

Royal United Hospital Bath NHS Trust

# Royal United Hospital Bath NHS Trust

## Quality Report

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

## Ratings

# Summary of findings

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# Summary of findings

## Overall summary

The Royal United Hospital Bath NHS Trust (RUH Bath) provided acute treatment and care for a population of around 500,000 people in Bath and the surrounding towns and villages of North East Somerset, North and West Wiltshire, Somerset (Mendip) and South Gloucestershire. The trust provided 595 beds and a comprehensive range of acute services, including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services. The trust had an annual budget of around £230 million and employed 4,600 staff.

We chose to inspect the RUH Bath as one of the Chief Inspector of Hospital's first wave inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care was likely to be lower. From the information in our Intelligent Monitoring at this time, the RUH Bath was considered to be a medium-risk trust.

The trust had faced significant challenges in the past year, particularly over the last winter period of December 2012 to March 2013:

- There was a high demand for trust services and the trust did not have sufficient capacity to cope with emergency admissions. The trust had three periods of 'black escalation' in January, February and March 2013. Patients were waiting in the corridors of the accident and emergency (A&E) department for treatment. The day surgery unit was being used for overnight stays. The trust received £2.35 million of NHS winter pressures funding to improve services.
- The NHS patient safety indicators on falls, catheter and urinary tract infections, blood clots and pressure sores were above the national average and incident report rates were low compared with other trusts.
- Elective surgical procedures were being cancelled and patients had long waiting times for surgery; this was worse than other trusts.
- The staff survey results identified that the level of staff engagement was in the bottom 20% of trusts.
- Patient complaints and concerns increased during this time.

- The trust was not meeting standards and there were compliance actions following several CQC inspections for respecting and involving service users, care and welfare, safeguarding, and assessing and monitoring the quality of service provision.
- We served a Warning Notice after our inspection in June 2013 because the trust did not meet standards for Regulation 20 (1) (a) and (2) (a) (b) (Records) of the Health and Social Care Act 2008.
- In 2012, the trust had gained approval to be a foundation trust from the strategic health authority. The initial assessment with the healthcare regulator, Monitor, was between November 2012 and March 2013, and the trust was focused on this corporate, financial and governance challenge on service provision.

The trust also had positive areas of practice:

- Surgical procedures were safe and the trust had not had a 'never event' for 18 months.
- Infection control rates were similar to those of other trusts.
- Over all mortality rates were similar to those of other trusts. The hospital standardised mortality ratio (HSMR) is a measure for deaths in hospital for specific conditions and procedures. This was significantly lower than other trusts and there was no difference between weekday and weekend mortality.
- The trust participated in national clinical audit and could demonstrate many areas where national guidelines were adhered to.
- The trust was supportive of innovation in services, for example, in dementia and end of life care.
- Patient feedback from surveys and NHS Choices was largely positive.

During this inspection, we inspected services in A&E, medical care, surgery, critical care, the children's centre, end of life care and outpatients. We did not inspect maternity services because these were part of Great Western Hospitals NHS Foundation Trust.

From this inspection, the trust has demonstrated that it could lead significant change effectively. It had been open and transparent with partners about challenges and funding had been used to support innovative

# Summary of findings

changes. It had engaged the national Emergency Care Intensive Support Team (ECIST) to change services in both the trust and across the local health and social care community to improve the management of patient admissions and discharge. The changes had significantly improved how the trust managed the demand for its services and ensured

that patients received good quality and safe care. Staff told us there had been a tangible shift in culture over the past few months from a corporate to a patient focus, and the trust was in a better position to manage winter pressures and unexpected demand for services.

Patients received safe and effective care. Surgical services were safe, for example, and infection rates were similar to those of other trusts. Patients were being treated according to national guidelines and clinical outcomes for them were good. Patients told us staff were caring and that they were treated with dignity and respect. Services were more responsive to patients' needs and the trust had made changes to improve how it handled and responded to complaints. The trust was making progress in providing a seven-day service, and new models of care in A&E, medicine and surgery had meant patients were receiving quick and effective treatment and their length of stay in hospital was reduced. The environment on two wards, Combe Ward and the neonatal unit, had been redesigned and refurbished to reduce anxiety and improve the comfort of patients with dementia and of children and parents, respectively.

The CQC standards identified in the Warning Notice, and all but one of the compliance actions from our inspection in June 2013, had now been met. The Warning Notice has now been lifted.

We also identified a number of areas where the trust needed to improve. Staffing levels were safe but needed to improve in some areas, particularly in the critical care and neonatal units. Incident reporting had improved but information was not shared effectively so that staff could learn from mistakes. Patients were safeguarded, but more staff need appropriate safeguarding training to protect children, and some staff needed a clearer understanding about the rights to independence of patients who are at risk of wandering. Staff were caring, but at busy times in busy areas, such as admission and short stay wards, patients' care needs were not always being met. Patients still had long waiting times for some planned surgery and outpatient appointments, and there were discharge delays for some patients with complex needs. The trust needed to engage with staff in lower pay bands who spend much of their time with patients and in patient areas, such as cleaners, who told us they did not feel valued or listened to. The trust was well-led but it needed to further improve how it assessed and monitored its quality and safety procedures. We identified actions for the trust to take to improve its services.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### **Are services safe?**

Patients received safe care and were protected from risks, and incident reporting had improved. Services had changed to cope at busy times and patients who were transferred to non-specialist wards were managed appropriately. The trust was taking action to address staffing levels to ensure patient care needs were met; this was particularly required in the critical care and neonatal units. Infection rates were similar to those in other trusts and the environment was clean. Most equipment was checked as required and medicines were prescribed and administered correctly. Some staff did not have up-to-date training in safeguarding children and some needed a clearer understanding about the rights to independence of patients who are at risk of wandering. Patient records had improved and included accurate and appropriate information.

### **Are services effective?**

Patients' care and treatment were effective. National guidelines and best practice were applied and monitored, and outcomes for patients were good overall. Staff worked in multi-disciplinary teams to coordinate care around a patient, and end of life care was integrated with GP and community services. Staff were supported to innovate services and develop their clinical skills. However, some training for staff working with children needed to improve.

### **Are services caring?**

People at our listening events had mixed views about the care and services they had received. Most people who contacted us to share their experiences were concerned about poor care and the loss of dignity and respect. However, during our inspection, we observed that staff were caring and patients confirmed this, saying also that staff were compassionate and treated them with dignity and respect. Staff in the critical care team provided outstanding emotional support. There were instances though, at busy times, and in busy areas such as admission and short stay wards, when patients' care needs were not met and this was a concern. Patients had a good choice of meals and were supported to eat and drink appropriately. They did not have mixed-sex accommodation.

### **Are services responsive to people's needs?**

Demand for trust services last winter meant that the trust was not meeting waiting times in A&E and bed occupancy was at a level that had had an impact on the quality of care. This had now improved but there were still long waiting times for some elective surgical procedures and outpatient appointments. The trust had already started work on developing seven-day services and this was improving patient diagnosis and treatment. Care was improving for patients who were vulnerable as a result of their experiences, although the transfer of elderly patients at night was a concern. Discharge was better

# Summary of findings

coordinated in the hospital but needed to improve by engaging with community partners to reduce delays. The trust was developing a more open culture in how it handled complaints but there were still some delays in responding to patients when a complaint was investigated. Information and translation services were available.

## **Are services well-led?**

The trust was clear about its clinical and governance strategies and was developing its approaches to improve its performance and monitoring arrangements. There had been a renewed focus on patient quality and safety issues and these were being managed more effectively alongside corporate and financial challenges as the trust aimed to achieve foundation trust status. There were, however, gaps in monitoring and the trust needed more information on service risks and quality. Staff told us they were proud to work in the trust and most felt valued by the trust leadership. Staff were involved in innovative projects and service development, and the trust had radically changed and developed services to cope with demand. The leadership team was improving its engagement and communication to ensure they were listening to patients and staff about their concerns and experiences.

# Summary of findings

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

### Accident and emergency

Patients received safe and effective care. Their safety was a high priority and risks to patients were identified and managed effectively. There were good clinical outcomes for patients. Patients with mental health needs were waiting too long for assessment out of hours and at weekends, although efforts were being made to improve this. Staff were compassionate and caring and patients' feedback was good. The A&E department was well-led and the staff in the department worked as a strong and cohesive team. The trust had taken a whole-hospital approach to managing demand for services and staff in the department were confident that winter pressures would be better managed in 2014.

### Medical care (including older people's care)

Patients received safe and effective care. There were good outcomes for patients and the trust had improved its record-keeping to ensure patients received appropriate and safe care. Staffing levels on medical wards, particularly in the medical admissions unit (MAU), was a concern. The trust was actively recruiting staff but current levels were having an impact on patient care. Staff were caring and most patients said they had been well cared for and staff were attentive. There were some concerns, however, when staff were busy, and in busy areas such as MAU when patient care needs were not always met. The care and treatment of older patients, especially those with dementia, was improving. Patients' discharge was well supported but there were delays for some patients with complex needs. The service was well-led and staff told us of their pride in working for the hospital. They said they felt better prepared to deal with service demands and winter pressures.

### Surgery

Patients received safe and effective surgical care. There were good safety checks and management of risks to patients. The reporting of incidents to learn from mistakes was improving. Cleanliness and infection control were good. The surgical environments were well managed, but some areas could have been better maintained. Equipment was usually available when needed, although some checks were not done as required. Staff were caring and services were responding to patients' needs. However, levels of nursing staff sometimes delayed surgery and delayed patient transfers between theatre, recovery and ward areas. There were some concerns, when staff were busy, and in busy areas such as the short stay surgical unit, when patients' care needs were not always met. Staff had improved their understanding and approach to the care of people who were vulnerable, such as patients with a learning disability or dementia. They were dedicated, and most teams worked well together to coordinate patient care. Staff told us they were proud of the work they did.

# Summary of findings

## Intensive/critical care

Patients received safe and effective care although staffing levels in the critical care unit needed to improve to reduce the pressures on staff. Obtaining patient consent was done well but capacity to consent to care and treatment was not documented appropriately. Clinical outcomes for patients in the unit were good and often above the national average. The consideration and compassion shown by staff to their patients in critical care were outstanding. Staff morale was improving and there was effective team working, although training and professional development needed to improve. There was an unacceptably high level of delayed discharges because of capacity problems elsewhere in the hospital, and this added to the pressures on the unit. The trust was taking action to manage risks, but national delays to recruiting staff had not been effectively communicated to staff. Staff told us risks were now being managed effectively.

## Services for children & young people

Children received safe and effective care in the children's centre. Staffing arrangements were flexible to meet the needs of children, and children's care and treatment followed best practice guidance. Staffing in the neonatal unit needed to improve to meet intensive care standards, and the supervision of children in A&E needed to improve. Parents told us staff were caring and the nurses were described as "attentive" and "very helpful". The service was responsive to children's needs and parents praised the neonatal unit and commented on how it created a feeling of calm and wellbeing. Staff engaged well with the children and treated them with dignity and respect. Staff told us they felt supported and took pride in their work, although in some areas they needed further specialist training. Risks needed to be better monitored to demonstrate that these were being managed effectively.

## End of life care

Patients received safe and effective end of life care. Their care needs were being met and the service was integrated with GPs and community services, which supported effective discharge arrangements and care at home. Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect, from reception staff through to consultants. Staff had appropriate training and supported patients to be fully involved in their care and decision making. The service was well-led and staff were dedicated to improving standards of end of life care across the hospital.

## Outpatients

Patients received safe and effective outpatient care and staff were caring. However, staff throughout the outpatient services did not demonstrate a robust understanding of the Mental Capacity Act (2005) in relation to consent from adults who were vulnerable. Patients' waiting times were within national targets, although some patients waited longer for appointments at the pain



# Summary of findings

management clinic and some patients waited a long time for consultations when clinics were busy. Patients told us that the breast care clinic was outstanding. The outpatient clinics were managed differently by departments and information on quality and safety was just beginning to be shared. The trust had commissioned work to review and further improve outpatient services.

# Summary of findings

## What people who use the trust's services say

The trust was rated about the same as other trusts in the 2012 Adult Inpatient Survey, while exceeding the national performance on some of the 'care and treatment' questions. In November 2013, the trust performed above the national average in the A&E department and inpatient

Friends and Family Test. The trust was ranked in the top 20% of all trusts for 12 out of 64 questions and in the bottom 20% for five questions in the national Cancer Patient Experience Survey.

## Areas for improvement

### Action the trust MUST take to improve

None

### Action the trust SHOULD take to improve

- The trust needs to ensure that there are effective operations systems to regularly assess and monitor quality of the services provided; to identify, assess and manage risks and to make changes in treatment and care following the analysis of incidents that resulted in, or had the potential to result in harm.

### Action the trust COULD take to improve

- The use of the early warning score needs to improve across the trust and there should be clearer referral criteria for critical care outreach, particularly as the service is not currently available seven days a week.
- The supervision of children needed to improve. Pathways for children need to improve from A&E to the children's ward to avoid children waiting unnecessarily in a mixed A&E department.
- 'Do not attempt cardiopulmonary resuscitation' (DNA CPR) forms on the oncology ward need to be completed so that resuscitation decisions are always clear.
- Staff need to understand the Deprivation of Liberty Safeguards and to be clear of their responsibilities under the new policy to reduce the risks for patients with dementia that may wander.

- Staff training needs to improve, especially around fire safety, safeguarding children and the Mental Capacity Act.
- The environment in the post-anaesthetic care unit (PACU) needs to be maintained for good infection prevention and control.
- The trust needed to continue to monitor and improve the segregation and disposal of clinical waste to maintain its compliance with standards.
- The trust needs to work more effectively with the mental health liaison team and intensive team to improve assessments for patients with mental health conditions.
- The trust needs to ensure multi-disciplinary team working is appropriately developed in all areas.
- The trust needs to ensure that patient care needs are met particularly at busy times and in busy areas, such as on admission and short stay wards.
- The number of elderly and confused patients who are transferred between wards at night should be reduced.
- Patients should have shorter waiting times for the pain management clinic appointments and for consultations in some busy clinics. GPs need to receive letters on patients' investigation and treatment within two weeks.
- The chronic pain management clinic needs review in terms of consultation time with patients and specialist staff.
- Better resources are needed to support people with a learning disability. Areas for improvement

## Good practice

N/A

# Royal United Hospital Bath NHS Trust

## Detailed findings

### Services we looked at

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

## Our inspection team

### Our inspection team was led by:

#### Chair:

Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

#### Team Leader:

Joyce Frederick, Head of Hospital Inspections, Care Quality Commission

The team of 27 included CQC inspectors and analysts, doctors, nurses, patients and public representatives, Experts by Experience and senior NHS managers. We also had observers from the King's Fund and Manchester Business School, NHS Improving Quality and CQC senior management team.

## Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Between September and December 2013 we are introducing our new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care according to our new surveillance model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, the Royal United Hospital Bath NHS Trust was considered to be a medium-risk trust.

## How we carried out this inspection

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

- Is it safe?

# Detailed findings

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

The inspection team inspected the following core services at this inspection:

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

# Are services safe?

## Summary of findings

Maternity and family planning is a core service to be inspected. This service was not inspected at the Royal United Hospitals Bath NHS Trust because it was run by the Great Western Hospitals NHS Foundation Trust.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations, such as clinical commissioning groups, the NHS Trust Development Authority and the healthcare regulator, Monitor, to share what they knew about the hospital.

We carried out an announced inspection visit on 5 and 6 December 2013. During the visit, we held focus groups with a range of staff in the hospital, including nurses, doctors, physiotherapists, occupational therapists, pharmacists, administration and clerical staff, domestic staff and porters.

We talked with patients and staff from all areas of the hospital including the wards, theatre, outpatient services and the A&E department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' records of personal care or treatment.

We held two listening events at Bath Racecourse and Trowbridge Town Hall on 5 December 2013, when patients and members of the public shared their views and experiences of the trust. We carried out an unannounced visit to the hospital between 4pm and 10pm on Saturday 14 December 2013.

## Our findings

The trust had improved its services and patients were receiving safe care.

### Patient safety

The trust was better prepared to manage 'winter pressures'. Over the winter period of 2012 and 2013, there was a high demand for the trust's services. The trust did not have sufficient capacity to cope with emergency admissions and was on 'Black Escalation' on three occasions in January, February and March 2013. Patients were waiting to be treated in the corridors of the A&E department and the day

surgery unit was being used for overnight stays. There had been a number of serious incidents during this time, and care was unsafe. Patients' concerns and complaints had increased.

The trust engaged the support of the national Emergency Care Intensive Support Team (ECIST) during the spring of 2013 as well as commissioners and other health and social care agencies to ensure a joint approach to planning. The hospital received £4.4 million in NHS winter pressures funding for 2013/14. A number of initiatives were introduced to relieve the pressure on services and actively manage patient flow through the hospital. These included employing more consultants in A&E and in the medical admissions unit (MAU), a new escalation policy to cope with fluctuating demand, and operational changes to wards, bed management monitoring and discharge support. For example, there were new models of care, such as short stay wards for older people and surgical patients, and ambulatory care that enabled patients who required low-risk urgent care to be investigated and treated quickly. Clinical practice also changed to actively manage the treatment and discharge of patients. For example, the number of daily ward rounds for patients had increased.

The trust had a 'hospital at night' team that included medical and nursing staff, staff from bed management and a clinical site team. A database of patients' care needs was kept so that doctors could attend those with the most urgent needs. We observed medical and surgical evening handovers, the medical handover was better structured and there was more of a team approach to ensuring patient safety issues were not missed.

The trust was implementing a policy of the right patient on the right ward. When the hospital was busy, patients could be transferred to a ward that may not be right for their condition (patient outliers). To reduce these risks, patient outliers were reviewed by a specific medical team.

Staff told us the trust was better prepared to cope with the high number of admissions expected over the winter period, but the reality of the demand for services meant that there could still be occasions in future when the hospital would be full. If this happened, the trust was better prepared to manage quality and safety risks.

Patients who became critically ill were managed effectively by the critical care team but there could be delays in receiving appropriate treatment. The early warning score

# Are services safe?

was used to assess patients at risk and there was evidence that rapid response was, for example, preventing cardiac arrests. However, practice across wards varied, and staff in the critical care outreach team were working to improve this so that patients received timely specialist support. The critical care unit was often full because patient discharge was sometimes delayed as a result of staff shortages on the wards. Patients needing critical care had support from the outreach team or from staff in the post-anaesthetic care unit (PACU), until a bed became available. This was not ideal but staff told us care was safe. However, some patients were discharged too early from critical care and this was a concern.

## Managing risks

The trust was managing patient safety risks. The NHS Safety Thermometer is designed to measure a monthly snapshot of four areas of harm: falls, pressure ulcers, catheter-related urinary tract infections and venous thromboembolism (blood clots). The trust was below average for patients developing pressure ulcers but was above the national average for the other areas. The trust has identified that blood clots were not an outlier as the trust was a tertiary centre for treating pulmonary hypertension, which is coded as contributing to blood clots and therefore counted in the figures, and falls data showed decreased numbers. There were working groups and action plans in each of these areas and this had led to ongoing improvements in preventative care on both medical and surgical wards.

