided a priority service for patients who were receiving end of life care.
- The community respiratory team, how they worked with others, lead training initiatives for GPs and physiotherapists and held brief informal training updates to nursing teams during their lunchbreaks. There were weekly teleconferences and meetings every six weeks between colleagues to discuss the latest guidance. The lead nurse also chaired quarterly meetings of a respiratory network of health professionals who worked in respiratory services.
- The tissue viability team led by a nurse consultant demonstrated an outstanding level of evidence-based practice and innovation in the management of pressure ulcer care. Regular, quarterly pressure ulcer audits contributed to a quality improvement collaborative for pressure ulcers work plan and the organisational action plan for pressure ulcer reduction. An estimated £40,000 a year was expected to be saved due to the reduction in the length and frequency of nursing visits, with time saved to be used to visit more patients. Great Western Hospital is the first provider nationally to roll out the use of these systems.
- Specially trained health visitors and school nurses took part in an on-call unexpected child death rapid response team. When a child or young person who lived in Wiltshire died unexpectedly, the police would be contacted alongside the rapid response team. Whilst the police would investigate the circumstances surrounding the death, the staff within the rapid

Summary of findings

response team were responsible for providing emotional support to the parents. By using health visitors and school nurses that had been specially trained, it utilised their skills at communicating with parents to support them at the worst moment in their lives.

- The children and young people's community teams had excellent multi-disciplinary and multi-agency working. This extended across the local communities they served, health and social care as well as the ministry of defence to support children of military families.
- The leadership across the children and young people's community team was very visible and staff were full of praise for their immediate team leaders and wider management team within the community. They felt supported and valued by their team leaders and managers.
- The looked after children team had produced a health passport for all their children and young people. This contained full details of each individual child's health and medical history. Details of appointments, immunisations were also included. Young people were able to take these passports with them once they left the care of the local authority to help them make a good start in their adult lives.
- The children and young people speech and language therapy team (SALT) were linked directly to local schools. This was to make sure children and young people received more intensive support and received early intervention when necessary.
- The Governance Database developed and used by the Integrated Community Health Division (ICHD) was a spreadsheet used by staff to record audit information and outcomes, serious incidents and investigations that took place and training records. There was also information about staffing levels, complaints and safeguarding issues. Staff at all levels were aware of and used the database regularly.
- The division had recently developed a four day community induction programme. Once staff had completed the GWH trust induction they were expected to undertake the community induction. This applied to new staff, staff who had a new role within the trust and staff employed in the last year that had not had a chance when they started to attend the specific community induction. The programme was very detailed and staff told us they had really appreciated the induction as it gave them an insight into the services offered and lone working, fire safety and medical cover for example.
- Two consultants provided bespoke training on some of the community hospital wards. This was well received and attended by staff. They felt this enhanced the feeling of working in partnership to ensure the best care and support is provided for the patients.
- The community services participated in 'IWantGreatCare', this was a continuous, real-time collection, monitoring and analysing quantitative and qualitative patient and relative feedback and could act as an early warning system.
- People's individual needs and preferences were central to the planning and delivery of services. The service was flexible, provided choice and ensured continuity of care in the wider community. The involvement of other organisations and the local community was seen to be integral to how patient care was planned and ensured the service met people's needs.
- End of life care had become part of the induction and mandatory training programme, these programmes of learning had been devised by the palliative consultant and end of life nurse.

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

Importantly, the trust must:

- Ensure staff receive up to date safeguarding, mandatory training appraisals and training on the Mental Capacity Act.
- Improve governance processes to demonstrate continuous learning, improvements and changes to practice as well as board oversight and assurance.
- Ensure there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.
- Ensure effective infection prevention and control measures are complied with by all staff.
- Ensure safe storage of medicines, including intravenous fluids.
- Improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards and reduce occupancy to recommended levels.

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- Review nurse staffing levels and skill mix in the emergency department (ED), including children's ED, the ED observation unit and minor injury units, using a recognised staff acuity tool.
- Take steps to ensure there are consistently sufficient numbers of suitably qualified skilled and experienced staff employed to deliver safe, effective and responsive care.
- Ensure all staff who provide care and treatment to children in the emergency department are competent and confident to do so.
- Make clear how patients' initial assessment should be carried out by whom and within what timescale within the ED.
- Monitor the time self-presenting patients wait to be assessed in the emergency department and take appropriate action to ensure their safety. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Ensure that clinical observations of patients in the emergency department are undertaken at appropriate intervals so that any deterioration in a patient's condition is identified and acted upon.
- Risk assess and make appropriate improvements to the design and layout of the emergency department observation unit to reduce the risk of patients harming themselves or others.
- Clarify the use of the observation unit, setting out its purpose, admission criteria and exclusion criteria to ensure that patients admitted there are clinically appropriate and receive the right level of care.
- Ensure best (evidence-based) practice is consistently followed and actions are taken to continually improve patient outcomes.
- Ensure chemicals and substances that are hazardous to health (COSHH) are secured and not accessible to patients and visitors to the wards.
- Ensure sharps bins are used in accordance with manufacturer's guidance to prevent the risk of a needle stick injury.
- Ensure staff members are aware of the risk of cross infection when working with patients with isolated infectious illness.
- Ensure risk assessment tools in place to identify risks of thrombosis, pressure damage, moving and handling, nutritional and falls are consistently completed and appropriate action taken.
- Ensure National Early Warning Scores used to identify from a series of observations when a patient was deteriorating are appropriately actioned when high indicator scores were seen.
- Ensure that patients with mental health issues on medical wards are appropriately managed.
- Ensure appropriate review and action are undertaken when Deprivation of Liberty Safeguards have been put in place.
- Ensure consistent compliance with the Mental Capacity Act. Ensure all appropriate surgical patients have their mental capacity assessed and recorded to ensure consent is valid, and the hospital is acting within the law.
- Ensure patients' records are fully completed and provide detailed information for staff regarding the care and treatment needs of patients.
- Ensure the provision of single sex accommodation.
- Ensure all areas of the premises and equipment are safe and secure, and patient confidential information is held securely at all times.
- Ensure patients being admitted overnight to the day surgery unit have appropriate facilities which meet their needs, maintains their privacy and dignity, and reflects their preferences.
- Provide a responsive service to reduce waiting times and waiting lists for surgery procedures. Theatre efficiency, access and flow, delays, transfers of care, and bed occupancy must be improved to ensure patients are safely and effectively cared for.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Great Western Hospitals NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust provides a number of services across Wiltshire, to a population of around 480,000 people in Wiltshire and the surrounding areas, with acute services provided at the Great Western hospital, Swindon. The hospital was built under the Private Finance Initiative at a cost of £148million and opened in 2002. The trust became a foundation trust in 2008.

Wiltshire Local Authority is in the 40% least deprived areas in the country. 19.0% of the population are under 16 (equal to the percentage in England). The percentage of people aged 65 and over is 19.5% (higher than the England figure of 17.3%). There is a lower percentage of Black, Asian and Minority Ethnic (BAME) residents (3.6%) when compared to the England figure (14.6%).

We conducted this inspection as part of our in-depth hospital inspection programme. The trust was identified as a low risk trust according to our Intelligent Monitoring model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

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

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

We also inspected community services and looked at:

- Community health inpatient services (visiting all three hospitals where there were community inpatients; Chippenham, Warminster and Savernake)
- Community services for children's and young people
- Community services for adults
- Community end of life care

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop, Professional Advisor, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included of 58 people included 17 CQC inspectors and a variety of specialists: A retired chief executive, a director of nursing, a safeguarding specialist, a paramedic, a senior sister in emergency medicine, a consultant surgeon, a consultant in anaesthesia, a consultant neonatologist, a consultant in paediatric palliative care, a consultant haematologist, four community matrons, a health visitor, a speech and language therapist, two physiotherapists, an occupational therapist, specialist nurses in end of life care, medicine and maternity, a junior doctor, a student nurse and an expert by experience.

