

University Hospitals Bristol NHS Foundation Trust

University Hospitals Bristol

Main Site

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Accident and emergency

Good



Medical care

Requires improvement



Surgery

Requires improvement



Critical care

Good



Maternity and family planning

Good



Services for children and young people

Good



End of life care

Good



Outpatients

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals Bristol Main Site consists of seven hospitals situated in the centre of Bristol: Bristol Royal Infirmary (BRI); Bristol Royal Hospital for Children; Bristol Heart Institute; Bristol Oncology and Haematology Centre; St Michael's Hospital; Bristol Eye Hospital and The University of Bristol Dental Hospital. This report relates to findings across the University Hospitals Bristol Main Site and will refer directly to individual hospitals within the narrative as necessary.

It provides acute services to a population of approximately 300,000 in central and south Bristol. In addition, it provides specialist tertiary care in cardiac surgery, children's services, haematology, oncology and bone marrow transplants to a population of approximately six million across the whole of the South West of England and South Wales.

University Hospitals Bristol NHS Foundation Trust has a staff of 8,442, the majority of whom work on the main site.

We carried out this comprehensive inspection as part of our in-depth inspection programme.. The trust moved up two bands in our 'intelligent monitoring' system from a low risk to a medium risk between March 2014 and July 2014. Our inspection was carried out in two parts: the announced visit, which took place on 10, 11 and 12 September 2014; and the unannounced visit, which took place on 21 September 2014.

Overall, this hospital was rated as requiring improvement. We rated it good for being caring and as requiring improvement in safety, effectiveness, being responsive to patients' needs and being well led.

Our key findings were as follows:

Safety

- Safety required improvement within surgery, medical and outpatient services.
- Risks to patients were understood and there were systems in place to report, investigate and learn from incidents across the main site. However, there were concerns with regards to the management of medicines within medical and surgery services. These related to both the safe and secure storage of medicines and also the principles of safe medicines' administration. Within medical services, not all resuscitation trolleys were fit for purpose.
- In a number of services within the main site, for example within maternity services, there were innovative solutions in place to ensure safe staffing levels. However, within medical and surgical services there were shortfalls in staffing. Within theatres, staffing fell below recognised guidelines and wards were not always fully staffed to their rostered numbers and skill mix as bank and agency staff could not be recruited. There was frequent use of temporary staff within the urgent and emergency services and occasions when these services were forced to manage without a full complement of nursing staff.
- Despite the ongoing building work on the site, the environment was generally clean and well maintained. However, within the outpatient services there were issues with the maintenance of equipment and the environment within the fracture clinic was not safe. We were told that a risk assessment had been completed for the building work which was ongoing but staff were unable to locate this.
- Records were generally found to be well kept. However, in outpatient services there were issues with missing patient notes and records were not stored appropriately in order to maintain confidentiality.

Effective

- Services were found to be effective in all but surgery. Patient outcomes were below the England average for hip fractures. Fewer patients than the England average received surgery within 48 hours or were seen by an orthogeriatrician. The standardised relative risk of readmission rate was significantly higher for both elective and non-elective cases in upper gastrointestinal surgery. The processes in place for managing the patient pathway were not always consistent for these patients.

Summary of findings

- There were effective pain management processes in place. A variety of tools for monitoring a patient's level of pain were in place, in order to meet the patient's needs. For example, specific tools were in place for use with children and patients with cognitive impairment. Audits of pain management were carried out in all areas. Although we found that patients had received adequate pain assessments and pain relief had been recorded, audits showed room for improvement in documentation.
- There was effective multidisciplinary working throughout the trust. This was notable within the children's hospital where the recent centralisation of all children's services had improved the multidisciplinary working on emergency trauma cases. Staff spoke of good working relationships and easy access to other specialist advice where required.
- Services were working towards seven-day working across the hospitals. There was access to imaging services out of hours and at weekends. There was one theatre manned 24 hours a day, seven days a week in the Hey Grove suite. Allied healthcare professionals provided some cover over weekends. There was on-call specialist end of life care support out of hours. However, cancer clinical nurse specialists and the diabetes specialist nurses provided a service from Monday to Friday, 9am to 5pm, and there were no plans for seven-day working.