Surgical procedures were safe and the trust achieved consistently high compliance with the World Health Organization checklist. The trust had not had a 'never event' in 18 months. Never events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken.

The trust was developing an open culture to learn from mistakes to improve patient safety. Since 2004, trusts had been encouraged to report all patient safety incidents (including those that were low risk or resulted in no harm) to the National Reporting and Learning Service (NRLS). The trust reported 70 incidents between July 2012 and June 2013, and it was identified as under-reporting incidents when compared with other trusts. The NHS Staff Survey (2012) showed that similar numbers of staff said they reported errors, near misses or incidents when compared

with staff in other trusts. The trust, however, was worse than other trusts for staff being open about witnessing incidents or for considering the reporting process to be fair or effective.

The trust had won funding from the Health Foundation to fund a research project to look at the cultural issues around incidents. Incident reporting was encouraged and a new electronic reporting system was introduced. Staff were clear that that they would not be penalised for reporting incidents, but said they were often too busy. Reporting rates were improving and the most recent data indicates that the trust's reporting of incidents was now similar to other trusts. However, staff said the systems were frustrating to use, and the learning from incidents was not regularly shared to encourage openness and prevent reoccurrences. For example, the trust had a serious fire in the critical care unit in November 2011, but only 67% of current staff had up-to-date fire training and the trust standard was 80% rather than 100%. During our inspection, we averted a potential fire from a portable heater in the PACU, when an electrical flex had been draped over the front and top of the heater and the flex was exposed to the heat. This near miss was immediately escalated by staff in the department.

Trust risk registers were completed and graded for risk escalation, but they did not always show that risks were mitigated or monitored effectively.

## Staffing

The trust had employed a number of new consultants and this meant that there was a senior medical presence at weekends in the A&E department and for emergency medical and surgical admissions. Doctors at registrar level were present out of hours. Junior doctors told us they were busy but felt well supported, and that on-call arrangements were working.

In the NHS Staff Survey (2012), 74% of staff said they worked long hours, and the trust was in the bottom 20% of all trusts. There were nurse vacancies across most wards and a high turnover of staff in areas such as the MAU and critical care. Bank and agency staff were used to fill vacancies, although at times they were unavailable. Nursing staff told us they worked long hours. When they were rushed, patient personal care needs were not always met. The trust had used a national benchmark tool to assess staffing levels and the intention was to increase

# Are services safe?

staffing above existing levels once vacant posts were filled. The trust was recruiting staff to fill vacant posts and additional healthcare assistants had been appointed to wards.

In critical care, staff had worked under pressure for some months, but staffing was improving. In the neonatal unit, there were too few nursing staff, and inadequate and inexperienced paediatric cover for the unit to be compliant with Department of Health standards for high quality neonatal services, and emergency care was a concern.

Therapy staff said they had few vacancies and they had changed their services to be able to support patients throughout the week.

Support staff, such as administration staff and porters, were positive about the trust. However, the cleaners told us they worked very hard but were short staffed and they felt standards had dropped. Their managers were not supportive and they did not feel valued. Porters told us they would like more trolleys and patient notes were not always kept confidential in an envelope when they transported patients.

## Cleanliness and infection control

Patients were protected from the risk of infection. The trust's infection rates were within an acceptable range and similar to other hospitals for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile. The trust had higher numbers of Clostridium difficile infections than expected against their own target for 2013/14 and was reviewing this to understand the cause (some infections include community acquired infections).

In the NHS Staff Survey (2012), only 51% of staff said hand washing facilities were always available and this was worse than expected. We found that all wards were clean and cleaners used appropriate cleaning schedules. Patients and visitors were given information on how to prevent infections and there was hand hygiene gel in all areas for patients, staff and visitors to use. Staff used protective equipment and clothing, such as aprons and gloves, appropriately and were observed using hand hygiene gel. Regular audits were undertaken for hand hygiene and other infection prevention and control measures, and these showed good practice.

The trust did have suitable arrangements for management of clinical waste, but clinical and non-clinical waste were not properly isolated on some wards. The children's ward, in particular, had clinical waste left on the floor and waste was being transported through the ward.

## Equipment

Most equipment was checked and available for use. However some of the regular checks for emergency resuscitation equipment in surgical ward areas and the electrocardiogram (ECG) equipment used on medical wards were not done appropriately. There was a risk to patient care if the equipment that was needed did not work.

## Medicines management

Medicines were prescribed, administered and stored correctly. There were only a few examples when this did not occur. A few administration charts were incomplete on the older people's wards, and there were out-of-date drugs in the PACU and in one anaesthetic room cupboard. Some of the regular checks on the temperature of medicine fridges in surgical ward areas were not done. These issues were identified for staff to rectify.

## Environment

Buildings in the hospital were safe. The trust mainly consisted of new buildings and there were plans for the older parts, built in the 1940s, to be replaced with a new cancer and pathology centre. Art and design features were integrated across the trust and this had enhanced and enlightened the environment for patients. The environment on two wards, Coombe Ward and the neonatal unit, had been redesigned and refurbished to reduce anxiety and improve the comfort of patients with dementia and of children and parents, respectively.

Some environments required improvement. For example, the PACU needed refurbishment to reduce infection control risks. The medical short stay and critical care units were cramped and the stroke unit and neurology wards had limited space for rehabilitation facilities. Patients told us the trust's numerical signage for wards, rather than names, could be confusing, and many told us the hospital was "too hot".

# Are services safe?

## **Safeguarding**

Staff knew about the need to protect patients from abuse, and understood how to do so. However, many did not have the required up-to-date safeguarding training, particularly training on how to protect children, although procedures were safe and effective in paediatrics.

From the information we reviewed before our inspection, the trust was an identified risk for staff whistle blowing. It had a whistle-blowing policy but staff had contacted us to raise concerns, particularly earlier in 2013 when they identified that the trust was “struggling to cope” with capacity problems. The trust had recently re-launched its policy called ‘Raising concerns’. Most staff were aware of this and more were reporting concerns via this route.

The trust had a compliance action from our inspection in June 2013 and did not meet standards for Regulation 11 (2) (a) (b) (Safeguarding) of the Health and Social Care Act 2008. We identified that it did not have suitable arrangements to protect people from excessive control. During this inspection, the trust had introduced a new safe wandering technology policy to monitor the movements of patients who may be confused and prone to wandering. The trust policy states that assessment of adherence to Deprivation of Liberty Safeguards is required in all cases when the use of safe wandering technology is being considered, for example patients with dementia could wear wrist sensor bracelets if they were at risk of wandering. Staff

understood how to protect people when they had concerns regarding patients who may benefit from wearing assistive technology, but were less clear of when and whose responsibility it was to complete a Deprivation of Liberty Safeguards application.

## **Patient records**

The trust had a Warning Notice from our inspection in June 2013 and did not meet standards for Regulation 20 (1) (a) and (2) (a) (b) (Records) of the Health and Social Care Act 2008. The standard of patient records for discharge planning, recording weight, nutrition and hydration, and nursing documentation had put patients on the older people’s wards at risk of inappropriate and unsafe care. During this inspection, we identified that the trust had revised its nursing documentation and had introduced safety measures. These ensured electronic records, paper records and patient information on ward wipe boards were consistent and accurate. Records were monitored weekly and those on the older people’s wards, and across the trust, now included accurate and appropriate information on risk assessment and patients’ care and treatment.

‘Do not attempt cardiopulmonary resuscitation’ (DNA CPR) forms were used across the trust. We reviewed a small sample and most were completed appropriately. However, half the forms for patients on the oncology ward did not indicate the decision to resuscitate.



# Are services effective?

(for example, treatment is effective)

## Summary of findings

Patients' care and treatment were effective. National guidelines and best practice were applied and monitored, and outcomes for patients were good overall. Staff worked in Multi-disciplinary teams to coordinate care around a patient, and end of life care was integrated with GP and community services. Staff were supported to innovate services and develop their clinical skills. However, some training for staff working with children needed to improve.

## Our findings

Patients received effective care and treatment.

### National guidelines

Patients received care according to national guidelines. The trust was using National Institute for Health and Care Excellence (NICE) guidelines and best practice professional guidelines. Services had a lead to ensure these were implemented and monitored, and outcomes for patients were good overall. For example, the trust was similar to or better than other trusts in how patients with chest pain, stroke or hip surgery, or those who were critically ill, were treated.

The trust had a compliance action from our inspection in June 2013 and did not meet standards for Regulation 9 (1) (a) (care and welfare) of the Health and Social Care Act 2008. We identified inconsistent assessment of nutrition, hydration, pain management and pressure areas. During this inspection, we found that care had improved and most patients had had appropriate care. The trust had introduced 'comfort rounds' and nurses were checking that patients' care and welfare needs were being met. We identified a few areas that needed to improve, and these were pain management in A&E and on the surgical short stay unit (SSSU), and patients at risk of dehydration or weight loss who needed to be monitored more effectively on the older people's wards.

Most staff understood consent procedures and the requirements of the Mental Capacity Act 2005 to act in

people's best interest if they had temporary or permanent cognitive impairment. Staff in outpatients were not fully informed and documentation in the critical care unit did not support mental capacity assessments.

Patients at the end of their life were being cared for according to the Department of Health interim guidelines. This was done in response to the national independent review More Care, Less Pathway: A Review of the Liverpool Care Pathway published in July 2013. The trust had not used the Liverpool Care Pathway previously, but had used its own integrated pathway of care with community and GP services.

### Clinical audit

The trust's plans for clinical audit included national and local audit. The trust participated in 34 (87%) national clinical audits during 2012 and 2013 and performed similar to or better than other trusts, for example, in the treatment of bowel cancer and heart attacks. However, some areas needed to improve, such as the management of childhood epilepsy. Quality standards, patient experiences and risk indicators were used to prioritise local audits and most resulted in improvements to clinical care and treatment.

### Patient mortality

Overall mortality rates (October 2013) for patients covering 30 days after admission were similar to other trusts and there was no difference between weekday and weekend mortality. The specific hospital standardised mortality ratio (HSMR) is an indicator of the quality of care and compares deaths in hospital for specific conditions and procedures. The trust's HSMR was significantly lower than expected. Mortality rates were monitored and actions taken to address any issues that arose.

### Multi-disciplinary team work

Staff worked well together in teams to coordinate care around patients. The NHS Staff Survey (2012) identified that the trust was similar to others for effective team working. We found Multi-disciplinary team approaches in all service areas and collaborative working across different departments, such as with X-ray and pathology to speed diagnosis and decisions. The end of life care team had also developed an integrated care pathway with GPs, the community hospice and a local hospice to provide seamless care.

The trust had a compliance action from our inspection in June 2013 and did not meet standards for Regulation 9 (1)

# Are services effective?

(for example, treatment is effective)

(a) (care and welfare) of the Health and Social Care Act 2008. We identified that patients had experienced delays in being assessed by a mental health specialist. This was particularly a problem out of hours and at weekends. During this inspection, we found the NHS winter pressures funding had been used to fund additional staff to extend the mental health services provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). The trust had started to work with AWP to improve referral and liaison so that the services could be better coordinated.

## **Staff skills**

The NHS Staff Survey (2012) showed that the trust was in the top 20% for the percentage of staff who felt able to contribute to improvements at work. It was supportive of innovation, and clinical staff and managers had developed new models of care, for example, the rapid assessment

team in A&E, the older people's assessment and comprehensive evaluation (ACE) unit in medicine, the emergency ambulatory care unit in surgery, and dementia care across the trust. Most staff had appropriate teaching and training. There were concerns, however, around training to care and protect children. Some staff did not have a formal post registration neonatal nursing qualification. Others in the children's centre did not have the required level of training to safeguard children. The trust as a whole was not meeting key training targets for infection control, moving and handling, fire safety and safeguarding. The NHS Staff Survey (2012) showed the trust was similar to other trusts for staff appraisal. Staff told us they had appraisals and were supported and monitored to develop their clinical skills.

# Are services caring?

## Summary of findings

People at our listening events had mixed views about the care and services they had received. Most people who contacted us to share their experiences were concerned about poor care and the loss of dignity and respect. We observed that staff were caring and patients confirmed this, saying also that staff were compassionate and treated them with dignity and respect. Staff in the critical care team provided outstanding emotional support. There were instances though, at busy times, and in busy areas such as admission and short stay wards, when patients' care needs were not met and this was a concern. Patients had a good choice of meals and were supported to eat and drink appropriately. They did not have mixed-sex accommodation.

## Our findings

Staff provided a caring service to patients but there were concerns at busy times.

### Compassionate care

In the Care Quality Commission (CQC) Adult Inpatient Survey (2012), the trust was similar to other trusts on survey questions but better than expected for staff providing emotional support to patients. The Cancer Patient Experience Survey (2013) was designed to monitor national progress on cancer care. The trust scored similar to or better than the national average, for example, on listening to patients, privacy and dignity, and pain control. The trust was worse than expected in a few areas: waiting times, documentation and information about support groups.

We spoke with 33 people at our listening events. People had mixed views and described good and poor experiences of care. Some commented on caring staff, good services and good treatment. They also commented on not being treated with dignity and respect, and the poor attitude and communication of staff. Forty people contacted us to share their experiences. Most of their comments were negative in that people described poor care, staff not responding to them or ignoring their concerns, and loss of privacy and dignity on inpatient wards. This was particularly when staff were under pressure at busy times.

Most patients we talked with said staff were kind, caring and helpful, and that their care needs were being met. We observed staff providing compassionate care and outstanding emotional support in the critical care unit. On busy wards, such as the medical admissions unit (MAU) and surgical short stay unit (SSSU), there were instances when nurses had less time to spend with patients so patients experienced delays in their care needs being met.

### Involving patients in their care

In the CQC Adult Inpatient Survey (2012), the trust was similar to other trusts in communicating, listening, and providing information but was better than other trusts at providing explanations about care before surgery. Most patients said they were listened to and involved in discussions about their care. They were satisfied with the level of information they had been given about their care, treatment and discharge.

### Dignity and respect

In the CQC Adult Inpatient Survey (2012), the trust did better than other trusts for privacy and dignity, and response to call bells.

The trust had a compliance action from our inspection in June 2013 and did not meet standards for Regulation 17 (1) (a) (respecting and involving people that use services) of the Health and Social Care Act 2008. We identified that patients' privacy and dignity were not respected because patients using call bells for help with personal care or assistance were not being responded to in a timely manner. During this inspection, most staff maintained patients' privacy and dignity by drawing curtains when providing personal care or undertaking examinations. Staff conducted conversations quietly so as not to be overheard. There were 'quiet rooms' for relatives who might be in distress or needed privacy. We observed instances when call bells were not answered promptly on the MAU and SSSU. Patients told us the nurses were "rushed off their feet". Some patients were accepting of the delay, but others had needed support.

The CQC Adult Inpatient Survey (2012) identified that the trust was in the lowest 20% of trusts for patients sleeping in mixed-sex wards or using mixed-sex bathroom and shower facilities. We observed that patients had single-sex accommodation and the trust had not breached this target since October 2013.

# Are services caring?

## **Patient feedback**

The NHS Friends and Family Test was introduced in April 2013 and asked patients whether they would recommend hospital wards to friends or family if they needed similar care or treatment. In November 2013, the inpatients and A&E department scores were above the national average.

## **Food and drink**

Patient-led assessments of the care environment (known as PLACE) were introduced in April 2013. Patients scored the trust as above the national average for food and drink. When patients were admitted, their risk of dehydration and

malnutrition was assessed. The trust had a protected mealtimes policy and patients who needed assistance received meals on a red tray to ensure staff were aware. Staff supported patients to eat and drink appropriately and drinks were within easy reach and replenished often. After feedback from patients, the trust had reintroduced hot meals in the evening. Patients with special diets (including vegetarian, diabetic, gluten free and soft or pureed) had a choice of meals. Catering had improved and many patients commented on some freshly prepared meals.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

Demand for trust services last winter meant that the trust was not meeting waiting times in A&E and bed occupancy was at a level that had had an impact on the quality of care. This had now improved but there were still long waiting times for some elective surgical procedures and outpatient appointments. The trust had already started work on developing seven-day services and this was improving patient diagnosis and treatment. Care was improving for vulnerable patients although the transfer of elderly patients at night was a concern. Discharge was better coordinated in the hospital but needed to improve with community partners to reduce delays. The trust was developing a more open culture in how it handled complaints but there were still some delays in responding to patients when a complaint was investigated. Information and translation services were available.

## Our findings

The trust was improving its services to respond to the needs of patients.

At our listening events people had mixed views. Some commented on the quick speed of investigation and treatment, others on long waiting times and poor complaint handling. People also commented on problems with physical access for people who had difficulty walking or who used a wheelchair, for example, to some toilets, outpatient clinic rooms and car parking.

### Bed occupancy

The trust bed occupancy exceeded the national average and had at times been at a level where the quality of patient care could be affected. Between January and March 2013, bed occupancy was 97% and between April and June 2013 it was 93%. The non-maternity national average was 88.5%. The trust received many concerns and complaints at that time. We spoke with 33 people at our listening events, who shared their experiences with us, and many also identified concerns about the quality of their care during that period.

The trust had taken action to improve bed occupancy and was now actively managing patient flow by ensuring that the right patient was in the right bed at the right time.

### Waiting times

Waiting times were improving in most areas. Before May 2013, the trust was not meeting the national A&E waiting time of 95% of patients to be admitted, discharged or transferred within four hours. It had undertaken a series of changes to manage emergency admissions and was now meeting the A&E target, and it had improved the time taken to admit and transfer patients to inpatient wards.

Most patients were not waiting more than six weeks for diagnostic tests, and waiting times for cancer treatment (January to March 2013) were within the expected range. Elective surgery in the trust, however, was affected by the high number of emergency admissions last winter and operations were cancelled. The proportion of patients whose operations were cancelled for non-clinical reasons (January to March 2013) was higher than the national average and many of these patients were not being treated within 28 days. The trust had a backlog of patients waiting for operations and some patients were now waiting longer than the national target of 18 weeks for elective or day case surgery. The trust was treating patients on the basis of urgency or clinical need but this had increased the complexity of surgical lists. Staffing problems on surgical wards and in the critical care unit meant that some current lists were not being completed as planned, and there was pressure on staff in those areas.

### Outpatient appointments

Most patients were waiting between six and seven weeks for an outpatient appointment. The trust was aiming for appointments within five weeks. There were, however, longer waiting times for the ear nose and throat (ENT), eye and pain management clinics.

Waiting times in clinics varied enormously and were affected by emergencies that took doctors away. Some patients were seen promptly but some waited more than an hour. Outpatient clinics were managed differently across specialties and some were better managed than others. Information was beginning to be shared on good practice to meet service demands.