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Great Western Hospital NHS Foundation trust. These included the local commissioning groups, Monitor, the local council, Healthwatch Swindon and Healthwatch Wiltshire, the General Medical Council, the Nursing and Midwifery Council and the royal colleges. We

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also talked to the provider of community services in Swindon, and the company who own, run and manage the hospital building, providing domestic and portering staff, meals and facilities management.

We held one listening event in Marlborough on 24 September 2015, at which people shared their views and experiences. In addition we ran a 'share your experience' stall in a shopping centre in Swindon on 22 August 2015. In total more than 50 people attended the events. People who were unable to attend either shared their experiences by email and telephone as well as on our website.

We carried out an announced inspection on 29 and 30 September and 1 and 2 October 2015. During this time we inspected services at the Great Western Hospital, Chippenham Hospital, Warminster Hospital and Savernake Hospital. We also looked at services delivered in clinics and people's homes. In addition we undertook unannounced inspections on Sunday 11 and Thursday 15 October 2015. We held focus groups and drop-in sessions with a range of staff, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists and pharmacists. We also spoke with staff individually as requested.

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

What people who use the trust's services say

The trust collected patient comments via the Friends and Family test.

Healthwatch Wiltshire and Healthwatch Swindon shared patient feedback that they had received in the run up to the inspection. In addition, we received information from people through the listening event, emails, our website and phone calls. Responses were a mix of positive and negative information. Some patients spoke highly of the care they had received, whilst other raised concerns. This information was used by inspectors during the inspection.

The CQC Adult Inpatient Survey 2014 received responses from 408 patients from Great Western Hospital NHS Foundation trust. For the majority of questions, the trust was rated the same as other trusts. There were two questions that the trust scored worse than the England average; Did you find someone on the hospital staff to talk to about your worries and fears? After you used the call button, how long did it usually take before you got help?

The results of the Patient Led Assessments of the Care Environment (PLACE) for 2014 showed that the trust was performing worse than the England average on cleanliness, food, privacy, dignity and wellbeing and facilities. Results also showed a poorer result when compared to 2013 for cleanliness and privacy, dignity and wellbeing.

From September 2014, the trust scored above 90% in the NHS Friends and Family Test, when asking patients if they would recommend the hospitals. The number of complaints dropped by over 100 from 2012/13 to 2013/14 (a drop from 466 to 360).

Facts and data about this trust

The Great Western Hospitals NHS Foundation trust provides acute hospital services at the great western Hospital which has a total of 450 beds (including 12 critical care beds and 38 maternity beds). It also provides community health services across Wiltshire. These services include community hospitals, community nursing teams, therapists and children's and young people's services. There are four wards spread across three community hospitals; Chippenham, Warminster and Savernake. The trust employs 4,408.6 whole time equivalent (WTE) staff (as at June 2015).

Summary of findings

Between July 2014 – June 2015 there were a total of 84,762 inpatient admissions including day cases, 490,740 outpatients' attendances (both new and follow-up) and 78,519 attendances at the emergency department.

At the end of 2014/15, the trust had a revenue of £149.7 million with a financial deficit of £6.2 million.

Bed occupancy was consistently above 92%, with occupancy 95% during quarter 4 2014/15. This was above the England average (85.9%) and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

The Finance Director and the Deputy Chief Operating Officer were new into post at the time of the inspection. The rest of the executive team and non-executive team were stable.

CQC inspection history

Since registering with CQC, there had been a total of Eight inspections covering a total of 16 outcomes. The most recent inspection occurred in December 2013 where six outcomes were inspected. The trust was found to be non-compliant in outcomes 1, 4, 8, 13 and 16 (Respecting and involving people who use services; Care and welfare of people who use services; cleanliness and infection control; staffing; assessing and monitoring the quality of service provision.) The trust was found to be compliant with outcome 21 (records).

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall, we rated safety of the services in the trust as 'requires improvement'. A total of twelve 'safe' judgements were made by the inspection team. Within the acute trust, six services were judged as 'requires improvement'. The Urgent and Emergency care services were judged as 'inadequate'. Only the end of life services were rated as good. Within the community, all four services were judged to be good. The trust was open and had a good culture for incident reporting. Safeguarding processes and practices were good. However we found concerns with staffing and how this impacted upon patient safety. Within the Emergency Department the design and layout meant that waiting patients, including children, were not adequately observed. The physical isolation of the observation unit and lack of environmental safeguards, posed unacceptable risks to patient and staff safety. Staffing levels did not always meet patient need. Staffing levels in the ED did not take into account the requirement to care for patients who queued in the corridor or the sub-waiting room. There were also concerns about the level of staffing within the children's ED and the ED observation unit. The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not achieved 100% of the time. Some accommodation in the ED and minor injury units (MIUs) was cramped and not conducive to the exchange of private conversations or the protection of patients' privacy and dignity. Compliance with level three safeguarding training within the maternity and gynaecology services was significantly below the trust standard. Not all staff were consistently adhering to good hand hygiene practices or using protective personal clothing. **Duty of Candour** • There was a system in place to ensure people were kept informed if something went wrong. There were also systems in place to ensure such incidents were investigated and actions were put in place. Although not all of the staff we spoke with understood the term, they all understood the importance of being open when mistakes were made and believed that the services acted within the spirit of the regulation. • Division maintained a duty of candour register and we saw evidence that the regulation was being complied with.	**Requires improvement** 

- Staff training records did not include details on the number of staff who had been trained in duty of candour.

Safeguarding

- Staff understood their responsibilities and were aware of the safeguarding policies and procedures and the processes for reporting suspected abuse. Staff were confident about what constituted a safeguarding incident and the action they would take to keep patients safe.
- There was a safeguarding lead nurse in the Emergency Department where the electronic patient record prompted staff to consider safeguarding in their assessment of each patient. There was also an appropriate system in place to ensure staff were identifying child safeguarding concerns as the clinical lead for children audited 10 children's records per week. We saw that relevant staff within the community were alerted when children had attended the emergency department or minor injuries units.
- A safeguarding web page had been developed on the hospital intranet for staff. Here staff were able to access referral forms and view a decision-making flow chart. The safeguarding lead nurse described an increase in reported safeguarding concerns as staff awareness increased. Learning from safeguarding concerns had been fed back into ward meetings and safeguarding was a standard item on the trusts divisional governance meetings.
- Whilst in most areas safeguarding training compliance was at or near the trust target of 80%, compliance with level three safeguarding training within the maternity and gynaecology services was only 36% and only 53% within the acute children's services. However, records showed plans were in place to address this, with staff booked on future training. Compliance with safeguarding training within the community was considerably higher than that within the acute setting, with some areas and teams achieving 100%.

Incidents

- Staff were aware of how to report incidents and were encouraged to do so. Situations such as staff shortages and waiting times had become normal and staff were not always completing incident forms for these when they occurred. The trust reported a lower number of incidents per 100 admissions compared to the England average (8.9 per 100 admissions compared with 9.4 per 100 admissions for the NHS England average in the period from February 2014 to January 2015).