Caring

- Throughout the hospitals, in all services we observed caring staff providing kind and compassionate care and treatment. We witnessed positive interactions between patients and staff.
- Friends and Family Tests for all the hospitals were positive, with the majority of patients saying that they would recommend the hospital.
- Patients and relatives with whom we spoke were complimentary about the care that was received. Patients had a good understanding of the care they were receiving. Patients and relatives told us that they felt involved in the care and were treated with dignity and respect.
- A range of services to support the emotional needs of patients and relatives was available throughout the trust. This included multi-faith spiritual spaces in a number of hospitals.

Responsive

- Services on the main site required improvements in order to be responsive to patients' needs. There were significant issues with access and flow in the hospitals. This had a particular impact on urgent and emergency services; surgery; medical; critical care; and outpatient services. There were high levels of bed occupancy and poor patient flow. We found patients who were fit for discharge awaiting social care packages or social service assessment.
- While there were significant challenges within the health economy regarding the availability of social care support for patients leaving hospital, these were not the sole reason for the access and flow issues. Processes for ensuring a timely discharge from hospital for patients requiring social care support were not always effective. There were also issues with the management of emergency theatre lists which meant that surgery was often cancelled or patients' access to theatres was delayed.
- The percentage of patients whose operation was cancelled and who were not treated within 28 days was consistently higher than the England average. Patients often went to theatre without an allocated bed having been identified. At times, patients were required to remain in the recovery area overnight. This included critical care patients.
- There were delays in transferring patients out of critical care units, which meant that patients could not be admitted. Patients were discharged home from the recovery area and from critical care units rather than from a ward.
- Some surgical patients were moved at night. This disturbed their sleep, and that of others in the areas they were moved from and to. There was an increased risk of falls and other patient safety incidents as a result of disorientation and confusion.
- The trust was not consistently meeting all five of the core accident and emergency (A&E) access targets. Although patients were mostly being assessed promptly on arrival, some patients arriving by ambulance were forced to queue in the corridor outside A&E because the department had no capacity. This compromised patient experience and put them at increased risk.

Summary of findings

- Outpatient services were struggling to meet the demands on their capacity and were not meeting the 18-week referral-to-treatment targets. There were long waiting times for people in clinics, with inconsistency in the information provided about those waits.

Well led

- Services required improvement in the well-led domain. This was particularly the case in surgery and outpatient services, although we found examples of good leadership at a ward and department level throughout the hospitals on the main site. Staff in surgery and outpatient services were not positive about the leadership, with some not feeling supported by more senior managers, and they reported a lack of visibility of the divisional management team.
- While governance systems were in place, in some divisions we saw that actions were not always taken to mitigate risks or to improve poor performance over a period of time.
- There were plans in place for the reconfiguration of surgical services; this involved the transfer of services to and from another provider. However, until the reconfiguration occurred, issues with patient flow and access remained. There was little evidence that actions were being taken to address the issues relating to discharge.
- We also found examples of good leadership: there was evidence of the hospitals working positively with partners across the health economy; staff had shared values and aims; and staff reported that they were supported by strong clinical leadership.
- The complexity of the management arrangements of outpatient services within different divisions meant that there was no overview of the services as a whole and there were inconsistencies in the monitoring and management of the services. This had been identified by the trust and plans had been developed, although not implemented at the time of our inspection.
- Maternity services were found to have outstanding leadership. We saw clear, coordinated team working across specialties and disciplines, which led to excellent communication throughout the services and to good outcomes for women. Staff recognised that the midwife-to-birth ratio was not as high as expected and were creative and innovative in putting systems in place to upskill other staff to support the midwives. The midwives could then be available for solely midwifery roles, for example providing care and support to labouring women.