### Seven-day working

The trust was developing seven-day working where staffing and services at the weekend were similar to those available

# Are services responsive to people's needs?

(for example, to feedback?)

during weekdays; this has been shown to improve outcomes for patients. Several seven-day services were already in place: consultants in A&E worked seven days, as did consultants in the MAU. Stroke services had developed a seven-day transient ischaemic attack (TIA) service and occupational and physiotherapists were also available at weekends to support the service as well as patients recovering from a fractured hip. The imaging service, too, provided X-ray, CT and MRI, and ultrasound scanning facilities for the hospital 24 hours a day, seven days a week.

## Vulnerable patients

Specific support was given to caring for people who were vulnerable. We observed, for example, facilities for relatives of patients in critical care and for parents of children. There was spiritual and coordinated support for patients receiving end of life care. Reasonable adjustments were made for people with a learning disability, although we did not see any specific resources to help, such as 'easy read' information.

The trust had developed the Dementia Charter Mark with the Alzheimer's Society for its model of dementia care at ward level. This was recognised regionally and nationally. There was good progress in the care of people with dementia. For example, the trust used the 'forget-me-not' flower sign on wards to identify people with dementia, and documentation called 'This is me' to support older people with their needs. This specific care did not happen consistently, but 11 wards now had a silver Charter Mark award and two had a gold award. The practice of transferring patients between wards at night happened because of pressure on beds, but it was a concern, especially for those who were elderly and confused.

## Accessible information

Information was available in ward areas. It was mainly in English but could be obtained in other languages from the trust intranet. The trust had an interpreter service that staff were aware of, and there was a sign language translator service that enabled staff to communicate with deaf people. An online service was also available within the hospital using a computer-on-wheels, and this provided interpretation services at short notice.

## Discharge

Patient discharge was well managed but there were delays for some patients with complex needs. The CQC Adult Inpatient Survey (2012) showed that the trust was similar to other trusts for patients being given enough information at

discharge. It performed better than other trusts for patients who stated that their discharge was not delayed by more than four hours because they were waiting for medicines, a doctor or an ambulance. Patients told us they were supported and had been given information about their discharge.

The trust was actively managing discharges. More equipment had been purchased to support elderly patients at home. Discharge coordinators had been appointed to support ward staff and stimulate improvements in community services. A discharge and therapy evaluation team oversaw arrangements for patients with complex needs. Ward staff spoke positively about these posts and how they were starting to have an impact, for example, in liaising with patients and relatives and identifying care resources in the community to speed discharge.

During our inspection, there were 18 patients in the trust who were medically fit for discharge but were awaiting appropriate care packages or a community hospital bed. Twice as many patients from Wiltshire were waiting compared with Bath and North East Somerset (BaNES) because the two areas have transparently different systems for accessing community and social services. The trust was working with its partners to improve the coordination and consistency of services.

## Complaints

We spoke with 33 people at our listening events, who shared their experiences with us, and some told us complaints were not handled appropriately. They said there had been delays in receiving responses to complaints and the trust had not responded to the issues they had identified. The trust received 372 complaints in 2012/13 and most complaints (307 [82.5%]) were upheld. The Independent Complaints Advisory Service identified the seriousness of the complaints, and how the trust handled complaints, as real concerns for the six months from April to October 2013.

The trust was undertaking a formal review of complaints and there were new procedures in place to prevent, respond appropriately to, and learn from complaints. Staff knew how to support patients to make a complaint or to raise a concern with managers or the Patient Advice and Liaison Service (PALS). In November 2013, the trust met its 25 day target to respond to complaints in 88% of cases. Information about complaints had now started to be collated and analysed.

# Are services well-led?

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

## Summary of findings

The trust was clear about its clinical and governance strategies and was developing its approaches to improve its performance and monitoring arrangements. There had been a renewed focus on patient quality and safety issues and these were being managed more effectively alongside corporate and financial challenges as the trust aimed to achieve foundation trust status. There were, however, gaps in monitoring and the trust needed more information on service risks and quality. Staff told us they were proud to work in the trust and most felt valued by the trust leadership. Staff were involved in innovative projects and service development, and the trust had radically changed and developed services to cope with demand. The leadership team was improving its engagement and communication to ensure they were listening to patients and staff about their concerns and experiences.

## Our findings

The trust had made some significant changes this year and its leadership was improving.

### Leadership

The trust board was fairly stable but they had made some significant changes in 2013. There was a new director of nursing, a chief operating officer (who had previously been the director of nursing), and a new deputy chief executive/director of finance. The leadership team was forming relationships and ways of working. There was a clear understanding of trust priorities and there had been a shift to emphasise quality and safety alongside the corporate and financial challenges that were occurring as the trust aimed to achieve foundation trust status.

There was increased attention to developing clear lines of accountability and governance arrangements. There was evidence of operational clinical performance monitoring and evaluation at trust and divisional levels and these were beginning to develop at service and ward levels.

There was a sense, from all staff, that in recent months the trust leadership had had a tangible shift in culture to focus on patients. The service pressures over the winter and the regulatory pressures from the CQC and Monitor had played

a part, but the shift was also considered to be based on an inherent will to run good quality and safe services. The NHS Staff Survey (2012) showed that the trust had fewer staff satisfied with the quality of their work compared with other trusts. Staff told us the quality of care no longer seemed like an individual responsibility, with its incumbent stresses and sense of failure, but one that was now being supported and developed by the organisation to improve.

The trust recognised its clinical priorities as delivering the highest quality care that would be assessed by patient safety, clinical outcomes and patient experience. They were doing this by developing services, working towards seven-day working, managing costs and engaging with staff. The trust had committees to focus on audit, governance and patient experience, and the level of challenge by the non-executive directors was improving and being monitored by the Chair of the trust. The leadership team performed walkabouts around the hospital to talk to staff and review quality and safety, although some staff commented that the frequency of these was not sufficient for them to have met or seen members of the leadership team.

### Managing quality and performance

The trust had a compliance action from our inspection in June 2013 and did not meet standards for Regulation 10 (1) (a) (b) (assessing and monitoring the quality of service provision) of the Health and Social Care Act 2008. We identified that the trust had systems to assess and monitor quality and risks but had not effectively monitored actions from our inspection in February 2013 to ensure these had been implemented. During this inspection we found that the trust had monitored the implementation of its action plans from our previous inspections, but there were still areas for improvement.

The trust leadership was improving its focus on the areas of concern identified by patients and staff. However, the overview of quality and risk was not yet in place from board to ward. The board had regular and improved information on risk and quality. The operational performance report had previously monitored NHS performance standards around, for example, waiting times and infection control rates. The information now included further standards around safety, effectiveness, caring, responsiveness and leadership.

The trust had a quality improvement programme and was monitoring information such as mortality rates, complaints, infections and serious incidents. There was evidence of the

# Are services well-led?

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

monitoring of operational and clinical performance at trust and divisional levels and this was beginning to develop at service and ward levels. Some monitoring information needed to be developed further. For example, information on clinical outcomes and serious incidents was thorough, but the learning from incidents and complaints was still developing. Better information was required on staffing and the impact on patient care. The trust also needed to monitor service risk registers, because these did not always demonstrate that risks were either mitigated or monitored effectively.

The trust board heard patients' stories to understand what it was like to receive care in the hospital. This was an NHS initiative for patients to tell their individual stories of good and poor care. The trust had also developed 'See it my way' events that provided staff with the opportunity to listen and learn from patients' experiences of care. Events included what it was like to live with a learning disability and what it was like to approach the end of life. However, information on patient experiences in general and action taken in response to feedback needed to be better collated, analysed and shared.

## Service improvement plans

The trust had taken on board the need to innovate services to sustain quality and safety and to meet service and financial targets. This was now understood not only as high-profile innovation projects but also innovation to ensure standards were being consistently followed. It was also understood that innovation was required across the trust, and the local health and social care community. There had been large-scale projects, for example, around emergency care in A&E and for older people, and around ambulatory care. The designation of some wards had also changed, for example, day surgery was now short stay for low-risk patients. Although attention was being paid to risks, the trust needed to monitor staffing and ward environments to ensure that they remained suitable during periods of change.

Clinical staff were involved in leading plans to improve services. The NHS Staff Survey (2012) identified that the trust was in the top 20% of all trusts for staff contributing towards improvements at work. Staff told us they felt supported to develop and innovate services. Innovation projects had flourished throughout the trust to improve services and generate funding or reduce costs, for example, the home intravenous therapy service. Staff projects

contributed to the trust's cost improvement programmes (CIPs). Information on CIPs was monitored by the quality board (which includes the medical director and director of nursing) to ensure risks to quality were effectively managed. There was ongoing work to improve how the trust assessed the impact on quality as a result of these schemes.

## Valuing staff

Most staff felt valued by the trust. The NHS Staff Survey (2012) identified that the trust was in the bottom 20% of all trusts for staff engagement. Research had shown that higher levels of staff engagement delivered a higher quality of care and financial savings because staff were more likely to understand and follow leadership decisions. The trust had increased its level of staff engagement in recent months and staff were positive about this. It was promoting its values through improved communication and meeting forums. There was a sense that the trust had a clearer direction and was focused on quality. Many staff told us they were "proud" to work in the trust and felt valued. They said they would like a greater emphasis on sharing solutions and learning across the trust. The trust acknowledged the need to develop engagement with staff in the lowest pay bands, such as cleaners and porters, who had a great deal of contact with patients. There was a high turnover of staff in the human resources department, which had a key role in promoting staff leadership and development.

## Openness and transparency

The trust was open and transparent when working with partners to improve its services. It had worked with commissioners to identify how NHS winter pressures funding should be spent to coordinate the management of emergency admissions and discharges, and to improve access to planned surgery to meet targets. There had been challenges to relationships in the past but the trust was considered to be open and honest and clearer about assurances and performance. The trust was developing its 'duty of candour' as a result of the Mid Staffordshire NHS Foundation

Trust Public Inquiry (the Francis report). It was extending its policies towards incidents, complaints and whistle blowing, which had been given insufficient attention in recent years, and it was now focusing on developing an organisation whose staff were encouraged to learn from mistakes and experiences to improve patient care.



# Accident and emergency

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The accident and emergency (A&E) department was open 24 hours a day, 7 days a week. About 69,000 patients (adults and children) attended each year. The department had an observation unit that was used for patients who needed ongoing observation, or assessment or diagnostic tests, before they were admitted to hospital, transferred to another service or discharged home. We talked with eight patients and three relatives. We also spoke with staff, including nurses, doctors, consultants, managers, therapists, support staff and ambulance staff. We observed care and treatment and looked at care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

Patients received safe and effective care. Patient safety was a high priority and risks to patients were identified and managed. There were good clinical outcomes for patients. Patients with mental health needs were waiting too long for assessments out of hours and at weekends, although efforts were being made to improve this. Staff were compassionate and caring and patients' feedback was good. The A&E department was well-led and the staff in the department made a strong and cohesive team. The trust had taken a whole-hospital approach to managing demand for services and staff in the department were confident that winter pressures would be better managed this year.

# Accident and emergency

## Are accident and emergency services safe?

A&E services were safe.

### Managing risk

Staff told us there was a 'risk aware' culture in the department and a willingness to learn from mistakes. Complaints, safety incidents and near misses were all openly discussed. Staff were able to describe risk-reporting procedures but acknowledged that there was under-reporting of incidents of violence and aggression, mainly because of time pressures.

### Staffing and seven-day working

The College of Emergency Medicine recommends that there should be enough consultants to provide cover 24 hours a day, seven days a week. The department had been under severe pressure with admissions last winter, and was on 'Black Escalation' on three occasions during January, February and March 2013. The trust received NHS winter pressures funding for 2013/14, and two new consultants had recently been employed in the A&E department, with a third about to start. The trust had 10 A&E consultants who worked between 8am and 10pm seven days a week. After 10pm there was a registrar who provided cover to A&E with a consultant on call. There had also been an increase in nursing staff in the A&E department including emergency nurse practitioners. Staff told us the increased access to senior medical staff had improved the care, treatment and safety of patients.

Staff felt they were well supported to deliver safe care. One staff member described a "supportive learning environment". Junior doctors who had just started work in the department told us they were well supported by experienced staff and had been given a "well-focused" induction.

### The environment and equipment

The environment was well laid out, clean and appropriately equipped. Resuscitation and suction equipment and supplies of oxygen were accessible and fit for purpose. Consideration was given to physical security and safety. The department had close-circuit television, with a monitor in reception, and was supported by security personnel. Staff were given the option to carry personal alarms, which, when activated, would result in the intervention of security personnel.

### Infection prevention and control

Staff were observing infection control procedures, including the dress code that required all staff to have bare arms below the elbow. There were adequate hand washing facilities and access to personal protective equipment, such as gloves and aprons. There were appropriate arrangements for the segregation and disposal of waste, including clinical waste and sharps.

### Medicines management

There were safe systems for the storage and supply of medicines. Medicines were regularly checked and were in date. Medicine administration charts had been appropriately completed. Consumable items such as dressings and bandages were accessible, suitable and intact.

### Safeguarding

Staff were aware of their responsibilities to protect adults and children who were vulnerable. They understood safeguarding procedures and how to report concerns. There was prompt access to patients' previous attendance and medical history, so that staff could be alerted to potential concerns. Older people were monitored appropriately, for example, to determine what level of support they had at home, when they had last had a meal and whether they were at risk of falls. The department had safeguarding leads who provided advice and support to staff. The children's safeguarding leads had supernumerary time to review children's medical records to ensure that any concerns were identified and addressed.

### Patient records

Patients' records were both electronic and in paper format on casualty cards. Staff told us the electronic system was logical and easy to use. Casualty cards were scanned by the night staff and formed part of the ongoing electronic record. Records provided evidence of assessment, investigations and observation, advice and treatment, and a discharge plan. Staff told us discharge letters were sent to GPs within 24 hours of a patient's attendance at A&E. The records system also allowed live department-wide patient tracking and was an effective workload management tool.

# Accident and emergency

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

A&E services were effective and action was being taken to improve assessment and treatment.

### Clinical management

The consultant and matron in charge of the A&E department told us they were really happy with how the department worked. The department was divided into sections. The 'minors' area was for patients who self-presented. Patients were assessed by a triage nurse who categorised them by priority. Although designated 'minor', patients with serious illness or injury were assessed immediately against set criteria and high-risk patients assessed and given pain relief and/or first-aid treatment when appropriate.

The 'majors' area received seriously ill patients, many of whom had arrived by ambulance. Within the majors area there was a high-care area, which had a higher ratio of staff to patients, and a resuscitation area where patients received intensive monitoring and intervention. Patients presenting with chest pain were prioritised and taken directly to the high-care area. We saw a patient arrive in the minors area, saying their GP had sent them because they had "problems with their heart". The patient was quickly transferred to the high-care area for treatment.

### National guidance

Patients received effective care and treatment based on national and best practice guidance. Staff followed established clinical pathways of care. This included pathways for life-threatening conditions such as stroke, heart attack and sepsis, which ensured that patients presenting with these conditions were quickly identified, assessed and treated. The department participated in national audits, and was benchmarked by the College of Emergency Medicine as performing in the median or top quartile nationally for the treatment of a range of medical conditions, including renal colic and fractured neck of femur. However, it was in the lower quartile for the treatment of sepsis. Re-admittance rates to the department were low. Participation in local audit was also improving practice, for example, an information sheet had been produced to better manage children's urinary tract infections.

### Pain management

The A&E department's clinical governance meeting held in November 2013 recorded that pain scoring "remained poor". This meant that early assessment of pain was not consistently taking place to ensure that patients were given prompt and appropriate pain relief. Patients we spoke with told us they were satisfied with the pain relief they had received, and patient care records showed that pain scores had been promptly assessed and recorded, and pain relief administered. Staff were able to describe to us the methods used to assess pain in adults, children and people with some form of cognitive impairment.

### Caring for people with mental health needs

On a previous CQC inspection in June 2013, we identified that patients had experienced delays in being assessed by a mental health specialist. This was particularly a problem out of hours and at weekends, when delays were reported to have caused increased distress to patients and added pressure to the department. Mental health services were provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). During the day there was a Mental Health Liaison Service. The out-of-hours and weekend service was provided by the intensive team. This team was also responsible for supporting people in crisis in the community who had been prioritised for assessment, and this caused delays in the A&E department. The additional NHS funding given to clinical commissioning groups in 2013 had been used to increase staffing in the mental health service, and the weekday service had been extended from between 9am and 5pm to between 8am and 6pm. There were plans to extend the service further until 8pm by January 2014. The intensive team was planning to extend the team by one staff member, although recruitment difficulties had delayed this. The Trust Director of Nursing was also now working with the mental health liaison service to improve referral and liaison so that the services could be better coordinated.

### Multi-disciplinary team working

Clinical staff and managers worked well as a team. We observed, for example, one patient arrive in the resuscitation unit where they were seen by a nurse and a doctor, who worked together quickly and calmly, demonstrating good team work. The shift coordinator in the majors area maintained an overview of activity and workload and skilfully directed resources to where they were needed. Staff told us specialist advice was available,

# Accident and emergency

both in the department itself and throughout the hospital. This included access to mental health practitioners and therapists and specialists in dementia, falls and learning disability.

There was prompt access to diagnostic imaging. There was an adjoining radiology department, which was shared with the fracture clinic. This was staffed 24 hours a day, seven days a week and provided general X-ray, CT and MRI, and ultrasound scanning facilities. Staff told us emergency patients were always given priority.

## Consent to treatment

Staff understood consent procedures and the requirements of the Mental Capacity Act 2005 for them to act in people's best interest if they had temporary or permanent cognitive impairment. Most interventions in the A&E department required informal or verbal consent. A nurse told us this might involve speaking with relatives or the patient's GP if the patient did not have capacity, and there were also resources to assist staff when dealing, for example, with people with dementia or a learning disability.

## Are accident and emergency services caring?

Staff in the A&E department provided a caring service.

## Compassionate care

Patients told us the staff were kind and caring. For instance, one patient told us about the emotional support they had received for a personal issue that was unconnected to their medical condition. We observed examples of compassionate care: a member of staff supporting a person who was disorientated and wandering through the department, and another member of staff escorting an elderly patient to the ward. Staff had also donated second-hand clothes that were given to patients who were in need.

## Patient feedback

The department used several methods to gain patient feedback. The NHS Friends and Family Test was introduced in April 2013 and asked patients whether they would recommend the service to friends or family who needed similar care and treatment. The A&E service scored higher than the national average with 81% of responders in

November 2013 saying they were "extremely likely" or "likely" to recommend the service. The department also had a suggestion box for comments to be posted. Patients also gave us positive comments about the service.

## Privacy, dignity and respect

Patients told us they were treated with dignity and respect. Staff introduced themselves to patients and relatives and all wore name badges. We observed staff speaking kindly and patiently. Patients' privacy was maintained. At the reception desk in the minors area, there were booths so that people could provide personal information without being overheard. Curtains were drawn around cubicles and conversations were conducted quietly to remain confidential. A central staff base in the major area, known as 'the goldfish bowl' (because it was surrounded by glass), had been soundproofed so that staff conversations and handover meetings could not be overheard. There were a number of 'quiet rooms' where distressed relatives could wait or have private discussions with staff.