- The trust had reported two Never Events in the period May 2014 – April 2015, one within surgery and one in Dermatology. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.) There had been no Never Events reported in the community setting. One further Never Event had been reported in August 2015. This was related to a procedure being performed on the wrong patient. The investigation had been completed but an action plan to prevent reoccurrence had not yet been implemented.
- Staff told us feedback and learning from incidents was provided in various forms, dependent upon the type and impact on patient care. This was provided on a one to one basis by senior staff and or cascaded through team meetings and staff handovers, and where they existed, newsletters. However, not all staff felt they received adequate feedback from incidents. Learning from incidents was not taking place in all areas, nor were the benefits of learning from serious incidents being shared in all areas or across the trust.
- The "don't walk by" safety approach adopted by the trust's provider of facilities was having a positive impact on safety. The introduction of a £25 prize for the best "don't walk by" report had been received positively.

Cleanliness, Infection control and hygiene.

- There were areas of concern with infection control practices. Although overall the environment was clean and tidy there were some exceptions to this. In the dermatology department there was dust and debris on high surfaces. In the day surgery unit there was debris on the floor and the female toilet was unclean, and in the critical care unit there was dried staining on beds and a commode. Staff were not consistently adhering to good hand hygiene practices or using protective personal clothing such as aprons and gloves when required. There had been 12 reported cases of Clostridium difficile up to the end of July 2015, therefore the trust was at risk of breaching its annual trajectory of 20 for the 2015/16 year.

Environment and equipment

- Whilst in most areas we inspected the environment was good, premises were not always fit for purpose. Within the Emergency Department the design and layout meant that waiting patients, including children, were not adequately observed. The physical isolation of the observation unit and lack of environmental safeguards, posed unacceptable risks to patient and staff safety. Some accommodation in the ED and minor injury units

(MIUs) was cramped and not conducive to the exchange of private conversations or the protection of patients' privacy and dignity. Equipment was not always appropriately and safely stored. Some equipment was also becoming unreliable or outdated, such as the decontamination and sterilisation equipment and equipment for measuring patient's visual fields. Not all maintenance checks were in date.

- Environmental hazards such as chemicals and substances that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. Cleaning materials including chlorine tablets were in the sluices, which were unlocked. Sharps bins were in place throughout the medical wards and departments for the safe disposal of used needles and other sharp equipment. However, these not consistently closed when not in use and some were over two thirds full and still being used, putting staff were at risk of a needle stick injury.

Staffing

- Staffing levels did not always meet patient need. Staffing levels in the ED did not take into account the requirement to care for patients who queued in the corridor or the sub-waiting room. There were also concerns about the level of staffing within the children's ED and the ED observation unit.
- The trust used the Shelford Safer Staffing Tool 2014. Acuity and dependency measurement currently took place at least twice yearly (January and June).
- Staffing requirements on SCBU or the paediatric ward were not calculated using a recognised acuity tool to determine how many staff were required to care for their patients.
- Nurse staffing within critical care did not meet the Core Standards for Intensive Care Units (2013) recommended ratio of one nurse to care for one level three patient, and one nurse to care for two level two patients.
- The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not achieved 100% of the time.
- Within the community caseloads were fairly and effectively distributed, with regular discussions occurring regarding caseload size. A capacity management tool had recently been introduced within the community which reviewed staffing numbers ad workload on a daily basis.
- Vacancy rates for nursing and therapy staff in some services within the community were high.
- Trust wide, the percentage of bank and agency staff was 2.5%, significantly lower than the England average of 6.1%. However,

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not all shifts were covered to provide a full cohort of staff. This was of particular concern in urgent and emergency care where the staffing levels did not take into account the need to care for patients who queued in the corridor or sub waiting room.
- The trust were making continuous efforts to recruit staff through local, national and international recruitment campaigns and 'return to acute care' courses for registered nurses.
- Medical staffing was at safe with low use of locum staff. The percentage of staffing grades was comparable with the England average.

Are services at this trust effective?

Requires improvement 

The team made judgements about 11 services. Outpatient services are not currently rated for effectiveness. Of the eleven judgements made, eight were rated as good, and three required improvement.

There was good multidisciplinary working to promote quality care. Patient outcomes, mortality and morbidity were generally monitored though action plans to address shortfalls were frequently incomplete so progress could not be assured. Whilst practice in some areas was good, consent to care was not consistently obtained in line with legislation and guidance including the Mental Health Act. Deprivation of Liberty Safeguards were not monitored and had expired without staff being aware.

Evidence based care and treatment

- Despite delays in discharges, predominantly for patients needing social care packages or continuing healthcare, the length of stay for surgical patients within the hospital was mostly below (better than) the England average.
- Guidelines were generally up to date and available via the intranet, although within the ED, some links to them were broken, were mainly generic from national colleges and had not been adapted locally. There was little evidence of audit to identify if they were followed.
- Within the community services the evidence based guidance and best practice was clearly seen, with staff seeking information and research nationally, using academic networks and professional associations. Systems were in place to ensure new information was appropriately cascaded.

Patient outcomes

- Information about patient outcomes was collected and monitored, with the trust participating in a number of national audits in order to benchmark practice and performance against

that of other trusts. In places we saw little evidence that actions had been taken to improve performance in areas where shortfalls had been identified. However systems were in place to monitor the completeness of actions within the community division.

- Patient mortality and morbidity was reviewed by the surgical teams, but with variable input and content, and insufficient evidence to show how agreed actions were delivering improvements.
- The unplanned ED re-attendance rate in 2014/15 was better than the England average but was generally higher (worse than) the set standard of 5%.
- At the time of the Inspection the Hospital Standardised Mortality Rate (HMSR) was 84.2 (August 2015). This placed the trust in the top quartile of organisations in the South West.

• There were a number of quality improvement programs underway such as projects to reduce catheter associated urinary tract infections and sepsis. Improvements made to the management of patients with sepsis had resulted in reduced critical care admissions, reduced length of stay and reduced mortality to well below the national average. At the time of the inspection, the trust was about to launch an initiative to save 500 lives over the following five years to include not just sepsis but also recognition of deterioration, acute kidney injury and a reduction in falls and pressure ulcers.

Multidisciplinary working

- Multidisciplinary working was evident throughout the services, promoting a quality service to patients. In the national lung cancer audit and bowel cancer audit, the trust was better than the England average for discussing patients at a multidisciplinary level. Within diagnostic imaging there was excellent multidisciplinary work both within and outside the hospital.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Whilst practice in some areas was good, consent to care was not consistently obtained in line with legislation and guidance including the Mental Health Act. In urgent and emergency care there was a lack of records of verbal or informal consent, and it was noted that only 62% of medical staff had received training on consent and the Mental Capacity Act. In medicine patients mental capacity had not been assessed and recorded where appropriate and it was not clear how best interest decisions

had been made. Deprivation of Liberty Safeguards were not monitored and for two patients had expired without staff being aware, this increased the risk of patients having their liberty restricted without the appropriate safeguards in place.

Are services at this trust caring?

Good

The overall rating for caring was good. We judged the caring provided by staff as good in every service within the acute trust and the community with the exception of community services for children and young people where we judged it to be outstanding.

Patients were treated with compassion, kindness, dignity and respect. Staff within the Children and Young Peoples community teams were focused on the needs of the children and young people, putting them at the heart of everything they did. Care was delivered with empathy and honesty. From September 2014, the trust scored above 90% in the NHS Friends and Family Test, when asking patients if they would recommend the hospitals.

Compassionate care

- Patients were treated with compassion, kindness, dignity and respect. CQC intelligence monitoring identified a risk for the inpatient survey when patients were asked 'did you find someone on the hospital staff to talk to about your worries and fears.' However feedback from people we met, including patients and their families, was mainly positive, and in some places such as community childrens and young peoples services, excellent. From November 2014 the trust performance was similar to the England average in the Friends and Family test. This is a single question survey as required by NHS England asking patients whether they would recommend the department to their friends and family.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 92.4% for privacy, dignity and wellbeing. The comparative England average was 85.1%. However some accommodation in the ED and minor injury units (MIUs) was cramped and not conducive to the exchange of private conversations or the protection of patients' privacy and dignity.
- From September 2014, the trust scored above 90% in the NHS Friends and Family Test, when asking patients if they would recommend the hospitals.