We saw several areas of outstanding practice, including the following:

- Teamwork in the A&E department was exceptional. Staff at all levels were committed, motivated and engaged. They worked very well with each other across all job roles and staff grades. They were cohesive and demonstrated excellent teamwork within their departments and with other departments.
- The maternity service (St Michael's Hospital) was an impressive and highly functional unit. Staff worked hard together to provide excellent services to the local populations and, as a regional referral unit, to the wider population of the South West and South Wales. Teams and individuals were highly flexible and the team was creative in finding ways to manage and mitigate the risks of working with a lower than optimal midwife-to-birth ratio. Multidisciplinary working within St Michael's Hospital, the local community and regional partners was well established, with the welfare of the mothers, babies and their families at the heart of the services provided.
- The children's hospital had outstanding safeguarding procedures in place. The safeguarding team had links in every department where children were seen. The trust considered child safeguarding issues in relation to adult patients in the Bristol Royal Infirmary: for example, A&E consultants checked all overnight admissions for safeguarding concerns. Weekly multidisciplinary meetings were held and there were clear links to the safeguarding board.
- The arrangements for young people to transition from children's to adult services, for example within oncology, were very good. The trust had a transition group that involved young people. This group highlighted and promoted good practice in order to replicate it in all areas.

Summary of findings

- The trust had a paediatric faculty of education. This had been put in place to support the development and retention of staff. Specialist courses, accredited by the University of Plymouth, were on offer up to and including at master's degree level. Courses included paediatric critical care. All the staff spoken with by the inspection team were highly complimentary about this. The trust planned to allow access to the courses to children's nurses from other organisations.
- A process to review any death of a child had recently been implemented. A full review and debriefing of the case occurred within 24 hours of a child's death (whether expected or not). Parents were involved in the reviews and kept informed of progress.
- The specialist palliative care team was passionate about the service it provided and demonstrated excellent team working. The team facilitated weekly end of life multidisciplinary meetings with other professionals to discuss patients' care. In addition, the consultants regularly attended seven different condition-specific multidisciplinary meetings that were held every week.
- The specialist palliative care team was innovative and adapted to local needs and national policy by continually developing and evaluating tools and training to promote good end of life care for patients. The team shared its knowledge and learning within the trust and published its research. The team's responsiveness, support and skill were highly regarded by colleagues throughout the trust. The team was established in wider palliative care networks, including the local hospice and clinical commissioning group.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, including details of their current medicines. There was evidence that this was improving the quality of care.
- The computerised patient record system was an excellent innovation. This had been developed by the critical care unit and alerted the consultant and nurses if a patient's safety and wellbeing were compromised.

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

Importantly, the trust must:

- Take action, with others as needed, to improve the flow of patients into and through the trust. This includes improving access to services, including A&E services, and ensuring that patients are cared for in the most appropriate place and that they are supported to leave hospital when they are ready to do so.
- Take action to ensure that staffing levels meet the needs of patients at all times in both wards and theatres.
- Ensure that staff are able to attend and carry out mandatory training, particularly annual resuscitation training, in order to care for and treat patients effectively.
- Work with partner organisations to ensure that people with mental health needs receive prompt and effective support from appropriately trained staff to meet their needs.
- Continue to improve patient flow through the Bristol Royal Infirmary to ensure that patients arriving at the A&E department by ambulance do not have to queue outside the department because there is no capacity to accommodate them.
- Ensure that the discharge process starts at an appropriate stage of a patient's care, so that discharges are not delayed due to the unavailability of care packages.
- Improve the flow of patients to reduce, as far as possible, the need for night-time moves and to reduce the number of patients nursed in areas other than specialist wards.
- Ensure that patients whose surgery is cancelled have their nutritional needs met.
- Ensure that the A&E department's observation ward provides same-sex accommodation so that patients' dignity is protected.
- Ensure that the privacy and dignity of patients who remain in the recovery areas overnight are maintained.
- Ensure that all resuscitation and safety equipment is checked regularly and that this is recorded and audited.
- Ensure that all medicines, including controlled drugs and fluids, are stored safely and appropriately.

Summary of findings

- Ensure that records accurately reflect the time at which medicines are administered and taken.
- Ensure that fire exits are clear and accessible.
- Ensure that patient records are stored securely, maintaining confidentiality, and are available to clinicians when required.
- Ensure that appropriate risk assessments are in place when building work is undertaken in areas used by staff and patients.