The observation unit was segregated but bathroom facilities were shared between male and female patients. Staff did not consider that this caused a problem, although they acknowledged it was not ideal because patients might stay on this unit for more than 24 hours.

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

A&E services had improved and were responsive to patients' needs.

## Waiting times

We spoke with 33 people at our listening events and some told us they had had short waiting times and care was "exemplary" in A&E. One person said the department was too busy to deal with the number of patients.

At the beginning of 2013, the trust was not meeting the national A&E target for 95% of patients attending A&E to be treated, discharged or transferred within four hours. During January, February and March 2013, the hospital was overwhelmed by the demand for services and was on 'Black Escalation' on three occasions. The trust introduced a number of initiatives to relieve the pressure on A&E.

# Accident and emergency

These included employing more consultant staff and nurse practitioners in the department, a new escalation policy to cope with fluctuating demand, and operational changes to wards, bed management and discharge. The medical admissions unit (MAU), the surgical admissions unit (SAU) and a new assessment and comprehensive evaluation of older people unit (ACE) received direct admissions from the community or provided short-term assessment following attendance in A&E before transfer to a specialist ward.

Patients awaiting admission were sometimes cared for on the observation unit. They usually stayed on this unit for no more than 24 hours. The unit was used for short-term assessment and often for patients needing neurological observation, mental health assessment and/or treatment following an overdose. There were two side rooms, which staff told us could be used for patients nearing the end of their lives.

Staff were aware of the escalation policy and there was guidance in each clinical area. They told us the procedures helped the hospital recover more quickly when there were peaks in demand, and the changes had improved patient flow and reduced the likelihood of a backlog of patients in the A&E department. Since May 2013, the hospital had met the A&E four-hour waiting-time target, dipping to 90% for only one week in September 2013. The trust had improved its performance against the target for patients waiting between four and twelve hours to be transferred to a ward after the decision to admit them.

The clinical lead told us 20% of patients seen in the A&E department at weekends could be managed by primary care practitioners, and they had plans to develop a primary care centre adjacent to the A&E department to address this.

## Rapid assessment and treatment

The A&E department had a new rapid assessment team known as 'senior with a team' (SWAT). The team consisted of a consultant or middle-grade doctor, a registered nurse and a healthcare assistant. This team had improved the speed with which patients who arrived by ambulance (excluding those who needed to go directly to resuscitation or the high-care area, such as patients experiencing chest pain) were assessed and investigated for blood tests or X-rays. The team was operating in a pilot phase from 2pm to 6pm, although there were plans to extend this to run between midday and 8pm.

We spoke with three ambulance crews who told us they considered the A&E department to be "the best, most organised and efficient A&E department" they attended. On arrival, ambulance crews were promptly directed by a coordinating senior nurse to an appropriate area and a receiving clinician so that the patient could be assessed.

## Responding to concerns and complaints

Complaint leaflets were available and staff knew how to support people to raise a concern. The matron told us face-to-face meetings were routinely offered. The department monitored complaints and there were 24 between April and December 2013. Of these, 20 were closed and over half were upheld; more than half had not been responded to within the trust's target timescale of 25 days. We did not see evidence that complainants had been kept informed of the delays, although the trust assured us that there was a process to track complaints and keep patients informed. Complaints were discussed at team meetings and there was evidence of learning and improvement.

## Facilities and the environment

Staff told us patients sometimes complained that the department was too hot because the air conditioning was not effective. The trust, however, assured us that the air conditioning was fit for purpose. They also complained about the lack of access to food and drink. Staff told us they tried to ensure that people had enough to eat and drink, but there was no structured approach. Volunteers helped by serving food and drink during the week. At weekends and during the evening, staff had to remember to offer these and patients might have to wait longer at busy times. Children had a separate waiting area that was decorated and equipped to make young children feel more comfortable and less anxious. There was a separate children's toilet, children's seating, a television and a selection of toys. The space was less suitable for older children or adolescents, but there was an alternative single room that could be used. The treatment area for children was similarly decorated and equipped with young children in mind, with brightly coloured curtains and mobiles.

## Informing and involving patients

Patients felt well informed about their condition and their plan of treatment. Staff told us there were facilities that helped them to communicate with people with hearing impairment or whose first language was not English. There was a sign language translation service that helped staff to communicate with deaf people. Staff told us they had

# Accident and emergency

access to interpreter services and could download information from the intranet in a range of different languages. There were also information leaflets in different languages about specific medical conditions and injuries, and these were given to patients to help them manage at home.

## Are accident and emergency services well-led?

The A&E service was well-led.

### Leadership and culture

The team was motivated and demonstrated pride in its service. There was good team working and communication, both within the department and with other departments. Staff told us they enjoyed working as part of a strong team and felt well supported by their peers and managers. They said managers were visible and accessible, and there was a general feeling that managers had used new investment wisely to improve quality and had “not just thrown money at the service by employing more staff in the department”. The managers we spoke with were committed and well informed. They told us the department was considered to be a good place to work and staff retention supported this.

### Monitoring quality and performance

All staff “from the cleaners to the consultants” attended regular weekly team briefing sessions when performance and issues of concern were discussed. Staff discussed

patient feedback, and were given the opportunity to raise issues of concern, which they said they could do openly. Complaints and incidents were discussed in a learning environment where no blame was attributed. The department had monthly clinical governance meetings that reported on updated national guidance, research, safety alerts, local audits, and learning from patient feedback and incidents. Regular and national audits took place and the department benchmarked itself against other departments nationally. There was a range of initiatives for service improvements. Staff were confident in the approaches taken to manage demand and said they were better prepared than in the previous winter.

The trust had 16 acute medical wards and five of these specialised in providing a service to elderly patients.

During our visit, we visited 10 medical wards including the five wards specifically for the care of elderly patients. These were Pulteney, Midford, Combe, older people’s assessment and comprehensive evaluation (ACE) unit, medical admissions unit (MAU), medical short stay and ambulatory care units, and cardiac, stroke and respiratory units. We talked with about 15 patients, 5 relatives and more than 22 staff including nurses, doctors, consultants, therapists, support staff and members of the senior management team. We observed care and treatment and looked at 38 care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

# Medical care (including older people's care)

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The trust had 16 acute medical wards and five of these specialised in providing a service to elderly patients. During our visit, we visited 10 medical wards including the five wards specifically for the care of elderly patients. These were Pulteney, Midford, Combe, older people's assessment and comprehensive evaluation (ACE) unit, medical admissions unit (MAU), medical short stay and ambulatory care units, and cardiac, stroke and respiratory units. We talked with about 15 patients, 5 relatives and more than 22 staff including nurses, doctors, consultants, therapists, support staff and members of the senior management team. We observed care and treatment and looked at 38 care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

Patients received safe and effective care. There were good outcomes for patients and the trust had improved its record keeping to ensure patients received appropriate and safe care. Staffing levels on medical wards, particularly in the medical admissions unit (MAU), was a concern. The trust was actively recruiting staff but current levels were having an impact on patient care. Staff were caring and most patients said they had been well cared for and staff were attentive. There were some concerns, however, when staff were busy, and in busy areas such as MAU when patient care needs were not always met. The care and treatment of older patients, especially those with dementia, was improving. Patients' discharge was well supported but there were delays for some patients with complex needs. The service was well-led and staff told us of their pride in working for the hospital. They said they felt better prepared to deal with service demands and winter pressures.

# Medical care (including older people's care)

## Are medical care services safe?

Patient received safe medical care.

### Patient safety

Patient risks were being managed. Information from the NHS Safety Thermometer Report – August 2012 to August 2013 showed that the trust had higher than the national average levels of falls with harm, catheter and urinary tract infections and blood clots. Overall, the number of patients who had developed a pressure ulcer was below the national average. The trust has identified that blood clots were not an outlier as the trust was a tertiary centre for treating pulmonary hypertension, which is coded as contributing to blood clots and therefore counted in the figures, and falls data showed decreased numbers. The trust had taken action to analyse the cause of the increased levels, and action plans had been developed to reduce the level of occurrence. For example, revised documentation and additional training in catheter use were introduced for nursing and medical staff. Additional staff were provided for patients who were at high risk of harm from falls or because of their behaviour.

Nursing staff undertook 'comfort rounds' at set intervals, and patients were checked for pain, nutrition, hydration, skin integrity, falls and general wellbeing. We reviewed 14 sets of patient records and these showed that risks to patients from pressure ulcers, falls, catheter and urinary tract infections, and the development of blood clots were being assessed and reviewed in line with trust policy. This information was being monitored by the trust and each medical ward displayed their monthly performance.

Staff responded well to risks of deterioration in a patient's condition, and were monitoring and tracking important clinical indicators. Safety briefings were held each day in respect of patients who had a heightened risk and these were recorded. There were, however, a few gaps. For example, staff were recording the food and fluid intake of two patients on Midford Ward, but the risk of dehydration in one patient and significant weight loss in the other had not triggered any investigation or referral to the medical team or other specialists. We identified these patients to the ward sister who subsequently referred them to medical teams and the dietitian.

The trust was implementing a policy of the right patient on the right ward. When the hospital was busy, patients could

be transferred to a ward that might not be right for their medical condition. During our visit, there were up to 18 medical patients on the wrong ward (called 'patient outliers'). Bed management meetings were held three times a day and the clinical site team met daily to review outliers and the level of risk assessment for each patient. The trust had appointed a consultant and two doctors who had a specific responsibility to review patient outliers and provide ward rounds to those patients.

### Managing risk

Staff told us they reported incidents but the electronic reporting system was not user friendly and could deter some people from reporting minor incidents. Ward staff discussed incidents at ward team meetings and senior nurse meetings, and changes in practice were highlighted. Staff said they were not routinely made aware of incidents that occurred outside their own ward so that the learning from incidents was not shared.

### Staffing

The trust had recruited two acute physicians to work in the MAU and this had increased senior medical staff presence at nights and at weekends. There were evening ward rounds seven days a week and lunchtime ward rounds at the weekend. Junior doctors told us they felt well supported by their consultants.

Patients did receive safe care but the staffing levels on some wards were of concern. Most of the medical wards we visited had vacancies. The trust was actively recruiting staff but current levels were having an impact on patient care. The MAU, in particular, was contending with vacancies, maternity absences and a high staff turnover. There was high use of bank and agency staff who had an appropriate induction to the ward, but this was affecting the continuity of care. MAU nursing staff told us staff shortages had an impact on assessing and monitoring patients. On the cardiac ward, nursing staff told us sometimes basic checks were not done if they were understaffed. For example, one patient had a pulmonary function test postponed because of staff shortages. These issues were identified on the trust risk register but the trust data on nurse vacancies did not match the information from staff.

### Medicines management

We checked how medicines were managed on Pulteney and Midford Wards. Medicines were appropriately managed and arrangements were legal and safe. Pharmacy staff were attached to each ward to ensure the safe use of



# Medical care (including older people's care)

medicines and we observed the pharmacist checking medicines for new patients. There were only a few examples of administration charts that were incomplete and these were identified to staff. Audits were done to ensure that standard medicines and controlled drugs were administered and disposed of appropriately.

## Infection control

Infection rates (August 2012–July 2013) were similar to other trusts for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile, although the trust had higher numbers of Clostridium difficile infections (which include community acquired infections) than expected against its own targets this year. We found that wards were clean and the environment generally well maintained. Hand washing facilities and hand hygiene gels were available in most areas and staff were observed using these. Personal protective clothing (such as gloves and aprons) was available in areas around wards for staff to access. Each ward had an infection control link nurse who provided guidance and support to other staff to ensure good practice was maintained. There were regular hand hygiene and infection control audits. The results were discussed at staff meetings and showed good practice.

## Equipment

All staff told us access to equipment for patients coming onto the medical wards with specific needs was not a problem. Specialist equipment could be ordered quickly from outside contractors or purchased if necessary. Electrical equipment had a portable appliance test annually. Night staff checked the resuscitation trolleys and records showed that this was done every day. Audits of the resuscitation trolley equipment were done by the resuscitation team. However, the electrocardiogram (ECG) machine did not have regular checks and staff would only know it was not working when they tried to use it. Ward-piped oxygen supplies were checked, although the methods for doing so differed between wards. Oxygen bottles were checked by porters, but ward staff were not aware of the recording system in use for them to be clear about available supplies.

## Environment

Ambulatory care was cramped for space. Staff told us there was a plan to enlarge it even at the loss of some beds in the MAU. The stroke unit and Helena Ward had limited recreational facilities for rehabilitating patients.

## Safeguarding

The staff we spoke with on all wards had received training in adult safeguarding; they understood what it involved and how to report concerns.

The trust had a safe wandering policy and this included, for example, a process of attaching sensor bracelets to the wrists of some people with dementia who were at risk of wandering off the ward. These would only be attached on the recommendation of the consultant for the ward. The trust policy detailed clearly when and how the bracelets could be used, and emphasised that this had to follow a Deprivation of Liberty Safeguards authorisation. We did not see the bracelets used, but medical and nursing staff were not clear about their responsibility to make and complete a Deprivation of Liberty Safeguards application.

## Patient records

The hospital used three main systems for recording patient information. These were patient paper records, an electronic patient record system (for most risk assessments) and, in the main reception area on wards, a whiteboard that provided information at a glance of the current risk and progress of each patient. The trust had a warning notice from our inspection in June 2013 and did not meet standards for Regulation 20 (1) (a) and 2 (a) (b) (Records) of the Health and Social Care Act 2008. During that inspection, we had identified that information about patients in these different formats differed, and that patients were at risk of inappropriate and unsafe care because their discharge arrangements, and their nutrition and hydration, were not recorded appropriately.

During the current inspection, we found that the paper records on most medical wards had improved. For example, risk assessments were completed and fluid charts filled in appropriately. Patient records included information on discharge planning 48 hours before discharge and packages of support had been confirmed. We checked the electronic records system on the stroke ward and this showed that the information there was consistent with that about the patient on the whiteboard and in the patient's notes. Medical staff, nurses, pharmacists and therapists were all completing the notes. The trust had introduced stickers for nursing staff on different shifts to record their comments in patients' notes. The trust now undertook a weekly ward audit of records and any shortfalls were discussed with the ward manager and staff.

# Medical care (including older people's care)

A few medical records still had some important information missing. For example, some fluid charts were not balanced, a task that would help to identify if a patient were dehydrated, and the risk level of a patient being treated to prevent blood clots was not completed.

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

Patients received effective medical care.

### National guidance

There was participation in national and local audit. The service was using national and best practice guidelines to care and treat patients. For example, the trust performed better than other trusts in the national audit of managing heart attack and similar to other trusts in the national audit on falls and bone health. Local clinical audit was undertaken and practice had improved.

### Patient mortality

Overall mortality rates for medical patient conditions (October 2013) covering 30 days after admission were similar to those of other trusts and there was no difference between weekday and weekend mortality. The specific hospital standardised mortality ratio (HSMR) is an indicator of the quality of care and compares deaths in hospital for specific conditions and procedures. The trust's HSMR was significantly lower than expected. Mortality rates were monitored and actions taken to address any issues that arose.

### Dementia care

The trust had received regional and national recognition and Dementia Charter Marks for its model of dementia care at ward level. There was a team of three clinical staff (equivalent to approximately one and a half clinical staff posts). The team aimed to see all patients admitted with dementia in order to reduce the number of transfers experienced by dementia patients between wards, make contact with family members to support their care, and ensure discharge was managed well. The team currently saw 60% of dementia patients.

The hospital had introduced a range of symbols to highlight to staff the different risks to specific patients, for example, a falling leaf symbol denoted those at risk of falling, an open door identified those at risk of wandering, and those patients with dementia were highlighted with

the 'forget-me-not' flower sign. These symbols were clearly marked on ward whiteboards and above patient beds. We found that they were in use but some patients were not identified appropriately. The trust had introduced 'This is me' documentation to inform staff about the individual needs of dementia patients. We reviewed four records for patients with dementia. The documentation should have been completed for three patients but was only partly completed for one. Staff showed awareness of the need to not move confused patients unnecessarily between wards. However, staff on the MAU expressed concerns about the number of patients being transferred at night, especially those who were elderly and confused.

Coombe Ward had been redesigned and refurbished as a dementia-friendly ward. There was clear signage, sensitive lighting and the environment was designed to feel more like home than a hospital ward.

### Multi-disciplinary team working

There was a good sense of team work in most areas. Staff on the MAU, medical wards and older people's wards worked well together and were dedicated and committed to providing a good service. There was good involvement of doctors, nurses, therapists and pharmacists in patient care. When patients required help from specialists (such as the tissue viability or learning disability matron), they received this, although there were some delays in identifying appropriate specialist support. There was cooperation with other healthcare providers. For example, staff on the MAU had direct access to a patient's GP records for emergency admissions. This meant critical information was available to them about patients attending for urgent unplanned care.

### Seven-day working

The trust had moved to seven-day working in some areas and staffing at weekends was similar to levels on weekdays. Consultant medical staff undertook ward rounds in the evening and at the weekend on the MAU, cardiology, oncology, gastroenterology and older people's wards. Stroke services had developed a seven-day transient ischaemic attack (TIA) service that was supported by occupational therapists and physiotherapists.

### Staff training and support

Staff told us they were given mandatory and more specialised training and received annual appraisals of their performance. Most staff felt well supported by their

# Medical care (including older people's care)

immediate line managers, and junior doctors said they felt supported by their consultants. At ward level, unregistered and registered nursing staff had individual induction and training programmes to monitor their competency.

## Are medical care services caring?

Staff provided a caring service to patients receiving medical care but there were some concerns when staff were busy.

### Compassionate care

We spoke with 33 people at our listening events and some told us their care was explained and they were dealt with quickly. Some told us their relatives had good dementia care. A few people noted that they had been transferred at night, and that when staff were busy they did not have time to listen or respond to personal care needs.

Most patients and relatives commented positively about their experiences of care on the medical wards. Many held the hospital in high regard and, as a result of successive admissions, some patients were able to compare positively their current experience with previous admissions. Patients and relatives said they felt well informed and consulted about care decisions. Patients told us staff were "caring" and "kind". In the neurology ward, one patient who had been admitted since September told us nursing staff were compassionate and "took time to know you as a person". They had managed her care with dignity and respect.

### Privacy and dignity

We observed staff to be busy but attentive and responding to patients promptly when possible. Call bells were in reach of patients, and staff also responded to patients when they called out. We saw that patients' privacy and dignity were respected by the appropriate use of curtains during delivery of personal care or examinations. Some staff told us about some concerns. Healthcare assistants said when they were busy, patient checks were not completed thoroughly and delivery of personal care took much longer. One patient told us that, at busy times, it took longer for staff to answer call bells, but they felt this was an acceptable delay.