Understanding and involvement of patients and those close to them

Summary of findings

- Overall patients understood and were involved in their care and treatment. The exception to this was in the medical wards where many patients did not know the plan for their care and treatment and felt communication relating to this was poor.
- Staff within the Children and Young People's community teams were focused on the needs of the children and young people, putting them at the heart of everything they did.
- Within the Children continuing care team, an agreement of care was produced setting out what each child and family could expect as well as expectations of the family.

Emotional support

- There was excellent emotional support provided to both children and their families within the community such as a rapid response service for unexpected child deaths that occurred in Wiltshire. Staff provided an on-call service working closely with the police to provided support to parents at such a devastating time.
- Chaplaincy support was available as well as a multi faith area and a room for people to use described on the trust website as "set aside for you to come and be quiet, whatever your philosophy of life, whatever your religion."

Are services at this trust responsive?

Requires improvement

Overall, we rated the responsiveness of the services in the trust as 'requires improvement'. Of the twelve judgements across the trust, four were judged to require improvement with seven found to be good, and services for children and young people within the community found to be outstanding, showing that although the trust was responding to people's needs this was not consistent.

The areas requiring improvements were Urgent and Emergency care, Surgery, acute services for children and young people and outpatients and diagnostic imaging services. The ED was not consistently meeting the national standard for 95% of patients to be discharged, admitted or transferred within four hours of arrival at A&E or for consultant-led referral to treatment time (RTT) targets in five of the six surgical specialties. Bed occupancy rates were higher than the England average. Both the acute and community hospitals faced a high number of patients who were fit for discharge, but without transfer of care packages.

Whilst not designed for that purpose, the day surgery unit (DSU) was frequently used to accommodate patients overnight.

Summary of findings

As a result of the second class post imposed due to financial pressures some patients missed appointments whilst others did not receive MRSA washes or preparations for endoscopy procedures in time.

Service planning and delivery to meet the needs of local people

- Services did not always meet the needs of local people. There was a lack of clarity with regard to the most appropriate pathway for patients who self- presented at ED with a minor injury. The observation unit, although not part of the general hospital bed base, was frequently used to accommodate patients who required an inpatient stay on a medical or surgical ward but beds were not available in the appropriate specialty. This practice reduced the effectiveness of the observation unit which was designed to avoid unnecessary hospital admissions and allow clinical decisions predicted to take more than four hours and less than 24 hours.
- Whilst not designed for that purpose, the day surgery unit (DSU) was frequently used to accommodate patients overnight.
- The hospital was not meeting NHS England consultant-led referral to treatment time (RTT) targets in five of the six surgical specialties (general, urology, trauma and orthopaedic, ear, nose and throat, and oral maxillofacial). The average percentage of patients treated within 18 weeks for August 2015 was 84.6% against the target of 92%. The average for the South of England NHS Commissioning area was 88%. Recovery to meet targets was planned for the end of the 2015/16 financial year (end of March 2016).
- As a result of the second class post imposed due to financial pressures some patients missed appointments whilst others did not receive MRSA washes or preparations for endoscopy procedures in time. As a consequence treatment and procedures were delayed.
- Within the community services, the trust worked in partnership with commissioners to plan and meet the needs of the population.

Meeting people's individual needs

- Policies and procedures were in place to help ensure those patients living with dementia and those with learning disabilities were identified and supported. A team of specialist nurses were employed to support patients living with a learning disability. The community learning disability services had an in

reach service, providing support to patients in hospital. Easy read information was made available. On admission to hospital, an alert system was in place to enable staff to make all adjustments needed to support the patient.

Dementia

- There was a dementia care strategy in place and dementia champions in wards and departments. Jupiter ward had undergone environmental changes to become a dementia friendly ward, including softer floors in case of falls, signage to aid direction for patients, dementia informative clocks, use of colours to define areas and a seating area mid ward.

Access and flow

- The trust had difficulties managing the access and flow of patients through the hospital despite a good understanding of occupancy and flow issues. The ED was not consistently meeting the national standard for 95% of patients to be discharged, admitted or transferred within four hours of arrival at A&E, although performance was improving with the target being met in June and July 2015. In addition the ED was not currently achieving the target for a median wait time of below 60 minutes. Patients queued in ED in the corridor or in a sub waiting room because at times of surge there were insufficient cubicles. Patients frequently stayed in the ED overnight as there were no beds available in the hospital. Speciality response times to ED were also variable. Following an external review in May 2015 an internal response time standard of 30 minutes was put in place. However this was not monitored.
- For those patients receiving care and treatment in outlier beds (beds in another speciality), a dedicated consultant and registrar team was in place to ensure prompt and appropriate care management.
- Despite a bed occupancy rate higher than the England average (between 92-96% since 2013/14 against an England average of 85.9%), cancelled operations were below (better than) the England average.
- The acute and community hospitals faced a high number of patients who were fit for discharge, but without transfer of care packages. This meant funded 'step up' beds could not always be used appropriately within the community hospitals.
- The trust was actively working towards seven day working. Preparatory work was underway, with funding of £600,000 allocated in June 2015 for the establishment of a larger ambulatory care and assessment unit and discharge lounge.

Learning from complaints and concerns

Summary of findings

- There was information available for patients and visitors on how to make a complaint. Clear processes were in place for the management of complaints and concerns. Investigations occurred, and lessons were shared.
- The number of complaints dropped by 106 from 2012/13 to 2013/14. The trust board reports for August 2015 showed they had received 11 high to extreme complaints. One new complaint case had been taken on by the Parliamentary Health Service Ombudsman (PHSO) and ten cases were awaiting outcome from PHSO investigations. Two cases were being considered for investigation by PHSO with three cases investigated with recommendations made.
- We reviewed a number of complaints case files which all demonstrated a supportive process to complaint management. The electronic system in operation allowed a clear trail of actions and timelines. Letters written to complainants were clear, and gave clear information about actions and timescales. However the chief executive only signed complaints rated as high. Complaints originally graded as high but downgraded by the divisions would not be signed at an executive level.

Are services at this trust well-led?

Requires improvement

The leadership, management and governance of the trust requires improvement in order to ensure the delivery of safe, high quality and person centred care. Of the twelve judgements across the trust, six were judged to require improvement with six found to be good.

At the time of the inspection the trust was in breach of its licence from Monitor following a significant departure from plan in late 2014 when a deficit of £9 million emerged against a planned surplus of £1million. The consequent actions, including independent reviews of governance arrangements, identified significant shortfalls that were in the process of being addressed. The trust had been committed to maintaining the quality of care in the face of this situation whist also striving to manage demands for services and the flow of patients into, through and out of hospital. At the time of the inspection the necessary improvements had not been made and sustained.

There have been changes at executive level and recent executive, interim and non-executive appointments had strengthened the board. Stakeholders and other regulators spoke positively about the leadership of the trust, in particular the chief executive. The leadership were dealing with significant internal and external challenges. Internally the financial situation and some aspects of performance, including the performance of the emergency

department and the recovery of referral to treatment targets, had highlighted some fundamental issues about the quality of information within the trust. This meant that some situations had not been anticipated although the trust have reacted when they have emerged, an example of this would be waiting list information.

The inspection team found, and stakeholders and commissioners commented, that the trust were open about the issues they faced and took feedback well. The trust were under significant scrutiny from regulators and commissioners and that was adding to the challenges for the leadership team.