In addition, the trust should:

- Ensure that nurse staffing levels are maintained consistently and that the use of temporary staff is minimised so that patients receive safe and effective care from suitably qualified and experienced staff.
- Ensure that the recruitment of additional senior nurses is undertaken so that the number of supernumerary nurses meets best practice guidance.
- Ensure that all patients receive a prompt assessment on arrival at the A&E department and that there are appropriate escalation procedures in place to ensure patient safety when delays are experienced in the minors area of the department.
- Ensure that inpatient areas are single sex, in line with national recommendations.
- Take steps to meet the national cancer target of 62 days for the first treatment following an urgent GP referral.
- Review the needs of people with dementia across the hospital to ensure that they are being met.
- Take steps to move to seven-day working for clinical nurse specialists: for example, some clinical nurse specialists are not available seven days a week and therefore support for patients is limited at weekends.
- Review the use of beds to prevent their inappropriate occupation outside specialties (for example, on the stroke unit).
- Complete an Abbey Pain Scale assessment tool for all patients with cognitive impairment who are unable to communicate their needs.
- Improve communication with histopathology staff and their involvement in the potential redeployment of the service to ensure that the service's vision and values are understood and fully supported by staff.
- Increase the opportunities for staff to express their concerns with regard to developments within the trust and how they affect their day-to-day work.
- Consider improving access to information in languages other than English.
- Consider ensuring that an identified professional development budget is available for both the critical care unit and the cardiac intensive care unit so that professional development standards and best practice guidance continue to be met.
- Ensure that additional pharmacists are available to provide advice and assistance to both the critical care unit and the cardiac intensive care unit in order to meet best practice guidance.
- Consider making a critical care outreach team available to support deteriorating patients on the wards.
- Consider improving the management of medical notes in the ante- and postnatal ward as we saw some notes left unattended in the nursery.
- Ensure that there are always enough cleaning staff to be able to clean the delivery rooms as soon as required to ensure that the flow through the department is not interrupted.
- Consider extending midwife cover in the early pregnancy assessment unit to include weekends. This would ensure that a consistent service is provided.
- Ensure that there are sufficient resources available to enable children to have access to play specialists as necessary.
- Ensure that patients are kept informed of the waiting times in outpatient clinics.
- Take action to ensure the consistent monitoring of the quality of outpatient services across the different divisions and display information on safety and quality performance in the outpatient clinic waiting areas.

Summary of findings

- Take action to improve patient satisfaction with communication relating to booking and arranging outpatient appointments.
- Take action to ensure that administrative staff in outpatient services are fully supported.
- Take action to ensure that there is consistent leadership across outpatient services.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Rating

Good



Why have we given this rating?

Patient safety was a high priority and risks to patients were understood and managed effectively. Patient outcomes were mostly good and there were few serious incidents. Patient feedback was mostly very positive; people told us that staff were kind and compassionate.

Overcrowding was the major risk faced by all of the A&E departments. At the BRI, frequent ambulance queues were a cause for concern. Significant work had been, and was being, undertaken by the trust to increase capacity, improve patient flow and reduce delays and risks to patients. At the BRHC, the physical environment was not large enough or appropriately configured to accommodate and effectively care for the increasing numbers of patients attending the hospital. This was being addressed by a programme of reconfiguration and refurbishment, which was nearing completion, to improve the efficiency of the department, alongside a hospital-wide project to improve patient flow and capacity.

Staffing levels were a concern. There were occasions in all three A&E departments when services were forced to manage without a full complement of nursing staff. This posed risks to safety and responsiveness, although there was a range of safeguards in place to mitigate risks.

At the BRI, we had concerns that the needs of people with mental health problems were not met promptly enough. Also, a lack of staff awareness of the needs of people with dementia posed the risk that they may not have received the specialist care they required.

Despite these concerns, staff in all three departments were highly motivated, engaged and committed. There was a culture in which learning and continuous improvement were encouraged. Staff shared values and aims and worked cohesively to achieve these, supported by strong clinical leadership.

Summary of findings

Medical care

Requires improvement



Patients received compassionate care and we witnessed positive interactions between patients and staff. All staff spoke highly about working at the trust.

We saw good facilities in the teenagers' and young adults' ward. We saw staff using the 'This is me' tool for people with dementia to tailor the care they delivered.