We observed a few incidents when staff lacked a person-centred approach. For example, on the medical admissions ward, we heard a patient referred to by their bed number. A dementia patient's notes described them as "aggressive" but did not say how they could be supported when they

exhibited this behaviour. A patient from an ethnic minority background told us their support was "okay but inconsistent". They had required personal care support, for example, for their hair and skin but their notes did not refer to the support they needed.

Patients told us there were appropriate arrangements for single-sex accommodation on the medical wards. The wards had maintained single-sex facilities.

### Patient feedback

The NHS Friends and Family Test was introduced in April 2013 and this asked patients whether they would recommend hospital wards to friends or family if they needed similar care or treatment. In November 2013, the trust inpatient survey scores were slightly above the national average.

### Meals

Patients received drinks when needed and were given assistance with meals. Red trays were used to identify patients who needed assistance and there were visual symbols on whiteboards above patient beds to alert staff. We observed lunchtime on an older person's ward and saw that patients were supported to eat and drink appropriately.

## Are medical care services responsive to people's needs? (for example, to feedback?)

Services were responsive to the needs of medical patients but there were discharge delays for some patients with complex needs.

### Length of stay

The trust had introduced measures to reduce patients' length of stay in the hospital. Ward rounds had increased to two or three times a day on medical wards, and were undertaken in the MAU, cardiology, oncology, gastroenterology and older people's wards by consultant staff. There was a triage team for the admission of older patients that identified those appropriate for a short stay on the new ACE unit because of their less complex medical needs. These patients had a planned discharge for within 72 hours of admission and would receive information and contact details on local community services. Patients whose condition worsened would be transferred to an older person's ward. The ward manager audited reasons for

# Medical care (including older people's care)

patient re-admission and gave staff feedback. The ambulatory care unit provided a location for the assessment of less sick patients who were likely to be able to return home the same day, as well as review clinics for patients attending for daily treatments, procedures or investigations. Unnecessary admissions for patients had been avoided because the unit provided diagnostic, assessment and senior clinical review of patients referred for admission.

## Patient discharge

Patients received appropriate information about their discharge but there were a significant number of discharge delays. During our visit, there were 18 patients on the medical wards who were considered medically fit to be discharged but were either awaiting appropriate care packages of support or a rehabilitation bed in a community hospital. These delays were affecting the flow of patients throughout the hospital because they were blocking beds.

## Transport home

A decision to change the provider of non-urgent patient transport was recently taken by the clinical commissioning group (CCG). Staff told us that this had caused some difficulties with patients not being picked up from wards or transport arriving too early or too late. Transport that was too late meant that patients could not return home that evening because they would have missed planned care support.

## Are medical care services well-led?

Medical care and care of older people was a well-led service.

## Leadership and culture

Staff in the medical division worked well together and were dedicated and committed to providing good patient care, and to improving care for older people, in particular. Staff said they felt supported by their line managers and junior doctors told us how they were supported and actively encouraged to be involved with projects that had a direct impact on the quality of the service offered. Some staff were aware of individual board members undertaking board rounds and expressing very caring attitudes. Other staff were less aware of the top management team and had never met any of them. Staff at all levels told us they were proud to work in the hospital.

## Managing quality and performance

Ward staff meetings were held when staff received feedback about ward performance. Ward staff were aware of the audits and displayed safety information. Sisters told us they undertook spot checks of their wards but these were not recorded and nor were any outcomes from them. Clinical governance meetings were held every three months and incidents, complaints and concerns were identified. The trust risk register identified the most serious patient safety risks and those that breached waiting time targets or good practice guidance. There were, however, some risks we identified, such as equipment checks and staffing issues that were not recorded on the risk register. Staff told us they were better prepared to manage winter pressures this year and staff engagement had improved in the trust.

# Surgery

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The surgery division consisted of seven surgical wards, a surgical admissions unit and 16 operating theatres in three separate suites. The hospital provided a range of surgery including trauma, orthopaedic, ophthalmic, urology, gynaecology and general surgery. The emergency and ophthalmic theatres provided a 24-hour service.

We visited four surgical admission wards, including the trauma and orthopaedic wards, the surgical short stay unit (SSSU), the surgical admissions unit (SAU) and the three theatre suites. We talked with 11 patients and 44 staff, including nurses, therapists, healthcare assistants, doctors, consultants, support staff and senior managers. We observed care and treatment and looked at six care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

Patients received safe and effective surgical care. There were good safety checks and management of risks to patients. The reporting of incidents to learn from mistakes was improving. Cleanliness and infection control were good. The surgical environments were well managed, but some areas could have been better maintained. Equipment was usually available when needed, although some checks were not done as required. Staff were caring and services were responding to patient needs. However, levels of nursing staff sometimes delayed patient surgery and delayed patient transfers between theatre, recovery and ward areas. There were some concerns, when staff were busy, and in busy areas such as the short stay surgical unit, when patient care needs were not always met. Staff had improved their understanding and approach to the care of people who were vulnerable, such as patients with a learning disability or dementia. They were dedicated, and most teams worked well together to coordinate patient care. Staff told us they were proud of the work they did.

# Surgery

## Are surgery services safe?

Patients received safe surgical care.

### Patient safety

We observed good surgical safety checks in place in the operating theatres we visited. These included the use of the World Health Organization (WHO) surgical safety checklist, which is designed to prevent avoidable errors. All the staff involved in a patient's operation had a responsibility to complete the checklist and staff told us it was "really thorough" and "nothing happens until everything has been checked". A monthly audit of the checklist started in 2010 and figures for August and September 2013 showed 100% compliance. The trust had not had a 'never event' (which is a largely preventable patient safety incident that should not occur if preventative measures are taken) within the last 18 months.

The surgical wards had a focus on patient safety. Nursing staff said a safety briefing was used at handover sessions and this covered key risks for patients, such as being at risk of a fall or being dehydrated. However, two staff said the handover on the SAU had recently been shortened and they did not feel as well informed as before. The whiteboards used on wards included known safety risks to patients and these were coded to protect confidentiality.

Information from the NHS Safety Thermometer Report – for August 2012 to August 2013 showed the trust had higher than the national average levels of falls with harm, catheter urinary tract infections and blood clots. The trust has identified that blood clots were not an outlier as the trust was a tertiary centre for treating pulmonary hypertension, which is coded as contributing to blood clots and therefore counted in the figures, and falls data showed decreased numbers. The trust had taken action to analyse the cause of these increased levels, and action plans had been developed to reduce the level of occurrence. For example, the trust had a clear policy on the prevention and management of blood clots, and 90% of eligible patients had preventative treatment in October 2013. Two patients on the surgical ward told us they had assessments for the risk of blood clots before surgery. Overall, the number of patients who had developed a pressure ulcer was below the national average. The trust had rolled out a 'Think Pink' scheme to prompt nursing staff to check the skin of patients assessed as at risk of pressure ulcers.

### Managing risks

Staff told us there had been a lack of good incident reporting in recent years, but this was improving. They explained the reasons for low reporting. Nursing staff in the main operating theatres who reported incidents had received poor or no feedback and this had discouraged the further reporting of incidents. Many staff told us the electronic incident reporting system was easy but frustrating to use. The system would "lock you out" and not save part-completed entries. Staff had to repeat the process or abandon it if they did not have the time. A doctor said they understood the value of reporting incidents and did report serious incidents, but staff were sometimes too busy to report events.

Staff said there had been a recent drive by the trust to improve reporting. However, the trust could do more to promote the value of reporting incidents. Staff said they were not made aware of any changes to avoid repeated incidents, and examples of positive changes that emerged in other areas were not shared. None of the staff we met said they felt they would be penalised for reporting incidents.

### Staffing

Staff and patients in most of the theatre departments said there were usually enough staff on duty at all times. Staff on the wards said they sometimes did not have enough staff for some routine or unexpected duties. The ward staff confirmed they sometimes "struggled" with competing priorities for the patients on the wards and those waiting to be collected. On Forrester Brown Ward, for example, staff said it was sometimes not possible to get additional staff when a patient needed extra support. They said there were sometimes not enough staff to respond to the assessed need for a patient to have more intensive support. In the post-anaesthetic care unit (PACU), staff told us there were sometimes problems getting patients taken back to wards. This was usually because there were not enough staff on the wards to come and collect the patients. A doctor said they had experienced how the pressure on nursing staff could affect the rest of the surgical division. If nurses were not able to collect patients from PACU when required, this had a knock-on effect for patients waiting for elective surgery and sometimes operations were delayed or cancelled.

Senior staff ensured operating theatre teams had the right skills and experience to work safely. Staff in the main

# Surgery

operating theatre said if there were any concerns about the skills or experience of agency staff, they would not be permitted to stay. A senior theatre nurse said the department would be prepared to cancel operations if there were not enough skilled and experienced staff due to unforeseen events. They said, "I will never put patients at risk for targets," adding that they felt supported by the department in this objective.

The SSSU managed low-risk patients, and admissions could vary depending on the demands on the service. Nursing staff said it was not always possible to staff the unit to an appropriate level for patient admissions. Patients on the SSSU told us sometimes there were not enough staff to meet their needs.

## Infection prevention and control

Infection rates (August 2012–July 2013) were similar to those of other trusts for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile, although the trust had higher numbers of Clostridium difficile infections (which include community acquired infections) than expected against its own targets this year. We found the wards we visited were visibly clean. Staff were using protective equipment and clothing, such as aprons and gloves. Hand hygiene gel was available at the entrances to surgical wards and units and staff were observed using these, although we did see staff approach a patient on the PACU without first washing their hands. There were regular hand hygiene and infection control audits. The results were discussed at staff meetings and showed good practice.

## The environment

Most surgical areas were well maintained. However, some areas of the PACU were showing signs of age and a lack of recent maintenance to support infection prevention and control. For example, in places, some of the skirting boards were coming away from the walls leaving exposed areas where dirt could accumulate. There was a poster taped to the wall with sticky tape. An area below a heater was in a poor state of repair. The main hand wash sink had stained sealant that was peeling and old. The PACU did not have enough wall-mounted storage for disposable gloves, which meant cleaning the surfaces they were then placed on, such as window ledges, was less efficient.

Most patients were happy with the environment. Patients we met said the wards were "not too bad", "relatively okay"

at night, and they could get some sleep and rest. A number of patients and staff said the hospital was "too hot". We also found the hospital was hot in meeting rooms and some of the ward areas.

## Equipment

Checks on emergency equipment were not always done. Some of the daily checks on resuscitation equipment were not done. Staff knew these checks were required each day. They said there was sometimes a lack of consistency in checking and agency staff were not always clear of their responsibilities. Staff on the PACU said there was no responsibility given to the next member of staff making the checks to find out why the previous check had not been made or not recorded.

Most areas had the equipment available when required. The anaesthetic rooms were well stocked with equipment and medicines. Theatre staff told us they generally had everything they needed. Some staff said some of the equipment was old and needed replacing, for example, the operating theatre tables were now too narrow for some obese patients. On one ward we visited, nursing staff told us they sometimes had a shortage of blood pressure monitoring machines. They said they needed to spend time looking for them.

A potential fire was averted in the PACU during the inspection. We observed an electrical flex draped over the front and top of a portable heater, which was switched on. The flex was exposed to the heat and there was a burning smell. We immediately alerted staff, who escalated the problem.

## Medicines

Medicines were stored and administered appropriately. However, we found two examples of where there were out-of-date medicines. These were in an anaesthetic room, and controlled drugs that were marked as expired were in the PACU cabinet. The PACU matron said they had asked the pharmacy team "on a number of occasions" to collect these controlled drugs for destruction. The temperature of medicine fridges were usually checked, but some of the temperature checks were missing.

## Patient records

Patient records were comprehensive and included patient information, assessments and plans of care. They showed staff recognised each patient as an individual with different needs. For example, the records of one patient with specific

# Surgery

mental health needs described how staff should communicate with the patient, the way food and drink should be given safely, and what the person did or did not like.

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

Patients received effective surgical care but care needed to be monitored on the surgical short stay unit.

### National guidance

National clinical audits were completed, such as the national bowel cancer audit, and the trust performance was similar to that of other trusts. Outcomes for patients with a fractured hip were better than those in other trusts. Information on patient reported outcome measures (PROMs) was gathered from patients who had groin hernia surgery or hip or knee replacement. Patients were asked about the effectiveness of their operation and the data showed no evidence of risk. Local audits were undertaken on surgical procedures and the use of medicines in surgery, for example, the availability of emergency medicines on the ward.

### Patient mortality

Overall mortality rates for surgical patient conditions (October 2013) covering 30 days after admission were similar to those of other trusts and there was no difference between weekday and weekend mortality. The specific hospital standardised mortality ratio (HSMR) is an indicator of the quality of care and compares deaths in hospital for specific conditions and procedures. The trust's HSMR was significantly lower than expected. Mortality rates were monitored and actions taken to address any issues that arose.

### Pain management

Most patients we met on our visit said their care had been effective. However, we had some concerns about the support to patients in the SSSU. Until recently, this unit was called the 'day surgery unit' (and remains under this title on the trust website). A few patients told us their pain was not being well managed. One patient, for example, said they had been asking for effective pain medicine and had been told by staff that only a basic analgesic was available. This patient said they felt no one on the ward was in control. A second patient was described by another as "sobbing in pain".

### Multi-disciplinary team working

There was a strong sense of team work in most areas. There was good involvement of doctors, nurses, therapists and pharmacists in patient care. The operating theatre teams said they worked well together and each member of the team was respected and included. The members of the emergency team in the SAU were particularly committed and dedicated to each other, and the service they provided. Other surgical teams and wards were also committed to ensuring patients received the best care, although some staff identified that working relationships could be more effective with the consultant staff.

There was cooperation with other healthcare providers. For example, staff on the SAU had direct access to a patient's GP records for emergency admissions. This meant critical information was available to them about patients attending for urgent unplanned care.

### Seven-day working

The trust had moved to seven-day working in some areas and staffing and services at weekends was similar to levels on weekdays. Consultant staff undertook ward rounds on the SAU in the evening and at the weekend. Services for patients with hip fracture were supported by occupational therapists and physiotherapists seven days a week.

### Staff training and support

Staff told us they felt training was generally done well and they were given time to attend or complete courses. We had mixed responses from staff in relation to professional development. Some staff said there was always time planned for them to learn or update professional skills. Others said it was one of their objectives, but the pressures of the job often meant other things took priority.

Staff said they felt generally well supported by their line managers and junior doctors told us they were well supported by consultant staff. All those we met had an appraisal each year. They said they could talk with their manager or senior people at any time and felt supported to be open and honest. All the staff we met said they were proud of the job they did and of working for the trust.

### Consent to treatment

Most of the patients we met said the process of giving their consent for the hospital to perform surgery was good.



# Surgery

Patients said they were given an adequate level of information to make a valid decision. This included the risks and benefits of a procedure. Their consent was checked again before the start of any operation.

Patients who could not give valid consent because of temporary or permanent cognitive impairment were considered appropriately. Staff in the operating theatres said they understood the requirements of the Mental Capacity Act 2005 to ensure treatment was provided in a patient's best interests. They said any decisions would be made with the input of people who could speak on behalf of the patient. Staff understood the treatment should be the least invasive and they were to explain to a patient what had been done if the patient regained capacity to consent. Staff also knew how the law enabled them to operate on a patient without meeting minimum legal requirements for consent in order to save the patient's life or prevent a serious deterioration of their condition. This would happen, for example, if a patient was unconscious after an accident.

## Are surgery services caring?

Staff provided caring services to patients receiving surgery.

### Compassionate care

We spoke with 33 people at our listening events and they had mixed views about surgical care. Some people said they had found most staff to be compassionate and caring. Others had concerns about staff lacking respect, or not having enough time to communicate. One person said of one surgical ward that some of the night staff were "not great" and their relative had been "scared" of them.

We observed staff to be thoughtful and considerate with patients. The CQC Adult Inpatient Survey in 2012 reported the hospital was better than other trusts in terms of anaesthetists or other members of staff explaining how they would put a patient to sleep or control their pain. We heard a patient who was nervous about an imminent operation told by a nurse that it was "perfectly normal to be nervous, and I would be too, but you are in great hands. You will be fine and we will look after you when you get back here." We observed a healthcare assistant on one ward politely asking all the patients if they were happy for a window to be opened. One patient said to us, "That's not for your benefit. Most of the staff are like that all the time."

A carer at one of our listening events told us about how they felt the hospital had changed and improved care. They said, "The care and support to my [relative] this year was fantastic. There have been real improvements." Almost all patients said staff were caring. Patients on Forrester Brown Ward said the staff were "excellent", "I think they're brilliant", and "They can't do enough for you." A patient we talked to on the PACU said care had been "amazing" and "The staff have been really kind." Another patient described the care in the surgical department as "really good. I could not fault them". A patient on the SSSU said, "They have been fabulous" and another commented, "I've not had a bad experience at all."

Most patients received care when they needed it. The patients we met on the surgical wards said they did not usually have to wait long for staff for assistance or regular duties. This included, for example, being given medicines and helped to wash or dress or get out of bed safely. Two patients on the SSSU said they did not receive help when they asked for it, but two other patients said staff were quick to respond.

### Patient feedback

The NHS Friends and Family Test was introduced in April 2013. This asked patients whether they would recommend the ward they stayed in to friends or family if they needed similar care or treatment. The trust inpatient scores for November 2013 were slightly above the national average.

### Privacy and dignity

Patients and their families were treated with dignity and respect. Staff generally talked in quiet voices so as not to be overheard, and they pulled curtains around a patient's bed space to increase privacy. At times, conversations could be overheard, but this was difficult to avoid in some circumstances, for example, if the PACU was busy and observations and close monitoring were essential for safety. The unit was relatively small and beds were close together. There were, however, curtains available for use around bays if needed. We observed a situation in the main operating theatre where exceptional consideration and respect was shown to a patient's relative.

Patients told us there were appropriate arrangements for single-sex accommodation on the surgical wards and on the SSSU. When we visited this unit on a Saturday evening, the single-sex arrangements were being respected.

# Surgery

## Meals

Patients received drinks when needed and were given assistance with meals. Red trays were used to identify patients who needed assistance. We observed lunchtime on a surgical ward and saw that patients were supported to eat and drink appropriately.

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

Surgical services were improving but needed to be more responsive to patients' needs.

## Waiting times

We spoke with 33 people at our listening events and a few told us about waiting more than 18 weeks for surgery and operations being cancelled.

The SSSU supported patients for day surgery and longer stays, for example, if a patient was not well enough to be discharged home, or the hospital had no bed capacity on other wards. This ward was only used for low-risk patients but it was not ideal for inpatients because, for instance, there were no windows or television facilities.

During January to March 2013, the trust had performed much worse than expected for cancelling operations for non-clinical reasons, and for patients not receiving an operation within 28 days following cancellation. The trust was meeting the national 18-week maximum waiting time for patients to have planned surgery overall, but waiting times were not being met for elective surgery in trauma and orthopaedics, oral surgery and cardiology, or for day cases in general surgery, trauma and orthopaedics, ear nose and throat (ENT), gastroenterology, cardiology and respiratory medicine.