The trust's vision had been communicated to staff and the trust values were well known. Staff across the organisation at all levels displayed a passion for providing good care and talked of their pride in colleagues and the services provided.

The trust had assessed themselves as Good across the five domains at trust level which raised questions about their insight into their performance. The executive team had rated themselves as requiring improvement for the well led domain but this had been changed to Good by the non-executive directors.

Vision and strategy

- The trust had set out their five year vision as follows:

"Working together with our partners in health and social care we will deliver accessible, personalised and integrated services for local people. We will provide high quality care whether at home, in the community or in hospitals empowering people to lead independent and healthier lives. "

- The Trust's vision was underpinned by four key strategic aims:

1. To provide safe, high quality care which patients are satisfied with and staff are proud to provide and ensuring our services are embedded in and valued by our communities
2. To maintain and strengthen relationships in our core markets in the communities of Swindon and adjoining parts of Wiltshire and further develop market share in the other areas of Wiltshire, Gloucestershire, Oxfordshire and Berkshire through:
    - Market growth (increase existing referrals).
    - Providing community services that we don't currently provide.
    - Tendering for (appropriate) services
    - Repatriation of tertiary services, where clinically safe and appropriate and we can make a profit or repatriated services would meet our strategic aims

3. In all services we will perform in the top 20% of similar sized hospitals and there will be a focus on productivity in all areas of our business
4. We will work in partnership in all we do to ensure delivery of the best healthcare for our patients, commissioners and communities.

- The trust was in discussion with commissioners, partners and other stakeholders about a revised strategy and the development of a five year plan. This was under development at the time of the inspection.
- The trust launched a Quality Strategy in March 2014 setting out their aims. This identified seven priorities for improvement as follows:
  - Delivering safe, effective care, delivering excellence
  - Leading the best patient experience
  - Releasing time to care
  - Visible inspirational leadership
  - Culture of innovation and embracing of continuous Quality Improvement
  - Measurement of essential quality standards, providing assurance of patient safety and clinical effectiveness
  - Staff will understand their contribution to the whole organisation.
- In August 2015 the board had agreed to sign off an initiative known as "500 lives". The purpose was to bring all the various quality and safety initiatives under one title and to help ensure that the focus on quality and safety was maintained during the financial pressures. The title refers to the ambition to save an additional 500 lives over the next five years.
- The trust has set our their values, known as STAR values, as follows:
  - Service – We will put our customers first
  - Teamwork- We will work together
  - Ambition – We will aspire to provide the best service
  - Respect – We will act with integrity
- These values were developed with staff involvement as part of the trust's application for foundation trust status which was granted in December 2008. The leadership of the trust refer to the values as being at the heart of everything the trust does and in the way that people work together and treat each other. The trust used the values as part of recruitment and appraisal processes. The trust had not developed the values beyond this, for example there was not a framework or similar document setting out expected behaviours. There was not a process in place for the trust to assure itself that staff were working in

accordance with the values. The values were well known by the staff the team met during the inspection. It was clear that in both the community and acute services the value of teamwork was highly valued and the team saw numerous examples of strong teamwork.

Governance, risk management and quality measurement

- The governance arrangements at the trust, in particular financial governance arrangements, had been subject to recent external review. There were action plans in place to deal with the identified shortfalls.
- The trust had a board assurance framework that was regularly reviewed and updated. The framework identified key risks, controls and gaps in assurance. The team considered that there had been some blurring between this framework and the trust risk register. For example some entries contained a running commentary on the actions taken to address gaps dating back over a number of months. This made the framework appear to be a management record rather than a tool to reinforce strategic focus and better management of risk. There were action plans in place to deliver improvements identified by the team. This work included an evaluation of the trust position on risks including appetite for risk and acceptance of long running risks. This was due to be delivered by the end of November 2015.
- The trust had seven board committees, all chaired by a non-executive director. The trust did not have a board committee with quality or safety in its title; these matters were dealt with by the Governance Committee. Over forty working groups and committees reported to the Governance Committee through a Patient Quality Committee chaired by the chief nurse. Matters relating to performance were dealt with by the Finance, Investment and Performance Committee. Executive directors were members, as opposed to attendees, of board committees. This raised questions about how executive directors were held to account within those committees. The membership of the board committees reflected the composition on the board in that there were a majority of non-executive directors who were members of each committee.
- Not all the divisional governance arrangements worked well. In places there was no reporting to the divisional board meeting of audit results or progress of actions plans. For example, within surgery the regular audit of the World Health Organisation surgical safety checklist was not presented. The staff who would be accountable for any required improvements identified were not being challenged about improvements in

quality and safety through clinical governance. The root cause analysis report from the Never Event made some recommendations, including how the quality of the checklist process was not considered, and how this carried a risk of it becoming too automated. There was no evidence of this recommendation being brought forward to clinical governance for consideration and action to improve theatre safety. The National Emergency Laparotomy Audit 2014 and Patient Audit 2015 had not been discussed at clinical governance despite a number of areas needing improvement.

- The internal audit function was effective and targeted and there was evidence of the impact of audit on improvement in some but not all areas across the trust.

Leadership of the trust

- The chair and chief executive had a strong supportive relationship and it was clear that they worked well together. The chair displayed a good grasp of the issues and had a clear division of where the trust is going although it was recognised that this was not yet fully articulated and had not been shared with staff. The chief executive was visible with Chief Executive Open Forums being well attended. Stakeholders, medical and non-medical staff referred to the visibility of the medical director and there was evident of clear impact in raising the profile of end of life care. The Chief Nurse had good visibility to matron level with this aspect of her role being delegated to her deputy. The leadership of community services was strong and visible and the level of engagement from the staff in this area was noticeably stronger that has been seen in similar services. There had been recent changes in some executive posts with the departure of the previous director of finance and chief operating officer; these roles had been filled at the time of the inspection, the latter with an interim appointment. Collectively the board had a good mix of skills and experience although it was clear that the executive team were very stretched to deal with all the current issues and the level of scrutiny.
- The non-executive directors displayed insight and commitment. The team observed part of a board meeting and considered that some important papers were received without sufficient challenge. For example a paper on emergency department performance was accepted although the associated action plan did not contain dates and indicators. In discussion about this it was suggested that discussion could and would take place outside the board meeting however this approach means that such discussions are not placed on the public record. The team reviewed a selection of board and

board committee minutes and noted that challenges were recorded. At the time of the inspection the trust were struggling to meet their target for mandatory training. Training compliance amongst the non-executive directors was 62.5% against a trust target of 80%. Action was being taken to address this. There was a board development plan in place.

- Staff side reported that relationships with the leadership of the trust were positive. Communication had improved and there was a good dialogue. Conversations could be challenging but on the whole the leadership is engaging on the right issues in a timely way.

Culture within the trust

- There was evidence that senior leadership across the trust made efforts to encourage appreciative, supportive relationships amongst staff. The trust recognised staff through a Star of the Month Award and annual staff excellence awards, the latter involving nominations from staff, patients and the public.
- Staff across the trust were open, transparent and very well engaged with the inspection process. There was good attendance at focus groups and drop in sessions in both the acute and community services. A number of staff also sought separate meetings with inspectors. Staff attending felt able to express their views and the majority said they had been encouraged to do so. It was clear from meetings during the inspection, from observations and from the examination of documents and records that there were many very positive examples of teamwork across the trust.
- Staff talked about the trust being friendly and welcoming and the team met many staff with significant length of service within the trust. Staff talked passionately about their focus on patients and delivering great care. This included a significant number of staff who were in support roles and who clearly understood how their work contributed to the quality of care being delivered. This positive engagement and patient focus extended to the PFI contractors.
- Student nurses were generally very positive about the support and training they received. All the students that the team met said they would be happy to work in or to be treated at the trust. This issues impacting on other staff had also impacted on students, for example the limited number of laptops available to support ward rounds. Junior doctors also mentioned the information technology challenges with too few computers. Both groups of staff praise the trust's Academy for the educational opportunities provided.