Safety in medicine was compromised. We found prescription medicines that were not stored appropriately; shortfalls in staffing numbers for nursing; and resuscitation trolleys were not checked appropriately.

We found examples of the trust working positively in conjunction with partners across community services.

There was poor patient flow in the trust and we found medically fit patients across the medicine division awaiting social care packages or social service assessment.

We found the service was working in line with the Royal College of Pathologists Guidelines 2012.

However, the trust had recognised the histopathology service was not meeting all of their targets for processing specimens due to low staffing levels for histopathologists. Not all staff felt their views were listened to by the executive team about the proposed changes to the service.

Surgery

Requires improvement



Overall, surgery services at the University Hospitals Bristol Main Site require improvement. While care was seen to be caring and compassionate across all areas, improvement is required in order to make the service safe, effective, responsive and well led.

Incidents were reported and investigated and there was evidence of learning from them. There had been five never events within surgery since June 2013.

There was evidence that action had been put in place following these. Compliance with the World Health Organization (WHO) surgical safety checklist was good. Wards, theatres and departments were clean. However, not all staff observed good infection control practices. Medicines were not always given on time and the principles of safe medicines administration were not always followed.

Staffing in theatres fell below recognised guidelines and wards were not always fully staffed to their

Summary of findings

establishment if bank or agency staff could not be recruited. Ward 700 had an increased activity due to the provision of a treatment room, when compared to ward 800. Despite this it was not reflected in the staffing numbers. Staffing levels on the surgical and trauma assessment unit were such that at times patients did not receive one-to-one care when required.

Patient outcomes were below the England average for hip fractures. Fewer patients than the England average received surgery within 48 hours or were seen by an orthogeriatrician. The standardised relative risk of readmission rate was significantly higher for both elective and non-elective cases in upper gastrointestinal surgery.

The beginning of the patients' pathway was good, with good access and provision of care at the preoperative stage. However, bed occupancy was high and patients were not being cared for in designated areas. Patients often went to theatre without an allocated bed available post-operatively. As a result, patients often stayed in the recovery area overnight and some even went home from there. Patients were kept 'nil by mouth' for long periods of time and cancellations often occurred late in the day. Patients also remained in hospital for longer than the England average. While there was good access to translators, written information was provided only in English.

While services were reported as being well led on wards and in departments, there was little visibility of the divisional management team. Plans had been made for a major reconfiguration of services, with some specialties moving to another provider. Managers told us that this would allow a protected bed base and increase their capacity to undertake elective and emergency work in a more timely manner. However, until reconfiguration occurred, issues with patient flow and access remained. There was little evidence that actions were being taken to address the issues relating to discharge.

Critical care

Good



Critical care services were judged to be good in the safe, effective, caring and well-led domains. The responsive domain required improvement. The trust's adult critical care services had a good patient safety record and performed better than

Summary of findings

other comparable trusts. We saw that there was a culture of learning from incidents and complaints. Risks were being managed appropriately. Staff were encouraged and supported to be involved in quality improvement projects and we were shown several examples of innovation. Arrangements for medicines were generally appropriate, but some improvements were needed.

Patients and relatives told us that staff were mostly caring and compassionate. There was appropriate medical cover for critical care wards and CICU. The imminent plan to recruit more experienced nurses will give greater assurance of the ongoing safety in both critical care and CICU.

Changes within the last 12 months to the leadership of both the critical care unit and CICU had been positive and were leading to improved opportunities for staff and an improved skill mix for nurses, which will enhance patient care. Clinical leadership from consultants within critical care was also seen to be good. However, there was a lack of clarity around governance arrangements from CICU consultants. The forthcoming opening of the new critical care unit (ward 600) will provide both staff and patients with an improved care and working environment. There will be improved facilities for visitors and additional quiet rooms, which will afford greater privacy for distressed and grieving relatives. The new unit will provide one additional bed compared with current availability. It is highly likely that problems will continue relating to access to critical care beds, resulting in cancelled operations and delays in transfer to critical care due to the lack of available suitable beds.