The trust planned to reduce waiting times based on the urgency or clinical need of patients rather than targets. However, senior staff in the main operating theatres told us they felt they were sometimes given "impossible lists" and staff had "no room for manoeuvre" should a procedure need more time. They said they "often"

worked longer than scheduled to try and finish a list. This inevitably meant elective surgery would have to be cancelled. However, staff said they felt they were doing their "very best" for patients when "no day is often what you planned or expected".

The trust had a new emergency surgical ambulatory clinic that was specifically designed to see patients with urgent general surgical problems such as gallstones, hernias and abscesses. Patients were assessed, diagnosed (and some had their procedures) on the same day. The clinic had helped to avoid hospital admissions and had reduced the time inpatients waited for emergency surgery.

## Discharge of patients

Patient discharge was done well. Patients we met who had been discharged from the PACU said they felt their discharge was safe, they were not discharged before they were ready and they did not have to wait in the PACU for too long. Staff on surgical wards and the PACU said sometimes there were not enough staff on duty to collect patients from the unit in a safe and timely manner. They would keep a patient on the unit until they were able to leave, but this had caused problems in the past with the flow of patients coming through from surgery.

## Vulnerable patients

The trust had increased its knowledge and skills for supporting people who were vulnerable. We observed care delivered with kindness on a surgical ward to a patient with learning disabilities. There was a hospital sister who supported people with learning disabilities and they had checked this patient to see if any additional support was required. Staff in the main operating theatre told us how they spent more time if needed and took a different approach to caring for people with dementia. They said they encouraged a patient's carers to stay with them as much as possible to give the patient reassurance.

## Are surgery services well-led?

The surgical division was well-led.

## Leadership and culture

Most staff in the surgical division worked well together and were dedicated and committed to providing good patient care. In some areas working relationships with consultant staff could be more effective. Staff said the management team was well respected. The trust had recently appointed

# Surgery

a manager for anaesthetic services who supported the surgical and critical care teams. Staff spoke highly of this person and comments included: “[They] have really made a difference” and “We feel really well supported now and confident for the future.” Communication between senior management and staff in the surgical team had improved. Staff told us the situation was better after recent appointments at management level, but there was still work to do. Staff in operating theatres said they “rarely saw” or “could not recall seeing” a member of the executive team visiting the department.

## **Risk management**

The trust identified and managed surgical risks. The trust risk register included risks identified, for example, cancelled operations, delayed discharges from the PACU and the lack of planned maintenance recorded. Staff could enter items on the risk register through the trust-wide reporting system. Each risk recorded had an action plan and deadline for completion of the action. Risks were discussed at departmental clinical governance meetings, and information from incidents, complaints and patient experiences was starting to be used to improve services.

# Intensive/critical care

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The trust's critical care unit included the intensive therapy unit (ITU) and the high dependency unit (HDU). These were located together and had 11 open beds, although the space was configured for 13 beds. A critical care outreach team assisted with the care of critically ill patients who were on other wards throughout the hospital. The critical care service had consultant cover 24 hours a day.

We talked with one patient, four relatives visiting the unit and 14 staff. These included nursing staff, a doctor, a consultant and senior management. We observed care and treatment and looked at four care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

Patients received safe and effective care although staffing levels in the critical care unit needed to improve to reduce the pressures on staff. Obtaining patient consent was done well but capacity to consent to care and treatment was not documented appropriately. Clinical outcomes for patients in the unit were good and often above the national average. The consideration and compassion shown by staff to their patients in critical care were outstanding. Staff morale was improving and there was effective team working, although training and professional development needed to improve. There was an unacceptably high level of delayed discharges because of capacity problems elsewhere in the hospital, and this added to the pressures on the unit. The trust was taking action to manage risks, but national delays to recruiting staff had not previously been clearly communicated to staff. Staff told us risks were now being managed effectively.

# Intensive/critical care

## Are intensive/critical services safe?

Patients received safe care but staffing in the critical care unit needed to improve.

### Patient safety

The critical care service had a good patient safety checklist for staff to deliver a safe and effective handover of patients when shifts changed. Each patient in an intensive care bed had one-to-one nursing care at all times, and for patients in a high dependency bed there was one nurse caring for two patients. This followed recognised guidelines.

There was an outreach team for the hospital led by a consultant nurse with two nurse staff. The team had increased its nursing staff by two following changes in the deployment of staff after the pressures on the hospital in early 2013. The outreach service ran for five days per week 8am to 8pm. The nurse manager told us it was well used. The early warning score for a patient, which was a system to standardise the assessment of acute illness severity, indicated when the ward should be contacting the outreach service. The trust had had a serious incident in June 2013 when staff had failed to act on a patient's high early warning score on multiple occasions. The outreach nurse said the system was working but "not flawless". Some wards were using the service well, but in others the use of early warning scores could be improved. The nurse manager felt the service "made a real positive difference to patients", and feedback from the wards was that staff were quick to respond and the support patients received was good.

### Staffing arrangements

There were sufficient medical staff, and consultant staff were on call out of hours and at weekends. Junior doctors told us they felt well supported.

The staffing levels, experience and skill mix of the nursing team on the unit were not sufficient. Staff told us the service had experienced a high turnover and they were struggling to retain staff. Staff had left because the unit was too busy and they did not feel supported. The nursing team said they had found it difficult to train and induct new staff and keep the unit running safely. Working with a lot of bank and agency staff also increased risks, because unfamiliar staff would always need orientation and supervision even if they were regular workers. This resulted in "more pressure on everyone".

Staff told us staff levels were not always safe. In the six months from June to November 2013, only 72% of working hours in the department were covered by employed registered nursing staff. When agency and bank staff were taken into account, this increased to 86% but left 14% of shifts for registered nurses unfilled. This number did not take account of any unplanned absences. Staff had evidence showing that for the two months of July and August 2013 the unit was staffed by only 20–30% of the substantive workforce. Some of the shortfall was improved by healthcare assistants, introduced in August 2013, who supported nurses on the unit. The trust had taken action to recruit overseas staff in December 2012 and January 2013, but these appointments were delayed based on national policy decisions on overseas recruitment. Nursing established numbers had also been increased. Staff felt that risks in critical care had not been treated as a priority. The trust has acknowledged that actions were not effectively communicated to the critical care staff, who were recognised as working under extreme pressure. The critical care team was optimistic about the arrival of the new manager in September 2013 and communication and staffing levels were improving. Staff concerns were put on the trust risk register in November 2013.

Staff were not always able to fulfil their roles and responsibilities. The post of nurse in charge was established as supernumerary to manage the running of the unit. However, the nurse in this post had spent more than 50% of her time last year on direct patient care. Staff said the nurse in charge spent "a lot of time organising shifts, moving staff and fighting for agency staff". Senior nurses were allocated one day each week for administration tasks. The nursing staff we met said this was "rarely" achieved. Staff said they wanted to work on the ward with patients rather than having to do further administrative tasks.

### Infection prevention and control

Infection prevention and control was well managed overall, although some infection rates were of concern. The Intensive Care National Audit and Research Centre (ICNARC) report published data from all the NHS trusts taking part in the audit (93% of eligible units). The latest ICNARC report showed unit-acquired methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile infections were, overall, very low and better than the national average. Infections in blood for ventilated patients

# Intensive/critical care

were higher than the national average since reporting started in 2008. The trust has implemented an infection reduction strategy and reported this on the trust register of risks.

We observed a good use of infection prevention and control within the unit. Each area around a patient bed was marked with red and green lines on the floor. Staff were required to ensure they had disposable gloves and aprons on when they were working within the red lines. They knew to not leave the bed space and withdraw into the unit without removing gloves and aprons first. Yellow aprons were worn to indicate staff working with a patient with an infection. Side rooms were used whenever possible to nurse these patients but the unit did not have sufficient isolation facilities.

## Facilities and the environment

The unit was normally divided into seven beds used for ITU patients and four for HDU. The bed configuration could be altered to meet changing priorities. The unit was comparatively small in size considering the trust had 600 beds. Patients were managed in the post-anaesthetic care unit (PACU) when numbers increased to over 11 patients. The PACU nurses had critical care competencies and an anaesthetist and ITU trained nurse remained in the department if patients required ventilation. Several ITU trained nurses currently worked in the PACU, and a rotational programme between the PACU and critical care was planned to support the maintenance of clinical knowledge and skills for high dependency care.

There was a centralised desk space in critical care where the staff team could observe the patients in the main area. Two of the four side rooms were directly in front of this desk. The other two side rooms were at the end of the unit, although obscured to an extent by equipment. There was a large visitors' room with facilities for making refreshments. There was one bedroom for relatives to stay overnight with a lounge area, kitchenette and bathroom facilities.

## Patient records

The patient records included comprehensive information on the assessment and monitoring of patients. The patient-safety checklists were completed at the beginning of each shift. There were patient assessment charts,

for example, on patient's wellbeing, communication, mental health and mealtime assistance. There were also

risk assessments and care plans on mobility, nutrition and pressure ulcer prevention. Records for clinical care included invasive line monitoring, arterial line care plans and ventilation care plans.

## Safeguarding

Staff understood safeguarding processes and knew how to report concerns. Many staff had had safeguarding training. Staff were, however, not clear about the Deprivation of Liberty Safeguards and whether this process should be used if a patient had to be restrained for their own safety or that of others.

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

Patients received effective critical care.

## National guidelines

Patients received care in line with national guidelines. There was a set of criteria for patients to be admitted to critical care and the early warning scoring system was used to refer patients to the critical care outreach team. The outreach team was responsible for reviewing patients to determine appropriate admission to critical care. Medical and nursing staff felt some patients continued to deteriorate on wards and were not referred early enough, and that there should be clearer referral criteria to critical care outreach particularly as the support was not available seven days a week.

## Consent to treatment

Staff understood how to gain valid consent, but it was not always documented. We did not see evidence of staff recording whether a patient in their care had the capacity to give informed consent. We checked the pack of documentation required for a patient in critical care and could not see where this process would be considered and recorded.

## Multi-disciplinary team working

Staff in the critical care unit said they worked well together and supported each other. A doctor said the nurses were "fabulous" and "I couldn't have coped without them". Staff morale had improved recently and the doctor said the core team of the long-standing staff was "incredibly resilient". Staff said they had a good support network with each other and they were a strong team. They said the hospital had a

# Intensive/critical care

“very good” employee assistance programme where they could get counselling support when needed. There had recently been a ‘listening event’ with critical care staff to listen to and discuss the issues faced by the team.

## Collaborative working

The hospital had escalation and support mechanisms when critical care beds were full. The critical care unit had limited facilities and skills to support critically ill children for long periods. In this situation, children were able to be admitted to the unit and would be looked after and stabilised until they could be transferred to a specialist unit (usually in Bristol). The paediatric intensive care unit (PICU) consultant for the area had come to the unit on an annual basis for a review of children transferred to the PICU in Bristol. Cases were discussed for shared learning and to consider any improvements that might be made.

## Staff training and support

Support for new staff had improved. We met a nurse who had joined the team recently. They said they were supported and mentored at all times. They had a good induction and their competency was monitored. They said their personal aim was “to emulate the nurses” because they were “so impressed with them”. Junior doctors said they received strong support, guidance and teaching.

Staff said mandatory training was mostly up to date, but there was little time for more specialist training. There was no education lead in the department. The trust action plan for the critical care unit said a business case had been prepared for funding to recruit to this post as soon as possible. That person would then develop a training needs analysis for the department. The medical team in the department often adopted new ways of working early in their induction. We found the staff innovative and wanting to improve skills and knowledge.

## Outcomes for patients

The outcomes for patients who were in the critical care unit were similar to the national average. The ICNARC report published data from all the NHS trusts taking part in the audit (93% of eligible units). The latest ICNARC report for this trust’s critical care services showed the unit mortality rates were similar to those of other units, and had improved since early 2012. The length of stay for patients on the unit was also similar to the national average.

## Are intensive/critical services caring?

Staff showed outstanding care and compassion for patients and their families.

### Compassionate care

A patient told us staff were “wonderful” and they were receiving an “excellent service”. A relative also said the unit was “wonderful” and staff were “so caring”. We observed care on the unit and found it to be delivered with kindness, professionalism and dedication. We met and talked with members of a team including a doctor, four nurses, a healthcare assistant and the critical care outreach team manager. One of the nurses was part of a recent recruitment of overseas staff. This nurse and the rest of the team talked in a personal and individual way about the patients they looked after. They told us they would ensure any patient who was at the end of their life was not left alone. A nurse would always sit with a dying patient if they had no family or friends with them.

We knew and appreciated how staff who worked in critical care were looking after patients who were acutely unwell. Staff told us statistically, around 20% of patients in critical care units do not survive, despite the very best care and efforts of staff. Staff were faced with this regularly as part of their working life. Those we met and talked with were dedicated to supporting patients and their families during admission into critical care. Their primary goal was to achieve excellent patient care.

They told us how they met and tackled each new challenge as it arrived, and how they found strength to absorb and work round the issues they could not control. These included staff shortages; a high turnover of staff; working with agency and bank staff; and recovering from and dealing with a serious fire in the department in 2011.

### Consideration of patients and their families

Staff were considerate of patients and their families. A family member said they had been kept well informed about their relative at all times by both nurses and doctors. They said they felt they could ask questions and were not made to feel intrusive. A patient said they were “made very comfortable”.

### Person-centred care

Care was centred on the patient. A patient confirmed they had “not been left all day” by nursing staff. They said they

# Intensive/critical care

had seen the doctor and were aware there was a doctor on duty at all times. We observed patients being supported by staff at all times. Staff were constantly checking that their care needs were being met, and providing clinical and emotional support to patients and their relatives.

## Are intensive/critical services responsive to people's needs? (for example, to feedback?)

The critical care service could not always respond to patients' needs because of the availability of critical care beds.

### Patient discharge

The critical care unit had many patients whose discharge was delayed. These were patients who were medically fit to be discharged to a ward but no beds were available. This meant that sometimes beds were not available and patients who needed critical care were not admitted to the unit. Conversely, when the unit was under pressure to admit patients, there was also early discharge for patients who would have benefited from a longer stay.

The ICNARC report published data from all the NHS trusts taking part in the audit (93% of eligible units). The latest ICNARC report showed the unit performed out-of-hours discharges (those between 10pm and 7am) significantly above the national average for the last three years. Around 80% of all discharges were delayed (the national average was around 40%) and around 80% were delayed by more than four hours (the national average was around 55%). A senior member of the team described this situation to us as "a high risk for patients", particularly if patients were not transferred to the correct ward. The hospital site team (who managed the patient flow) now came onto the unit each morning to review the current position. Senior staff said "smarter working" was being trialled in different ways to anticipate and reduce pressures and the trust was actively working to manage patient flow through the hospital. This was on the trust risk register.

### Access to services

Patient surgery was being cancelled because of a lack of available critical care beds. Staff in the unit and the trust risk register reported the cancellation of elective surgery, including cancer surgery, when the unit was full to capacity. From April to October 2013, there had been 16 elective

surgical procedures cancelled. When the unit was full, patients assessed as at a lower level of risk were cared for in the PACU or remained on a ward with support from the critical care outreach team. Staff told us the nursing team on the PACU were trained to manage critically ill patients and, although the situation was not ideal, the risk was well understood and managed. This was on the trust risk register and an action plan had been developed. The first meeting of a steering group to look at resolving the issues had been held in early December 2013.

### Information

The trust produced a leaflet for patients and family members about the unit. This explained how the unit was run. Staff recognised the stress for visitors coming into the unit, caused by, for example, the extensive use of equipment and the noisiness of the unit. Staff encouraged visitors to ask questions.

## Are intensive/critical services well-led?

The leadership of the critical care service was improving.

### Leadership and culture

The critical care unit was staffed by a dedicated and passionate team who worked well together. The department was innovative and wanted to deliver world-class care. A new manager for the department had been appointed in September 2013. Staff said this person was "a breath of fresh air" and "had made a dramatic difference". Staff said the manager was "visible" and came to the unit "all the time". One member of the nursing team said, "Just seeing if we are okay is a total change for us." Senior staff told us "smarter working" was being trialled to anticipate and reduce pressures.

### Risk management

The service was monitoring quality and safety issues and these were discussed in staff meetings. Participation in national and local audit was improving outcomes for patients. Risks to patients were identified and were on the trust risk register. Staff had taken some action to mitigate risks within their control and risks were being monitored to show that action was timely or effective, but there was no progress reported on some risks despite the rating of the risk having been downgraded. The trust had acknowledged the need to improve communication with the critical care



## Intensive/critical care

team and demonstrate the action taken on risks, such as on staffing. Senior management of the unit said they felt the issues were now being addressed and communicated effectively at trust board level.

# Services for children & young people

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

Children's care was provided in a children's centre. The children's centre opened in 2001 with outpatient facilities and 33 inpatient beds for children with both medical and surgical conditions. There was a paediatric assessment unit (PAU) within the children's centre that had five designated spaces. The neonatal unit opened in 2011.

We visited the children's centre, children's outpatient department, the neonatal unit and the accident and emergency department. We talked to 14 parents and children and 12 staff including doctors, nurses, pharmacists, healthcare assistants, domestic staff and managers. We observed care and treatment and looked at 12 care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

Children received safe and effective care in the children's centre. Staffing arrangements were flexible to meet the needs of children, and children's care and treatment followed best practice guidance. Staffing in the neonatal unit needed to improve to meet intensive care standards, and the supervision of children in A&E needed to improve. Parents told us staff were caring and the nurses were described as "attentive" and "very helpful". The service was responsive to children's needs and parents praised the neonatal unit and commented on how it created a feeling of calm and wellbeing. Staff engaged well with the children and treated them with dignity and respect. Staff told us they felt supported and took pride in their work, although in some areas they needed further specialist training. Risks needed to be better monitored to demonstrate that these were being managed effectively.

# Services for children & young people

## Are services for children & young people safe?

Children received safe care. Staffing in the neonatal unit needed to improve to meet intensive care standards and the supervision of children in accident and emergency needed to improve.

### Managing risks

Staff did not always report incidents that involved harm to children or the risk of harm but this was improving. Staff told us some 'near misses' were not being reported and that the time it took to report incidents could deter staff. Nurses said they had received guidance about reporting incidents and this was encouraging more reporting. One nurse commented on the learning that had taken place as a result of an incident in the neonatal unit, and this had helped to make the service safer for babies. A junior doctor said there was a good system in place and they told us how an incident they reported had been followed up with them.

The trust used a paediatric early warning score for children. This was a system to standardise the assessment of acute illness severity, and it indicated when the ward should contact the critical care outreach service. Four different forms were being used because these were age related.