- The trust ran an "In Your Shoes" scheme which enabled staff to challenge colleagues, and particularly managers, to take on their roles for a day. The team tested the awareness of this scheme across the services inspected and it was very variable. Those staff who were aware of it struggled to provide examples of changes and improvements that had resulted from it. In contrast senior managers who had participated described the insights it had given them into the issues faced by staff.

Fit and Proper Persons

- The trust had made preparations to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. This regulation came into force in November 2014. The trust has taken the approach of asking directors to confirm they meet the definitions, the use of due diligence for new appointments, monitoring through appraisal and through the declaration of interest process at meetings. The due diligence aspects included checks of the Insolvency Register and Companies House.
- This regulation and the action required by the trust had been considered by the board on 30 April 2015 in a paper entitled "Update on CQC new Fundamental Standards" and by the Governance Committee on 5 June 2015 in a paper entitled "CQC new Fundamental Standards action plans". The latter paper refers to the declarations being made by directors and notes "the vast majority now complete". We reviewed records and found that none of the processes had been fully completed. Specifically the checks undertaken were awaiting sign off by the chairman.
- We reviewed recruitment and personnel files for recent executive and non-executive appointments. These indicated that policies and procedures had been followed but the evidence was not complete on the files.
- The trust's approach, policy and procedures had not been documented except as they appeared in the documents referred to above. Given that both papers dealt with a number of requirements aside from Fit and Proper Persons and did not contain that in their title the team considered that the current arrangements did not constitute a clear and transparent process. This needs to be addressed.

Summary of findings

- In examining this issue the team found that the personnel and recruitment records examined were chaotic. References and HR checks were not on the personnel files examined and the related recruitment files could not be found. This needs to be addressed in order for the board to be assured.

Public engagement

- There were examples of positive engagement with patients and the public within individual services. There was also effective engagement with and through the trust's governors. Individually and collectively senior leaders demonstrated an authentic commitment to meeting the needs of the communities served by the trust. Examples of practical action included support for and participation in a range of health education programmes and health information events. However the trust did not have a strategy for public and patient engagement in the design and delivery of services.

Staff engagement

- The trust ran an "In Your Shoes" scheme which enabled staff to challenge colleagues, and particularly managers, to take on their roles for a day. The team tested the awareness of this scheme across the services inspected and it was very variable. Those staff who were aware of it struggled to provide examples of changes and improvements that had resulted from it. In contrast senior managers who had participated described the insights it had given them into the issues faced by staff.
- With exception of managers, staff within the community Children's and Young People's service did not feel engaged with the overall trust. Staff felt the trust overall had not taken an interest in them or in children's services as they were hosting the service and had not tendered for the provision of the service beyond March 2016.

Innovation, improvement and sustainability

- The team received mixed feedback from staff as to the extent to which innovation and improvement was encouraged. Some staff talked very positively about how they were encouraged to innovate and brought examples to the team to demonstrate that. Consultants talked about the trust being proactive in terms of research and that this was well supported by the medical director. Others felt that innovation had been stifled by the trust's current financial pressures. All staff spoken to by the team described how they had been invited and encouraged to submit ideas to save money.

Summary of findings

- It was evident that some of the cost saving measures, for example the requirement that all post be sent second class and a ban on colour photocopying or printing, had compromised care. This appeared partly to be a failure of communication as there were arrangements in place for concerns to be raised and for exceptions to be agreed but it was evident that many staff were unaware of these. Examples in respect of colour printing included the difficulty of reading neonatal early warning scores and stroke care plans (provided to patients) when printed in black and white. Examples in respect of second class post included patients not receiving MRSA washes or preparations for endoscopy procedures in time and consequently having their procedures delayed. These issues were raised with the trust during the inspection.
- There was evidence that the significant financial pressures, in particular the cash position, was impacting on staff and potentially on safety. The impacts on staff included the pressures on the finance team in dealing with daily internal and external enquires about the payment of bills to suppliers. Administrative staff in key areas within the trust described being contacted direct by suppliers about the non-payment of bills. Staff said they felt that these calls were often challenging to deal with. During the inspection there was an example where the actions of staff prevented the potential cancellation of surgery when an expected delivery of decontamination chemicals was not received because a supplier had not been paid. The finance team arranged for the bill to be paid to ensure delivery the following day (at an increased charge) and staff left the hospital to collect bottles of chemicals from other sites to ensure an adequate supply. This was raised with the trust during the inspection.
- Considerations about the sustainability of services were driving the discussions on medium and longer term strategy referred to above.

Overview of ratings

Our ratings for Great Western Hospitals NHS Foundation Trust

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

Overview of ratings

Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Great Western Hospitals NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

The diagnostic imaging team had some areas of outstanding practice, one of which, the palliative ascites drainage, was highly commended by the British Medical Journal (BMJ) in 2015. Innovative practice was seen with the introduction of the intra operative breast radiotherapy project.

In the critical care unit we were given examples of staff 'going the extra mile' for their patients, including a patient attending a family wedding in London, with transport being arranged by the unit and staff escorting the patient for the day.

The consultants provided specialist pre and post pregnancy counselling and support service to women. This and other specialist clinics developed to manage high risk pregnancies had been recognised as best practice. The lead consultant had won an All-Party Parliamentary Group Maternity Services Award during 2011. This service style had since been adopted by other Maternity Services across the country and show-cased at Harvard, USA.

The midwives successful audit and interdepartmental training to prevent cerebral palsy in pre- term babies born at the hospital

The multi-disciplinary working within the community. For example the neurology community team worked with a patient, their carers, social services, housing authorities and other clinicians including the palliative care team to arrange the adaptation of accommodation for a patient with motor neurone disease.

The wheelchair service who committed to providing wheelchairs for patients diagnosed with motor neurone disease within two weeks by prioritising the adaptations that were required to be completed. They also provided a priority service for patients who were receiving end of life care.

The community respiratory team, how they worked with others, lead training initiatives for GPs and physiotherapists and held brief informal training updates to nursing teams during their lunchbreaks. There were weekly teleconferences and meetings every six weeks between colleagues to discuss the latest guidance. The lead nurse also chaired quarterly meetings of a respiratory network of health professionals who worked in respiratory services.

The tissue viability team led by a nurse consultant demonstrated an outstanding level of evidence-based practice and innovation in the management of pressure ulcer care. Regular, quarterly pressure ulcer audits contributed to a quality improvement collaborative for pressure ulcers work plan and the organisational action plan for pressure ulcer reduction. An estimated £40,000 a year was expected to be saved due to the reduction in the length and frequency of nursing visits, with time saved to be used to visit more patients. Great Western Hospital is the first provider nationally to roll out the use of these systems.

Specially trained health visitors and school nurses took part in an on-call unexpected child death rapid response team. When a child or young person who lived in Wiltshire died unexpectedly, the police would be contacted alongside the rapid response team. Whilst the police would investigate the circumstances surrounding the death, the staff within the rapid response team were responsible for providing emotional support to the parents. By using health visitors and school nurses that had been specially trained, it utilised their skills at communicating with parents to support them at the worst moment in their lives.

The children and young people's community teams had excellent multi-disciplinary and multi-agency working. This extended across the local communities they served, health and social care as well as the ministry of defence to support children of military families.