Maternity and family planning

Good



The maternity and family planning services were found to be good in the safe, effective, caring and responsive domains and outstanding in the well-led domain. The maternity services provided care and support in accordance with recommended guidance. Audit systems in place meant that practices were monitored continuously and action was taken when improvements were required. Staff were confident in reporting incidents, telling us that they had confidence that any lessons learned would lead to the necessary change in practice.

Summary of findings

There were times when records were left unattended on the postnatal ward, meaning that confidentiality of information was not always assured.

The services had enough resources, including equipment and staff, to meet the needs of women, although the midwife-to-women in labour ratio was lower than the recommended level. On occasion, sanitary bins on the postnatal ward were overflowing and domestic staff on the labour ward had not always cleaned a room within the set timescales. Staff told us that discussions were ongoing with outside agencies who were involved in the provision of domestic staff.

Staff at all levels undertook the required training and assessments of their competencies were ongoing. Midwives had regular supervision of their practice. Staff reported that they had opportunities to develop their skills.

Women's individual needs and level of risk were taken into account when planning their care. As a regional referral centre, the maternity services worked with a range of other services to ensure that women's plans for their pregnancy were carried out where possible.

Feedback from women and their families was positive about the services they received, the level of support and information they received and the way in which their dignity and privacy were maintained. Leadership in the maternity and family planning services was outstanding. There was a high level of satisfaction amongst staff. There was evidence of strong collaboration and support across the service. Staff spoke of an open, supportive and friendly culture, with "great teamwork". Leadership was encouraged at all levels within maternity services. Staff were able to input ideas and were empowered to find and implement solutions. The team worked cohesively with open communication and all members of the staff team felt they were able to speak up and were listened to. This led to a highly functional team.

The service had a proactive and well-defined governance structure. Meetings existed that oversaw activity, performance, quality, safety, audit and risk. Issues were escalated within the trust, as required.

Summary of findings

There was strong engagement with patients and a focus on gaining greater involvement in the MSLC from patients groups who represented the local population using the service.

Continuous improvement was embedded within the service with multidisciplinary working parties empowered to develop, discuss and test new ideas and guidance. Innovative approaches were adopted to resolving challenges.

Services for children and young people

Good



Services for children and young people were found to be good. Children received good care from dedicated, caring and well-trained staff who were skilled in working and communicating with children, young people and their families.

Patient outcomes were routinely better than expected which was demonstrated through independent benchmarking. There was evidence of staff being involved in the development and review of policy, procedures and implementing a change practice, where improvements in outcomes were required. There was a strong commitment to the skills knowledge and competence of all staff. The trust had developed a Paediatric Faculty of Education at the hospital to develop the skills, competence and knowledge of staff. Transitional care was outstanding, young people had been involved in the development of the service and planning occurred from an early stage.

Children and their families were actively involved in their care and treatment and their feedback regularly sought and listened to.

The arrangements for safeguarding were excellent and staff told us about the open culture that encouraged them to report issues as they arose. Following a successful recruitment campaign, wards were staffed with well-trained and competent staff. The majority of comments from parents, children and young people were very positive. They thought the staff were brilliant and the facilities excellent.

End of life care

Good



The specialist palliative care team had developed a range of tools and processes in order to deliver, monitor and evaluate care in line with current best practice. They regularly reviewed patients within multidisciplinary forums to promote coordinated,

Summary of findings

safe and effective care. Care records demonstrated that potential problems for patients were identified and planned for in advance with action plans. This information was recorded clearly in care plans. We found that end of life care was effective and responsive to individual patient needs, particularly in the last days and hours of life. Improvements were needed to identify patients who were potentially in their last year of life in order to better plan care. End of life patients were not always able to be in their preferred place of care as the discharge-planning process was not fully effective. Intermediate improvements were required to the mortuary facilities while the planned redevelopment of this facility were completed. All the patients and relatives we spoke with told us that they had been involved in decisions, care was good and staff were respectful and kind. Staff throughout the trust valued the expertise and responsiveness of the specialist palliative care team.

Outpatients

Requires improvement



The environment in the outpatient clinics we visited was generally clean, reasonably comfortable and well maintained. We found that there were inconsistencies in the maintenance of a safe environment. This related to maintenance of equipment and the risk management of building work in one of the clinics.

There were consistent issues with missing patient notes and also with the protection of confidentiality with the storage of some patient records.