### Staffing arrangements

Nursing staff in the children's centre told us staffing was maintained at a safe level for children, and staffing was increased or decreased depending on the dependency levels of the children being cared for. Staff described a flexible approach in which they moved between different areas of the ward. However, these arrangements for meeting the needs of children with high dependency were not documented as protocols to ensure that there was a consistent approach to meeting children's needs. Staffing arrangements for student nurses and the supervisory role of senior nurses were also not clear. Staffing levels were kept under review and risks were recorded on the trust risk register.

Levels of nursing staff in the neonatal unit had been identified by the trust as a risk in October 2012. The unit did not meet the Department of Health Toolkit for High Quality Neonatal Services. Nursing levels did not meet the standards expected for a neonatal intensive care unit, nurses were working longer hours and babies had to be transferred to neighbouring units when levels became

unsafe. In January 2013, it was also assessed that there was inadequate and inexperienced junior doctor cover. It was reported that neonatal emergencies would not be responded to in a timely and effective manner. Staff told us the risks were being mitigated because they prioritised tasks, protocols were in place to maintain safe staffing levels and paediatric consultants were on call for emergencies at short notice. However, incidents were not routinely reported when, for example, the nursing skill mix was not right or consultant involvement had not been met. Staff told us that the unit was safe but the risks were to the quality of care and the patient experience. The action plan in the risk register said that a business case had been prepared in April 2013 to support recruitment. The trust was working with specialist commissioners to improve the service.

### Children in A&E

There was a separate assessment and treatment area for children, although seriously ill or injured children were taken directly to the majors area, or to one of the bays in the resuscitation area that were reserved for children. Most (85%) admissions to the A&E were adult. This meant that there were about 11,000 children attending the department, which was not a sufficient number to justify a dedicated children's service, because staff would see too few patients per week.

The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identified that there should be always be registered children's nurses in emergency departments, or trusts should be working towards this, and that staff should, as a minimum, be trained in paediatric life support. The department had seven trained children's nurses but could not guarantee that a children's nurse would be on duty all the time. We observed the care of one child who did not receive specialist and appropriate paediatric support. Children were being cared for in adult areas and did not always have a children's nurse allocated to them while the children's nurse was caring for adults. The children's area was observed to be left unsupervised for long periods because nurses were required to work between minors, triage and the children's area. Some children were waiting unnecessarily in the department because of delays in admission to the children's ward.

The trust was taking a number of steps to ensure that staff were competent to care for children. Ninety-five per cent of

# Services for children & young people

staff had received recent training in basic paediatric life support and all senior staff and medical staff (registrar and above) were trained in advanced paediatric life support. There were two lead registered children's nurses and a consultant with a specialist interest and responsibility for children. There was a range of education and support provided to staff, including 24-hour access to a paediatric registrar and consultant. Three registered nurses had been sponsored to undertake the registered children's nurse course.

## Infection prevention and control

Children received care and treatment in clean surroundings. Parents told us toilets and bathrooms were kept clean. We observed good practice in relation to infection control. For example, staff used hand hygiene gel when entering and leaving patient areas. In the neonatal unit, we heard visitors being reminded of the importance of washing hands and using the gel. However, we observed soiled laundry being left in bags on the floor on the children's ward despite the fact that suitable waste bins were readily available. Waste was also being transported through the ward, which increased the risks of infections.

## Equipment

Patient equipment was clean and regularly checked and serviced. Any equipment failures were quickly reported and fixed. This meant that risks to children, for example, from cross-infection and unsuitable equipment, were reduced. Nurses told us they had the appropriate equipment to provide safe care to children and babies. The trust risk register showed that equipment was monitored to ensure it was fit for purpose.

## The environment

Children's received care in a safe environment. There was a range of safety and security features in the neonatal unit and the children's centre. For example, access to the ward was controlled and nurses were readily available to supervise children. Children did not have the same security in the hospital's A&E department. Although part of the department was designated as a children's area, we saw that children and babies also received care in the adult areas.

## Safeguarding children

Parents told us they felt their children were safe. A mother in the neonatal unit commented that, when they had to leave the unit, they were confident that their baby was in safe hands. Staff were aware of the action they should take

to safeguard children and how to report any concerns, and there were procedures in place to protect children, which included liaising with the social work team based at the hospital. However, a number of staff had not attended the required level of training. This had been included on the trust risk register and action was being taken to increase attendance.

## Patient records

Comprehensive medical notes and nursing records were well maintained and there was good information about the children's care and treatment. Records, however, did not always show how parents and carers were involved in care planning.

**Are services for children & young people effective?**  
(for example, treatment is effective)

Children received effective care.

## National guidance

There was participation in national and local audit. The service was using national and best practice guidelines to care and treat children. The involvement in clinical audits had increased during the last year. National audits demonstrated the trust was similar to other trusts, for example, in managing pain in children. However, the trust was not meeting standards, for example, the Department of Health neonatal quality standards and the National Institute for Health and Care Excellence (NICE) guidance for childhood epilepsy. The department had produced a number of clinical guidelines in response to this and other clinical areas, and local audits had demonstrated improved clinical practice. For example, guidelines for junior doctors had been produced about the safe use of gentamicin (an antibiotic) to prevent toxicity in new-born infants, and the standard of documentation had improved in patient records. Staff told us audits were regularly done to check standards within the department and the quality of the service provided. These covered, for example, infection control, record keeping and DNA (did not attend) information.

## Multi-disciplinary team working

Children received an effective service from a Multi-disciplinary approach to supporting children. There was good involvement of doctors, nurse, therapists,

# Services for children & young people

pharmacists and play specialists in patient care. Records showed that children's care was coordinated and their care and treatment were reviewed daily; this included discharge planning arrangements. Parents said the service was meeting their needs. A mother in the neonatal unit, for example, described the service as "fantastic"; they felt that their needs were being met as well as their baby's.

## Staff training and support

Staff said they felt well supported to provide effective care and treatment to children. Nursing staff told us they undertook a programme of mandatory training and were not asked to carry out tasks for which they were not trained. Two nurses told us about 'role rotation', which they felt had been beneficial to their learning and development to gain experience in different parts of the children's centre. Junior doctors said they were well supported and that teaching and training were good. Staff had annual appraisals to support their professional development.

Some specialist training, however, was either not always available or cancelled at short notice. Some nursing staff in the neonatal unit told us they were not able to attend a 'caring for the critically ill child' course. The unit was below the appropriate level of staff who had received this training. The unit had funded three staff to attend but part of the problem was the availability of the course. This had a current impact on staff who were available to care for babies.

## Are services for children & young people caring?

Staff provided a caring service to children.

## Compassionate care

Staff demonstrated a person-centred approach when talking about the support provided. We observed positive interactions between nursing staff and the children and their parents. Staff did 'comfort rounds' when they checked on children at set intervals to ensure their care needs were being met. Overall, parents were appreciative of the care provided and how staff went about their work. The nurses, for example, were spoken about in terms such as "lovely", "attentive" and "very helpful".

Staff were kept up to date about the children's needs and changes in their care through regular ward meetings and handovers. Parents told us they felt involved in their child's

care and had mostly been given the information they needed. Information on children's care and the involvement of parents and children in planning their care was not always recorded in care plans. This meant that there was a risk that relevant information about a child was not readily available to staff. One parent commented that some nurses were "fabulous" in explaining what they were doing, but said this could be inconsistent.

## Children's feedback

The children's centre received feedback on the experiences of parents and children. Staff told us tablet computers were used to obtain feedback and these worked well with children on the ward. Information was displayed in the children's ward on the outcome of feedback and there was a good level of satisfaction. In October 2013, for example, 82% of respondents said the care was "excellent" and most said the food was "very good".

Comment cards were readily available to people in the children's ward. However, we did not see these in the outpatient department. This was a missed opportunity to gain people's views and to make improvements based on the feedback received.

## Privacy and dignity

The neonatal unit was described to us as a "calm" and a "caring" environment, which helped to create a feeling of well-being. Staff acknowledged that this was more difficult to achieve in the children's ward, which was busier and from where a number of services were provided. Children's privacy and dignity were maintained, however, through the use of privacy curtains and single-sex bays.

## Facilities for parents

Parents were able to spend time with their children throughout the day and stay overnight so that their children were less anxious about their stay in hospital. However, we heard mixed views from parents about the overnight accommodation, and beds for parents were not consistently available. The trust did have four new ensuite bedrooms in the neonatal unit available for parents who needed them.

# Services for children & young people

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

Children received services that were responsive to their needs.

### Range of support

A range of services was provided for children in response to the needs of the wider community. These included changes to outpatient clinics, an assessment centre that children attended following referral from a GP and the neonatal unit. Parents told us they appreciated the outpatient service provided. The nurse in charge said staffing had recently improved and there was now a core team of nurses working across the department. Appointment times were well managed and people received a service that was responsive to their needs.

The children's assessment centre provided the opportunity for children to be seen by a specialist at short notice on the recommendation of a GP. Parents and their children told us the service met their needs and they had a positive outcome to their visit. One parent told us they had been advised by the GP to expect to wait for up to six hours. However, a nurse confirmed that children were triaged and prioritised, and waiting times were shorter than this. There was no information about this aspect of the service available to parents.

### Involving children and parents

The trust had engaged with local people to improve the design and facilities in the neonatal unit. Parents were very positive about the unit and staff told us how the design of the unit helped them in carrying out their work. For example, it was easy to manoeuvre beds and incubators from one room to another.

The neonatal unit worked as part of a wider neonatal network. Intensive care was provided to babies over 27 weeks and the unit reported all babies needing more than 48 hours invasive ventilation. The trust receives intensive care transfers from other units in the network, and also transfers babies that fall outside of their care criteria to other specialist units (usually in Bristol). The PICU consultant for the area reviewed the children's transfer on an annual basis.

Cases were discussed for shared learning and to consider any improvements that might be made. The feedback we received from managers and senior nurses indicated that there was a coordinated approach and working relationships were well established.

### Social and education facilities

Parents and children were very complimentary about the social and educational facilities. There were toys and books for children of all ages, and a variety of play areas available. In the children's outpatient area, for example, there was a soft play area and games such as table football for older children. One patient spoke positively about the 'school room' on the children's ward. They commented, "The teachers are fantastic, they make it interesting."

### Interpretation services

The trust used interpreting services to ensure equal access to the facilities provided, and staff had a clear procedure to request interpreter services, such as British Sign Language for deaf people. An online service was also available within the hospital using a computer-on-wheels. This was designed to provide an interpretation service at short notice. Staff confirmed that this was useful but sometimes unreliable because sometimes there were IT connection problems.

### Patient information

The trust had information leaflets in the ward areas and outpatients for children and their families. The leaflets were in English and none were available in other languages or in adapted formats such as 'easy read' or braille.

## Are services for children & young people well-led?

The children's centre was well-led.

### Leadership and culture

The staff worked well as a team and this contributed to good outcomes for the children. Staff spoke knowledgeably about their role and responsibilities within the centre and the outpatient department. They described a service that was focused on the individual, with a person-centred approach to meeting children's needs. Many staff mentioned how proud they felt in being part of the team and in the service they provided to children.

# Services for children & young people

## **Managing quality and performance**

The service was monitoring quality and safety issues and these were discussed in staff meetings. Participation in national and local audits was improving practice and there was learning from incidents. Risks to children's care were identified and included on a risk register. The risk register covered areas such as non-compliance with NICE guidelines, suitability of equipment and staffing arrangements. There were action plans produced in response to these risks but the information on the register

did not show how the risks were being mitigated and managed. For example, an action plan and a business case had been produced for staffing levels in the neonatal unit and the lack of compliance with standards. Risks were being monitored, but outcome or interim arrangements were not detailed on the risk register to identify if actions were effective. Incidents were not routinely reported to monitor risks effectively. The trust, however, was working with specialist commissioners with the aim of improving neonatal services.

# End of life care

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The trust's end of life care service included end of life care services and inpatient and outpatient chemotherapy and radiotherapy for symptom and pain management. The trust's end of life care team was able to provide advice and support 24 hours a day, seven days a week, because of established links with a local community hospice. We visited seven wards where patients were receiving end of life care. We spoke with nine patients and relatives, and a range of staff (including the end of life care lead, occupational therapists, radiotherapists, nurses and doctors). We observed care and treatment being given to people, and looked at 14 care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

Patients received safe and effective end of life care. Their care needs were being met and the service was integrated with GPs and community services, which supported effective discharge arrangements and care at home. Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect from reception staff through to consultants. Staff had appropriate training and supported patients to be fully involved in their care and decisions. The service was well-led and staff were dedicated to improving standards of end of life care across the hospital.



# End of life care

## Are end of life care services safe?

Patients received safe and appropriate end of life care.

### Staffing

The trust has an end of life care nurse who has been seconded from the specialist palliative care team for the past two years. The specialist palliative team consists of three clinical nurse specialists (one of which works part time) and a part-time occupational therapist. The team aims to provide an integrated palliative care and end of life care specialist service across the trust. The trust had clear guidelines and a work plan on providing good end of life care based on the national an End of Life Care strategy published in July 2008. There were sufficient staff in the team but the lead nurse told us additional funding had recently been applied for to further develop the end of life care work plan across the trust. This work plan detailed standards for best practice in end of life care and a key aim was to embed these end of life standards in care throughout the hospital.

### Infection prevention and control

Staff on the oncology ward followed strict infection control protocols, including the use of personal protective clothing, such as aprons and gloves. Isolation rooms were clearly identifiable, which ensured patients were not exposed to infection risks. In all areas where people received end of life care, we observed staff and visitors following guidance on hand hygiene.

### Patient records for end of life decisions

When present, DNA CPR ('Do not attempt cardiopulmonary resuscitation') forms were located at the front of patient records. In general the DNA CPR forms used on the medical and surgical wards had been completed appropriately. The oncology ward used audit tools to check on the accuracy of care plans. However, we reviewed the DNA CPR forms for 13 patients on the oncology ward and found errors on seven forms. While discussions with patients and their families had been recorded, other parts of the DNA CPR forms had been incorrectly completed, such as information on the decision to resuscitate, and one form was stored in the wrong care file.

### Safeguarding

Staff had an understanding of safeguarding procedures and knew how to report concerns. Most staff had had

appropriate safeguarding training. Staff on the oncology ward demonstrated a clear understanding of the Mental Capacity Act (2005) and mental capacity assessments were in care records when required.

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

Patients received effective end of life care.

### National guidance

The trust had followed the Department of Health guidance National Strategy for End of Life Care (2008). The Department of Health recently asked all acute hospital trusts to review patients on end of life care pathways in response to the national independent review More Care, Less Pathway: A Review of the Liverpool Care Pathway (2013). The trust had done this and used a modified version of the Liverpool Care Pathway. Records showed this was planned to be phased out and replaced as soon as new guidance was published by the Department of Health.

### Meeting patients' needs

Care records showed pain relief, nutrition and hydration were provided according to patients' needs. Risk assessments for pressure ulcers, falls and nutrition were documented in care plans and patient's wishes for their end of life care were clearly documented.

### Quality monitoring

The National Bereavement Survey (2011) for the Bath and North East Somerset (BaNES) clinical commissioning area showed that BaNES was in the middle 60% nationally for 20 of the 26 quality indicators. Three indicators were in the top 20% and three in the bottom 20%. The trust had positive indicators for involving people in decisions but needed to do more around help with personal needs and support for people to spend their last two days at home. The trust had its own quality audit tool that showed the progress to improve standards of end of life care. This included seven action plans to better support bereaved families with care after a death.

### Seven-day working

Patients received effective support from the end of life care team, which was able to offer support and advice throughout the trust. The care team worked from 8am to

# End of life care

5pm and out-of-hours support was provided by the local community hospice. This enabled clinicians across the hospital to access expert palliative advice and support 24 hours a day.

## Multi-disciplinary team working and integrated care

The end of life care team responded swiftly to referrals throughout the hospital, and this ensured that all patients received an effective end of life care service. The trust had developed an integrated care pathway for end of life care that included links with community GPs, district nurses and the local hospice. This ensured patients had coordinated support out of hours and at home. Staff throughout the areas we visited were familiar with the integrated care pathway for end of life care and how this replaced all other medical and nursing notes. A full-time multi-faith chaplaincy service for patients, families and carers was provided and there was a bereavement coordinator to provide advice and support to newly bereaved families.

## Staff training and support

The end of life care team had specialist training and skills to support staff, patients and their families. Staff on the oncology ward showed an advanced understanding of end of life care. The end of life care team provided specialist advice to staff when required, and provided training, often in conjunction with the local community hospice. End of life training was available for staff at all levels, starting at staff induction, and across all departments and professions. The trust was introducing end of life care ambassadors for other wards whose role was to act as a link between the ward and the end of life care team, to cascade information and advice, and to support staff with their training needs. Staff also had access to additional information via the trust intranet, including e-learning end of life care modules. Staff told us they felt well supported by the systems in place.

## Are end of life care services caring?

Staff provided a caring service to patients receiving end of life care.

## Compassionate care

Most patients and their families had positive views about end of life care. A few patients and relatives contacted us to share their experiences of care and they reported poor care and nursing attitudes on some wards. We observed staff to

be caring and professional, especially on the oncology ward. We saw people's wishes were recorded in care plans. There were records of regular Multi-disciplinary discussions in response to the changeable needs of patients. We looked at one person's end of life care record on a medical ward. This stated where the patient liked the call button to be placed. We checked this patient and found the call button was placed as they had instructed. Records showed pain assessments had been completed and regularly reviewed. We looked at the care record for one person on the neurology ward who could not verbally communicate. Senior staff told us they observed body language and facial expressions to assess pain. We saw this had been done for the patient but was not documented.

## Involving patients

Families we spoke with during our inspection told us they were kept informed of changes to care, and that staff were sensitive and considerate. They told us staff asked their opinions when their relatives were no longer able to convey their wishes independently. One relative told us, "Staff are just excellent; nothing has been too much trouble. They have been looking after my mum beautifully and they have also been looking after me and my dad. Everyone has been so caring, kind and thoughtful and check us often to see if we are okay or need anything." Six wards were piloting the 'Conversation project', which aimed to engage patients identified as approaching the end of their life in discussions about their care. Staff told us initial patient feedback about the project was positive.

## Patient feedback

The trust had initiated a regular quality survey and contacted bereaved families three months after their relative's death. Thirty-seven families had been contacted so far and most feedback had been positive. The trust was taking action on feedback to improve communication, education and support, and the speed at which families can obtain death certificates.

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

(for example, to feedback?)

End of life care services were responsive to patients' needs.

# End of life care

## Responding to patients

The end of life care team was available across the hospital during working hours and the local hospice provided support and advice out of hours and at weekends. One person told us, “We know what is happening, with whom, how and when. It’s been very reassuring.” Staff on the wards we visited told us the end of life care team and chaplaincy services always responded promptly to referrals. We looked at one person’s end of life care plan on the oncology ward and saw they had requested a minister. Relatives confirmed that the minister had visited the same day.