The leadership across the children and young people's community team was very visible and staff were full of praise for their immediate team leaders and wider management team within the community. They felt supported and valued by their team leaders and managers.

The looked after children team had produced a health passport for all their children and young people. This

Outstanding practice and areas for improvement

contained full details of each individual child's health and medical history. Details of appointments, immunisations were also included. Young people were able to take these passports with them once they left the care of the local authority to help them make a good start in their adult lives.

The children and young people speech and language therapy team (SALT) were linked directly to local schools. This was to make sure children and young people received more intensive support and received early intervention when necessary.

The Governance Database developed and used by the Integrated Community Health Division (ICHD) was a spreadsheet used by staff to record audit information and outcomes, serious incidents and investigations that took place and training records. There was also information about staffing levels, complaints and safeguarding issues. Staff at all levels were aware of and used the database regularly.

The division had recently developed a four day community induction programme. Once staff had completed the GWH trust induction they were expected to undertake the community induction. This applied to new staff, staff who had a new role within the trust and staff employed in the last year that had not had a chance when they started to attend the specific community induction. The programme was very detailed and staff told us they had really appreciated the induction as it gave them an insight into the services offered and lone working, fire safety and medical cover for example.

Two Consultants provided bespoke training on some of the community hospital wards. This was well received and attended by staff. They felt this enhanced the feeling of working in partnership to ensure the best care and support is provided for the patients.

The community services participated in 'IWantGreatCare', this was a continuous, real-time collection, monitoring and analysing quantitative and qualitative patient and relative feedback and could act as an early warning system.

People's individual needs and preferences were central to the planning and delivery of services. The service was flexible, provided choice and ensured continuity of care in the wider community. The involvement of other organisations and the local community was seen to be integral to how patient care was planned and ensured the service met people's needs.

End of life care had become part of the induction and mandatory training programme, these programmes of learning had been devised by the palliative consultant and end of life nurse.

Areas for improvement

Action the trust MUST take to improve

Ensure staff receive up to date safeguarding, mandatory training appraisals and training on the Mental Capacity Act to meet trust targets.

Improve governance processes to demonstrate continuous learning, improvements and changes to practice as well as board oversight and assurance.

Ensure there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.

Ensure effective infection prevention and control measures are complied with by all staff.

Ensure safe storage of medicines including intravenous fluids.

Improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards and reduce occupancy to recommended levels.

Review nurse staffing levels and skill mix in the emergency department (ED), including children's ED, the ED observation unit and minor injury units, using a recognised staff acuity tool.

Take steps to ensure there are consistently sufficient numbers of suitably qualified skilled and experienced nurses employed to deliver safe, effective and responsive care.

Ensure all staff who provide care and treatment to children are competent and confident to do so.

Outstanding practice and areas for improvement

Make clear how patients' initial assessment should be carried out by whom and within what timescale within the ED.

Monitor the time self-presenting patients wait to be assessed and take appropriate action to ensure their safety. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.

Ensure that clinical observations of patients are undertaken at appropriate intervals so that any deterioration in a patient's condition is identified and acted upon.

Risk assess and make appropriate improvements to the design and layout of the emergency department observation unit to reduce the risk of patients harming themselves or others.

Clarify the use of the observation unit setting out its purpose, admission criteria and exclusion criteria to ensure that patients admitted there are clinically appropriate and receive the right level of care.

Ensure best (evidence-based) practice is consistently followed and actions are taken to continually improve patient outcomes.

Ensure chemicals and substances that are hazardous to health (COSHH) are secured and not accessible to patients and visitors to the wards.

Ensure sharps bins are used in accordance with manufacturer's guidance to prevent the risk of a needle stick injury.

Ensure staff members are aware of the risk of cross infection when working with patients with isolated infectious illness.

Ensure risk assessment tools in place to identify risks of thrombosis, pressure damage, moving and handling, nutritional and falls are consistently completed and appropriate action taken.

Ensure National Early Warning Scores used to identify from a series of observations when a patient was deteriorating are appropriately actioned when high indicator scores were seen.

Ensure the management of patients on medical wards with mental health issues are fully considered.

Ensure appropriate review and action are undertaken when Deprivation of Liberty Safeguards had been put in place.

Ensure consistently comply with the mental capacity act. Ensure all appropriate surgical patients have their mental capacity assessed and recorded to ensure consent is valid, and the hospital is acting within the law.

Ensure patients records are fully completed and provide detailed information for staff regarding the care and treatment needs of patients.

Ensure mixed sex accommodation is avoided.

Ensure all areas of the premises and equipment are safe and secure, and patient confidential information is held securely at all times.

Ensure the needs of patients admitted to the day surgery unit are met.

Provide a responsive service to reduce waiting times and waiting lists for surgery procedures. Theatre efficiency, access and flow, delays, transfers of care, and bed occupancy must be improved to ensure patients are safely and effectively cared for.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not taken appropriate steps to ensure that the care and treatment of service users (b) met their needs Surgery services were not meeting the referral to treatment times for all of the surgical specialties with the exception of ophthalmology. Theatre utilisation, bed occupancy, and access and flow for patients was sub-optimal. (a) be appropriate, (b) meet their needs Patients in the critical care service were not discharged in a timely way from the unit onto wards when they were ready to leave. The bed occupancy exceeded recommended levels too frequently.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The Medical Assessment Unit (Linnet) was seen to be providing mixed sex accommodation. This meant that male and female patients were in the same four-bedded bay.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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

12 (1) The provider did not provide care and treatment in a safe way:

· Self-presenting patients in ED did not always receive prompt initial assessment (triage). 12 (2) (a)

· Risks to patients were not always mitigated because staff did not follow plans and pathways. Patient observations were not consistently undertaken with the required frequency to ensure that any deterioration in a patient's condition was identified.12 (2) (b)

· The location, design and layout of waiting rooms did not ensure that waiting patients were adequately observed 12 (2) (d)

The location, design and layout of the emergency department observation unit was not suitable for the care of patients with mental health needs who presented challenging behaviour or were at risk of harming themselves and/or others. 12 (2) (d)

Regulation 12 (2)(h)

Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

Chemicals and substances that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. Cleaning materials including chlorine tablets were in the sluices, which were unlocked.

Sharps bins were in place throughout the medical wards and departments for the safe disposal of used needles and other sharp equipment. However, we observed these were not used in accordance with manufacturer's guidance as they were not consistently closed when in use and some were over two thirds full and still being used. This meant staff were at risk of a needle stick injury.

Staff members were not all aware of the risk of cross infection when working with patients with isolated infectious illness. We observed a staff member moving from an isolation area to ward to kitchen without removing an apron or washing hands. This did not

Requirement notices

prevent or control the spread of infection. We established the staff member had received infection control training. The audit scores for this ward did not include an observation of staff practice. The ward manager's review of wards does not include an observation of staff behaviour.

Regulation 12(2) (a) assessing the risks to the health and safety of service users of receiving the care or treatment.

Regulation 12 (2)(b) doing all that is reasonably practicable to mitigate any such risks.

National Early Warning Scores used to identify from a series of observations when a patient was deteriorating were not always appropriately actioned when high indicator scores were seen. The hospital used National Early Warning Scores to identify from a series of observations when a patient was deteriorating. The scores gave criteria for action and instructions for staff to follow. Two patient records showed National Early Warning Scores not always actioned and no explanation provided for actions not seen to be taken. We saw that in several records the MUST nutritional screening tool was not completed, a falls risk assessment was completed but with no associated care plan, the risk assessments for bed rails did not correspond with the scoring indicator but no rationale was provided for the decision to use bed rails. We saw that when a fluid and food record was indicated these were not consistently completed and reviewed to establish any risks.