Patients were very positive about the quality of clinical treatment and the professionalism of all the staff.

Staff were professional and promoted a caring ethos. Compassionate care was provided and staff interacted with patients in a friendly manner while treating patients with dignity and respect.

Some clinics had made progress in meeting the demands of increased capacity following the reorganisation of some services. Some of this followed the amalgamation of certain services from another provider. Several clinic services were able to respond quickly and directly to patients who required treatment.

Government targets for referral-to-treatment times were not being met in a number of the services.

Summary of findings

Patients were dissatisfied with communication with the hospital over the booking and arranging of appointments. The introduction of a more centralised booking system had produced limited improved outcomes for patients. However, this was still being rolled out throughout the service.

There were also long waiting times in some clinics and patients were not kept informed of the delays, or the reasons for them.

Staff were positive about the leadership within their medical divisions but some staff felt unsupported by the leadership above this. There were inconsistencies in the monitoring and managing of the quality of service in the outpatient clinics across the different medical divisions.

There was low morale among some administrative staff for reasons including increased workloads and the perceived slowness of the recruitment process to fill vacancies.

We found that all staff took pride in the quality of care and treatment provided by the outpatient department and were aware of the key trust values.

University Hospitals Bristol Main Site

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

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Detailed findings

Background to University Hospitals Bristol Main Site

University Hospitals Bristol NHS Foundation Trust comprises eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008.

The trust had 1,085 beds and employed 8,442 staff. In the financial year 2013/14, the trust had an annual turnover of £554 million and reported a £6 million income and expenditure surplus. After adjustments for technical items, a net deficit of around £5 million was declared. The trust had a healthy cash position at the end of the year. This was the 11th successive year of reported surplus for the trust. The trust was undertaking a significant building programme designed to upgrade and replace old accommodation and was making an investment in this of around £170 million.

The trust provided services to three distinct populations. Acute and emergency services were provided to the local population of around 300,000 in south and central Bristol. Specialist regional services were provided to a population of around 2.2 million in Bristol, North Somerset, Bath and North East Somerset, South Gloucestershire and Wiltshire. Specialist services were also provided across the whole of the South West, South Wales and beyond to a population of around six million.

The 2010 Indices of Deprivation showed that Bristol was the 79th most deprived local authority out of 326 local authorities. Life expectancy for men, at 78 years, was close to the England average of 78.5 years. Life expectancy for women, at 82.6 years, was very slightly better than the England average of 82.5 years. Bristol was significantly worse than the England average for the proportion of children living in poverty, levels of violent crime, long-term unemployment and educational attainment. There were significant variations in levels of deprivation within the city of Bristol and there were areas of prosperity within the city and the immediate

surrounding area. Census information showed that 16% of Bristol's population was non-white, with 6% declaring their ethnic origin as Black, 5.5% as Asian and 3.6% as mixed race.

We inspected all of the hospitals that make up University Hospitals Bristol Main Site:

- Bristol Royal Infirmary
- Bristol Royal Hospital for Children
- Bristol Heart Institute
- Bristol Oncology and Haematology Centre
- St Michael's Hospital
- Bristol Eye Hospital
- The University of Bristol Dental Hospital.

At the time of this inspection, there was a relatively stable executive team. The chief executive had been in post since 2011 and the chair since 2008. The chief nurse was the most recent appointment and had joined the trust in January 2014. There was a full complement of non-executive directors, some of whom had been in post since 2008 and some of whom had been appointed within the last 12 months. There were two non-executive board observers who had been appointed to enable continuity and an ordered succession when non-executives reached the end of their term.

We inspected the trust as part of our in-depth inspection programme. The trust had been identified as a medium-risk trust according to our 'intelligent monitoring' system and had moved from the low- to the medium-risk category between March and July 2014. Concerns had also been raised about the trust. Our inspection was carried out in two parts: the announced visit, which took place on 10, 11 and 12 September 2014; and the unannounced visit, which took place on 21 September 2014.