## Facilities

The hospital wards had quiet rooms for families, although the standard of these facilities varied. There were two overnight rooms available for families within the hospital. Both these facilities were included in the trust’s end of life care work plan for refurbishment. Families told us they felt supported by the provision of vouchers for parking and food, and there were no restriction times on visiting. The bereavement office had a separate private and comfortable room and the mortuary had a dignified viewing area.

## Discharge

The trust had a fast-track discharge process for patients who chose to return home. A Multi-disciplinary team discussion was held with patients and families about discharge, and families told us they were fully involved. Patients were either ‘fast tracked’ to community services or followed a ‘rapid discharge pathway’. These processes ensured patients were discharged safely with the right care and support.

## Information

Information on cancers and treatment options was available. Some departments, such as dental and

orthodontics, had developed their own information and resource packs for patients. Bereavement information booklets were available on the wards. These were written in English but had information in them written in multiple languages and the hospital had access to an interpreter service. We did not see any adapted end of life care resources, for example, in easy read formats for people with a learning disability.

## Are end of life care services well-led?

The end of life care service was well-led.

### Leadership

The end of life care team included staff who were passionate and committed to providing a good service. The staff worked well together as part of a Multi-disciplinary team, and also as part of an integrated team with GP and community services. The service was working to ensure national standards of best practice were embedded throughout the hospital and coordinated with patient care in the community or at home.

### Managing quality and performance

End of life care was effectively led by the end of life care team lead who worked to best practice standards and used information from incidents, complaints, audit and patient experiences to lead improvements across the hospital. The team lead had established an end of life care working group that met on a quarterly basis to monitor progress against standards. Membership of this group included clinicians from all disciplines within the hospital and also clinicians from local community services, including primary care and the hospice. The Director of Nursing was responsible for end of life care at trust board level.

# Outpatients

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The trust provided a range of outpatient clinics with around 313,800 patients attending each year. During our inspection, there were 33 different types of outpatient services covering general and surgical specialties. Most outpatient clinics were provided at the Royal United Hospital but outreach clinics were held in Warminster, Paulton, Devizes and Chippenham.

The hospital did not have a dedicated outpatient department but offered a 'clinical village' model. This meant most outpatient clinics were near their inpatient specialty wards. Some outpatient clinics had dedicated staff and others were managed by staff from the associated inpatient wards.

We visited 10 outpatient services in surgery, orthopaedics, gastroenterology, radiography, respiratory, neurology, ophthalmology, orthodontics, cardiology and oncology. We spoke to 21 patients and 34 staff, including consultants, doctors, matrons, nurses, healthcare assistants and administration clerks. We received 31 comment cards from patients attending the outpatient breast clinic, and 23 comment cards from the oncology outpatient clinic, which included haematology and radiotherapy clinics. We observed care and treatment. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

## Summary of findings

Patients received safe and effective outpatient care and staff were caring. However, staff throughout the outpatient services did not demonstrate a robust understanding of the Mental Capacity Act (2005) in relation to consent from adults who were vulnerable. Patients' waiting times were within national targets, although some patients waited longer for appointments at the pain management clinic and some patients waited a long time for consultations when clinics were busy. Patients told us the breast care clinic was outstanding. The outpatient clinics were managed differently by departments and information on quality and safety was just beginning to be shared. The trust had commissioned work to review and further improve outpatient services.

# Outpatients

## Are outpatients services safe?

Patients received safe outpatient care.

### Patient safety

There were adequate numbers of staff available to meet patients' needs. Bank and agency staff were used to fill unexpected or planned absences, and this ensured that there were sufficient numbers of suitable staff to run clinics safely. We observed frail patients were appropriately supported by staff from waiting rooms into private consultations. Staff knew what to do in the event of an emergency and we saw resuscitation equipment in some outpatient clinics for patients who may have had heart problems.

### Managing risks

Staff were aware of incident-reporting procedures and knew how to use the trust's online system for reporting incidents and accidents. However, they told us they were not always using the system because it was not a good use of their time. The outpatient clinics did not share learning from mistakes or from good practice.

### Infection prevention and control

The outpatient clinics were clean. There were hand hygiene gels available at the entrance to all outpatient clinics and by consultation rooms. We saw these were used by staff and patients.

### The environment

Outpatient clinics were wheelchair accessible. Two people at our listening events told us the diabetes clinic was too narrow for wheelchair access, but the clinic was accessible. The orthodontic department had two reception areas. The one nearest the treatment rooms was small. We observed there was not enough seating for all patients in this area and some people stood, blocking doorways and exits.

### Safeguarding patients

Staff understood safeguarding processes and what to do if they needed to raise an alert. They told us they attended mandatory training on safeguarding children and vulnerable adults from abuse.

### Patient records

Medical records were available for most patients attending clinics. The trust monitored the percentage of missing notes at each clinic, as this could have an impact on

patient care. Monthly figures showed that less than 0.2% of records were missing every month. Records were stored securely and were accessible to staff in the outpatient clinics.

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

Outpatient care was monitored to ensure patients received effective care.

### National guidelines and clinical audit

The trust had completed 28 clinical audits and surveys in outpatient clinics since October 2012. These included, for example, audits on the information given to patients to manage their condition, audits on procedures such as ultrasound and radiology, pre-admission clinics, such as for vascular surgery, cleanliness audits, and audits to understand why patients did not attend (DNA) clinics. There was evidence of changes as a result. For example, the trust had taken action to text people to reduce the DNA rate and patients in the breast unit told us about the excellent information and explanations on treatment and tests.

### Clinical management

Patients told us they were allocated enough time with staff when they attended outpatient clinics. Staff told us new patients were given longer appointment times. This enabled investigative tests to be completed and treatment plans to be discussed with patients. Patients said when they needed additional tests, the outpatient services were efficient at trying to organise these while they were at the clinic so as to avoid the need for further appointments.

We spoke with 33 people at our listening events, and a few people told us of the good service they had received at the breast care, prostate and eye clinics. There were a few concerns, however, about the chronic pain management clinic because consultations were short and there was no specialist pain management nurse.

### Consent to treatment

Staff told us they spent time discussing treatment options and plans with patients. They were aware of consent procedures. However, we found that outpatient staff in most areas did not understand the Mental Capacity Act (2005) and how this related to vulnerable adults in terms of best interest decisions and informed consent.

# Outpatients

## Staff training and support

Patients told us they felt doctors and nurses were skilled and knowledgeable. Healthcare assistants and nurses from associated wards were allocated to work in outpatients based on their skills and experience. Staff talked about the benefits of Multi-disciplinary working to ensure patients care was coordinated. Senior nursing staff told us they worked with new junior doctors when they began their rotation in outpatient services. This helped the junior doctors to understand the new systems and processes which ensured the outpatient clinics ran effectively and efficiently.

## Are outpatients services caring?

Staff were caring to patients in outpatient departments.

## Compassionate care

We spoke with 21 patients in the 10 different outpatient clinics we visited. Most told us they were satisfied or pleased with the service they had received, stating that staff were “kind, caring and helpful”. Patients said they felt involved and that their opinions were taken into consideration when discussing treatment plans.

Patients in the outpatient breast clinic gave us 31 comment cards that were overwhelmingly positive about the kindness, care, dignity and respect they had been shown. For example, one patient reported, “I found my treatment in the breast clinic to be very caring and extremely helpful. Nothing has been too much trouble and I was encouraged to see someone if I had anything to discuss.” Another patient said, “Staff were caring and thoughtful and treated me as an individual, respecting my own needs. Thorough, but not patronising. It was so lovely to be treated by kind, calm and intelligent staff.” Patients using radiotherapy, oncology and haematology outpatient clinics gave us 23 comment cards that said staff were kind and caring. The words ‘amazing’, ‘excellent’ and ‘outstanding’ featured in many patients’ reviews.

We observed staff to be sensitive and caring to patients attending the outpatient clinics. Staff from several outpatient clinics told us that, when they were preparing for clinics, they would review the patients’ notes; this would alert them to patients who might be anxious as a

consequence of test results or at the prospect of potentially invasive investigations. Staff told us they offered these patients extra time in private rooms to discuss any concerns.

## Patient feedback

Patient’s views and experiences in outpatient clinics had been obtained in some clinics. Satisfaction surveys had been carried out, for example, in the ultrasound, urology, breast care, children’s oncology and gastroenterology clinics, to improve the quality of the service. GPs had been asked their views about the rapid access Transient Ischaemic Attack clinic.

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

Outpatients services were responsive to patients’ needs, but some patients had long waiting times for consultation within clinics. GPs were not informed about investigations and treatment in a timely way.

## Waiting times

Administration staff in most outpatient clinics were responsible for processing appointments and monitoring the capacity of clinics. The trust was meeting the Department of Health standards of two weeks for urgent cancer referral waiting times. Performance information for October 2013 showed that patients were waiting about seven weeks for an appointment against a standard of about five weeks. The trust was meeting the national 95% non-admittance performance target for patients waiting 18 weeks. Some patients in ear, nose and throat (ENT) and eye clinics waited longer, but this was similar to other trusts. Waiting time for pain management clinic appointments were longer when compared to other trusts.

Patients we spoke with told us they were informed of waiting times for consultation on arrival at outpatient clinics. Some clinics provided additional information on wipe boards. For example, in the stroke and neurology outpatient clinics, there was information about how long clinics were delayed, the names of the doctors and the name of the lead nurse managing the clinic.

Waiting times for consultation varied between clinics. Staff told us waiting times varied day by day, dependent on unpredictable factors such as clinical emergencies that

# Outpatients

took doctors away from clinics and patients who did not turn up or cancelled appointments. Some patients were seen promptly, for example, in cardiology outpatients. Some patients had to wait more than an hour, for example, in neurology. Some clinics had escalation procedures to manage waiting times. Senior staff in gastroenterology and surgical outpatients told us that, if new referrals peaked, making an impact on appointment waiting times, they notified the lead consultant who provided another doctor and additional clinics to meet service demands.

The radiology service was unique because one of its primary functions was to provide services to all the other outpatient clinics. We spoke to senior staff who told us the service functioned 24 hours a day, 7 days a week, and had specialist radiographers on call to cover any staffing gaps. Patients' waiting time in radiology varied and could be lengthy because the service had referrals from inpatients, the A&E department and the GP walk-in service.

## Letters to GPs

Within radiology, staff told us they used a specific IT system that allowed results from urgent referrals to be sent back to GPs on the same day. GPs were notified of the results of routine investigations within about one week. Patients from other outpatient clinics, including gastroenterology and neurology, told us it had taken weeks for their GPs to receive letters. We heard similar views from a few people at our listening events.

## Vulnerable patients

We observed staff responding to the needs of patients, especially those who were vulnerable and needed specific support. Nursing staff escorted patients to diagnostic tests in some clinics. In one clinic, we saw a nurse explain to a patient where they needed to go for a test because the patient was anxious about getting lost. The nurse was unable to leave the busy clinic so, while giving clear directions, she also drew a map which the patient found reassuring. Staff in the cardiac outpatient clinic explained how they had adjusted services to provide care in people's homes for patients who were vulnerable or had a disability. They had recently done investigative tests at home for two patients, one with mental health issues and another with severe physical disabilities, because attending a busy clinic would have caused them severe distress.

## Patient information

Patient information leaflets were available in all outpatient clinics. All were in English and none were adapted for people who could not read well. Staff told us leaflets were available in other languages and braille, but this information was not readily available to patients unless requested.

## Are outpatients services well-led?

Outpatient services were well-led but required better coordination.

## Leadership

There was strong clinical leadership visible in the outpatient departments. The staff we spoke with were passionate and proud of the services they ran. Senior clinicians were present in outpatient clinics and were knowledgeable and supportive to patients and staff. The outpatient clinic consisted of 28 separate departments. Some staff in outpatient clinics told us they felt like "poor relations" compared with other specialties and departments within the hospital, because there was not a shared vision for the service across all the specialties.

## Managing quality and performance

The trust had matron leads for each outpatient specialty and they had started to have regular meetings to discuss quality and safety issues. The matrons had recently identified several common themes with potential for service improvements. These included the need for quality monitoring to share best practice between departments, the time taken to inform patients' GPs of the outcome of investigations and treatment plans, and the waiting times in outpatient clinics.

The trust board receives information on the performance of outpatient services as part of the monthly performance report. The trust did not have an outpatient services policy to ensure a consistent service but had recently commissioned a company to review outpatient services. Outpatient risks were recorded on the trust risk register and these were mainly around the potential failure to meet the national 18 week response to treatment times and the absence of IT to support the electronic records. However, the action taken to mitigate these risks and the progress was not clearly recorded or monitored.

# Good practice and areas for improvement

## Areas of good practice

### **Our inspection team highlighted the following areas of good practice within the hospital:**

- The trust had made good progress towards seven-day working where staffing and services at the weekend were similar to weekdays, for example, in the A&E department, for patients receiving emergency medical and surgical care.
- Patient in-hospital mortality rates were lower than expected and there was no difference between weekday and weekend mortality.
- The trust had developed a number of innovative services to cope with winter pressures and a high demand for services.
- The A&E department had a rapid assessment team known as 'senior with a team' (SWAT). This team had improved the speed at which patients who arrived by ambulance were assessed, investigated and treated.
- The trust had received regional and national recognition for developing Dementia Charter Marks (with the Alzheimer's Society) for its model of dementia care at ward level.
- Coombe Ward had been redesigned and refurbished as a dementia-friendly ward. There was clear signage, sensitive lighting and the environment was designed to feel more like home than a hospital ward.
- The use of the World Health Organization surgical safety checklist was well embedded in the surgical department. Staff understood its value and importance. This had contributed to there being no never events in surgical theatres for 18 months.
- The emergency surgical ambulatory clinic was specifically designed to see patients with urgent general surgical problems. Patients were assessed and diagnosed (and some had their procedures) on the same day. The clinic had helped to avoid hospital admissions and had reduced the time inpatients waited for emergency surgery.
- Staff in the critical care unit were struggling with staffing levels and being able to discharge people in an appropriate way, but they showed complete dedication to the service and provided outstanding compassionate care.
- The neonatal unit created a calm environment and was designed to enhance people's feeling of wellbeing.

- The end of life care team had developed an integrated pathway of care with GP and community services and provided a 24-hour service based on good out-of-hours arrangements with a local hospice.
- Patients overwhelmingly told us that the breast care clinic provided an excellent service.
- 'See it my way' events were held for staff. These events had patient telling stories of their experiences of care that had inspired and motivated staff. Events had included what it is like to live with a learning disability and what it is like for a patient coming to the end of their life.

## Areas in need of improvement

### **Action the hospital SHOULD take to improve**

- The trust needs to ensure that there are effective operations systems to regularly assess and monitor quality of the services provided; to identify, assess and manage risks and to make changes in treatment and care following the analysis of incidents that resulted in, or had the potential to result in harm.

### **Action the hospital COULD take to improve**

- The use of the early warning score needs to improve across the trust and there should be clearer referral criteria for critical care outreach, particularly as the service is not currently available seven days a week.
- The super vision of children needed to improve. Pathways for children need to improve from A&E to the children's ward to avoid children waiting unnecessarily in a mixed A&E department.
- 'Do not attempt cardiopulmonary resuscitation' (DNA CPR) forms on the oncology ward need to be completed so that resuscitation decisions are always clear.
- Staff need to understand the Deprivation of Liberty Safeguards and to be clear of their responsibilities under the new policy to reduce the risks for patients with dementia that may wander.
- Staff training needs to improve, especially around fire safety, safeguarding children and the Mental Capacity Act.
- The environment in the post-anaesthetic care unit (PACU) needs to be maintained for good infection prevention and control.



# Good practice and areas for improvement

- The trust needed to continue to monitor and improve the segregation and disposal of clinical waste to maintain its compliance with standards.
- The trust needs to work more effectively with the mental health liaison team and intensive team to improve assessments for patients with mental health conditions.
- The trust needs to ensure that patient care needs are met particularly at busy times and in busy areas, such as on admission and short stay wards.
- The number of elderly and confused patients who are transferred between wards at night should be reduced.
- Patients should have shorter waiting times for the pain management clinic appointments, and for consultations in some busy clinics, GPs need to receive letters on patients' investigation and treatment within two weeks.
- The chronic pain management clinic needs review in terms of consultation time with patients and specialist staff.
- Better resources are needed to support people with a learning disability.
- The trust needs to work with community partners to ensure that patients who are medically fit for discharge do not remain in hospital because community support or rehabilitation beds are not available.
- The trust needs to continue to improve how it handles complaints so that people are satisfied with the service they receive.
- Staff engagement needs to continue and specific staff groups, such as cleaners and staff in human resources, need to feel valued by the trust.
- The trust needs to continue to work with its partners to diagnose and treat patients effectively and ensure safer services when there are increases in demand.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	<p>Staffing levels were monitored but some of the information collected did not match the information from the wards, for example on the MAU and surgical wards. Risk registers did not always include staffing concerns or the mitigating actions.</p> <p>The trust uses indicators to monitor quality and safety at trust and divisional levels but these need to be further developed at service and ward level.</p> <p>Systems to report incidents had improved but were still frustrating to use and learning from incidents was not regularly shared to encourage openness and prevent reoccurrences. For example, the trust had a serious fire in the critical care unit in November 2011, but only 67% of current staff had up-to-date fire training and the trust standard was 80% rather than 100%. We averted a potential fire from a portable heater in the PACU.</p> <p>Staff training was monitored but the trust was not meeting their targets particularly around infection control, fire safety, safeguarding children and the Mental Capacity Act. Mitigating actions were not clearly stated.</p> <p>The learning from complaints and good practice, for example was not routinely shared across the trust.</p> <p>Trust risk registers were completed and graded for risk escalation, but they did not always show that risks were mitigated or monitored effectively.</p> <p>The impact of staffing, ward and service changes were not monitored appropriately. For example, the care and pain management of people on surgical short stay unit and the high proportion of bank and agency staff on the medical admissions unit had an impact on patient care.</p> <p>Surgical lists were not monitored effectively and staff identified that they were placed under undue pressures.</p>

This section is primarily information for the provider

## Compliance actions

Some equipment was not always appropriately checked and available for use and this was not monitored appropriately.

Staffing levels on the critical care unit needed to improve and monitored to ensure staff were not working under undue pressures.

Patient flow needs to be monitored to ensure patients are cared for on the most appropriate ward, for example patients that require critical care.

Patient care needs were not always met, particularly at busy times and on busy wards, and this was not monitored effectively.

Medical and nursing staffing arrangements on the neonatal unit did not meet Department of Health standards for intensive care. Action was being taken but risks were not appropriately monitored, for example through incident reporting.

The supervision of children in A&E should be monitored.

### **How the regulation was not being met:**

The trust must protect people from the risks of inappropriate and unsafe care and treatment by means of effective operations systems designed to – regularly assess, and monitor of the quality of services; identify, assess and manage risks; and make changes in to treatment or care relating to the analysis of incidents that resulted in, or had the potential to result in harm.

Regulation 10 (1) (a) (b) and (2) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity

Regulation

<Regulation 2>

Regulated activity

Regulation

<Regulation 3>