The management of patients on medical wards with mental health issues was not fully considered. For patients with a high risk of attempting suicide consideration of ligature risks on the ward were not recorded.

We saw that an assessment of a patient had taken place in the emergency department to identify suicide risks but no ward-based assessment had been completed and no close observation was in place to reduce this risk. Staff did not have a ward management plan or staff training in place for ligature risks.

Deprivation of Liberty Safeguards had been put in place; appropriate review and action were not always undertaken. We looked at four Deprivation of Liberty safeguards forms, which had been completed to ensure

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the patients safety. Two of the four forms had expired without review taking place. This meant that staff might have deprived those patients of their liberty without legally being in a position to do so. No tracking facility was in place to ensure that the safeguards were reviewed and updated as necessary.

The trust used Treatment Escalation Plans (TEP) to identify the patient's choices for resuscitation. We saw that when a patient was identified as not having capacity to be included in the making of the decision to resuscitate the appropriate assessments under the mental capacity act were not consistently completed. This meant that the patient's best interests might not be appropriately considered in the decisions being made. We saw this on Jupiter ward and Neptune ward.

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

g) The proper and safe management of medicines

Intravenous fluids were not being stored securely in the critical care unit.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensure all premises and equipment used by the service provider was: (a) secure The day surgery unit was unsecure and unauthorised people had access to the premises and equipment. 15(1) All premises and equipment used by the service provider must be: (a) clean

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems and processes were not established and operating effectively to ensure compliance with the requirement in this part of the Act. The service risk register in the Emergency department did not reflect the multifactorial risks to safety and quality. Measures to reduce or remove identified risks were not introduced in timescales that reflected the level of risk. 17 (2) (b) The audit system was not effective; the service was not acting promptly or consistently in response to results of national audits. 17 (2) (f) There was limited evidence that the views of people who used the service were actively sought and acted upon. 17 (2) (e) Regulation 17(2)(c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Records were not fully completed and did not provide detailed information for staff regarding the care and treatment needs of patients. The care plans were generic pre-printed task-focused lists that staff ticked and dated when they had provided care to patients. These did not
	15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. Equipment and environmental areas in the critical care unit were not thoroughly cleaned. Checks were in place after cleaning but these failed to identify inadequate hygiene and cleaning standards

Requirement notices

provide detail on the individualised care needs and requirements of patients. For example, the records for personal care did not detail the patient's preference or how much help they needed.

Regulation 17(2)(b)

Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The effectiveness of governance systems was not evident in some areas. We saw that areas of concern had not been identified and actioned. For example, the management of the Deprivation of Liberty Safeguards did not have systems in place to identify when the safeguards were about to expire. Shortfalls in the completion of Treatment Escalation Plans and mental capacity assessments affected patients' choices and decisions. The trust had put systems in place to develop training however, in the interim, it was evident that the systems in place did not ensure patients safety. It had not been identified that patients at risk due to mental health issues were being cared for in an inappropriate environment and that staff and patients safety was ensured.

The provider had not operated systems or processes to:

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, and

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and the decisions taken in relation to the care and treatment provided.

The surgery service was not able to demonstrate effective clinical governance, continuous learning, improvements and changes to practice from reviews of incidents, complaints, mortality and morbidity reviews, and formal structured clinical audits with actions and results. For example, there had been no action taken

This section is primarily information for the provider

Requirement notices

with clinical governance following the National Emergency Laparotomy Audit (NELA) or recommendations from an investigation and action plan following a Never Event in surgery.

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

The critical care unit did not have a governance structure. There were limited governance systems or processes in place.

17(2) Such systems or processes must enable the registered person, in particular, to:

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

Regular audits and other systems and processes were not in place in the critical care unit to assess, monitor and improve services.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. There were times when the critical care unit did not have sufficient nursing staffing levels for the dependency of their patients. 18(2) Persons employed by the service provider in the provision of a regulated activity must: a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to carry out the duties they are employed to perform. Compliance with mandatory training and appraisals within the critical care unit were below target. The critical care unit did not have a minimum of 50% nursing staff holding a critical care award.

This section is primarily information for the provider

Requirement notices

18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

Care and treatment must be provided in a safe way. There were inadequate numbers of midwives to meet the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. The midwife to patient ratio consistently exceeded the recommended ratio of 1:28 for safe capacity to achieve one-to-one care in labour. One to one care was consistently not achieved for all women in established labour, and the first two hours following birth. The community midwives had ante and post-natal caseloads of 1:150 which exceeded the recommended level of 1:100 (Birthrate Plus, Royal College of Midwives). The redeployment of community midwives for extended working hours resulting from using the escalation plan may have increased risks to patient care.

The provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed to meet the requirements of the fundamental standards. 18 (1)

Staffing levels had not been reviewed or adapted to respond to increased demand and changing needs. 18 (1)

There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in the emergency department or minor injury units. 18 (1)

Safe levels of staffing and skill mix had not been defined in relation to caring for patients who could not be accommodated in cubicles in the emergency department. 18 (1)

There were insufficient numbers of staff employed in the children's emergency department who had received appropriate training to equip them to care for children. 18 (1)

There was an unstructured approach to nurse training and nurses did not consistently receive protected time for training or clinical supervision. 18 (2) (a)

This section is primarily information for the provider

Requirement notices

Staff caring for patients with mental health needs who had been assessed as being at high risk of harming themselves and others had not received specialist training to equip them for this role. 18 (2) (a)

Regulation 18(1) sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in all areas of the medical division.

When wards were short of staff, staff from other wards were moved to provide cover. This meant that staff numbers and skills were depleted on the staff's normal ward. The trust attempted to backfill on those wards with agency staff, but this was not always possible so those wards worked short of staff.

The provider had not taken appropriate steps to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed for the purposes of carrying on the regulated activity.

There were not always sufficient numbers of nursing staff on duty in the surgery division to provide safe care and to meet people's needs.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Care and treatment are not being provided in a safe way for service users. A. The location, design and layout of the emergency department observation unit at the above location, combined with inadequate staffing levels and staff training, presents risks to patients and staff. While these have been known risks (as identified in the unscheduled care division's risk register), measures to mitigate these risks have not been sufficiently timely or effective. B. Systems to ensure accurate records were maintained in respect of patients' care and treatment were not effective. We could not be assured appropriate care and treatment takes place in a timely manner. C. There was a lack of assurance that nurse staffing levels had been appropriately established or that planned levels of staffing were consistently achieved to ensure that patients attending the emergency department received timely, safe and effective care and treatment. D. There were insufficient numbers of staff employed in the children's emergency department who had received appropriate training to equip them to care for children. Planned staffing levels were not consistently maintained. This, combined with the design and layout of the department, presented unacceptable risks to patients. These risks were not addressed and steps to mitigate risks were not adequate or effective to ensure safe care and treatment. E. There was inadequate oversight and monitoring of staff training to ensure that staff had the right qualifications, skills, knowledge and experience to provide appropriate care and treatment in a safe way. **Systems or processes have not been established and operated to ensure:** **a. the assessment, monitoring and improvement of quality and safety of the services provided,**	Great Western Hospital

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

b. the assessment, monitoring and mitigation of risk relating to the health, safety and welfare of service users, and others who may be at risk which arise from the carrying on of regulated activity.
c. that accurate, complete and contemporaneous records are maintained in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
The governance systems and processes in place within the trust, were not effectively operated and as such were not able to demonstrate effective clinical governance, continuous learning, improvements and changes to practice from reviews of incidents, complaints, mortality and morbidity reviews. This was particularly evident within the unscheduled care division and planned care division.