Our inspection team

Our inspection team was led by:

Chair: Michael Wilson, Chief Executive, Surrey and Sussex NHS Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Detailed findings

The team of 51 included CQC inspectors and a variety of specialists. These included two consultant surgeons; two consultants in paediatric cardiology; a consultant neonatologist; a consultant in obstetrics and gynaecology; a consultant intensivist; a consultant geriatrician; a consultant in emergency medicine; a

consultant in sexual health; a chief nurse; two associate directors of nursing; specialist nurses in paediatrics, medicine, surgery and theatres, and end of life care; a midwife; a human resources specialist; a specialist in complaints; and two experts by experience.

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at the University Hospitals Bristol Main Site:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning group (CCG), the Trust Development Authority (TDA), NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Bristol on 3 September 2014 where 35 people shared their views and experiences of services provided by the trust. Some people who were unable to attend the listening events shared their experiences via email or telephone. The team also took account of information that had been shared by patients, the parents and families of patients and people supporting patients during a series of communications and meetings during 2014.

We carried out the announced inspection visit between 10 and 12 September 2014 and the unannounced visit on 21 September 2014. We held focus groups and drop-in sessions with a range of staff in the hospitals, including nurses, midwives, junior doctors, consultants, physiotherapists, occupational therapists, administrative staff, healthcare assistants and support workers, non-executive directors and biomedical scientists. We also spoke with staff individually, as requested.

We talked with patients and staff from across the hospitals, including ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We interviewed the chair and the chief executive, and met with a number of executive and non-executive directors, senior leaders from the clinical divisions and managers.

Facts and data about University Hospitals Bristol Main Site

The University Hospitals Bristol NHS Foundation Trust had 1,085 beds and employed 8,442 staff. The trust provided district general hospital services to the local population of around 300,000 in central and south Bristol. The trust also provided a range of specialist services

across the South West and in parts of Wales, serving a population of around six million. Specialist services included cardiac care, children's services, bone marrow transplantation, cancer and haematology services.

In 2013/14 the Trust had approximately 72,000 elective admissions, of which 57,000 were day cases. The Trust

Detailed findings

had a further 36,000 emergency admissions and 20,000 non-elective admissions and provided approximately 618,000 outpatient appointments. During the same year, the emergency departments dealt with 115,000 attendances.

With the exception of St Michael's Hospital (the maternity service), the trust had consistently high bed occupancy;

this regularly reached over 88% and was recorded as 90.3% between January and March 2014 (the latest figure available). It is generally accepted that when occupancy rates rise above 85%, they can start to affect the quality of care provided to patients and the orderly running of the hospital.

Detailed findings

Our ratings for this hospital



Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and family planning	Good	Good	Good	Good	Outstanding	Good
Services for children and young people	Good	Outstanding	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Accident and emergency

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Good	
Overall	Good	

Information about the service

There were three accident and emergency (A&E) departments providing emergency care and treatment to people in central, south and north-west Bristol. These were located at the Bristol Royal Infirmary (BRI), Bristol Royal Hospital for Children (BRHC) and Bristol Eye Hospital (BEH).

BRI

The A&E department was open 24 hours a day, seven days a week. The BRI's A&E saw 60,000 patients per year, of which about 40% arrived by ambulance, indicating a high acuity profile. The catchment area was a deprived one and the BRI A&E department saw a high proportion of patients with psychiatric and/or drug- or alcohol-related problems.

Patients were cared for in two main areas: minors and majors. The minors area had a waiting room, six cubicles and two consulting rooms for the assessment and treatment of ambulant patients and a plaster room. The majors area had 10 cubicles, a side room and a six-bedded resuscitation room with digital x-ray facilities. There was an eight-bedded observation unit and a relatives' room. There was an ambulatory care unit on the next floor, where patients were seen who required diagnostic investigations, observation, treatment and rehabilitation but who were not expected to require an overnight stay.

We visited the department over two and a half days, including an evening visit. We spoke with approximately 25 patients and 10 relatives.

BRHC

This was a dedicated children's A&E department for patients under the age of 16. The department was open 24 hours a day, seven days a week. The department, which became a major trauma centre in May 2014, saw approximately 35,000 patients per year.

There was a waiting room, two triage rooms, three cubicles, five bays and a resuscitation area. There was also an eight-bedded observation ward. The department was undergoing a rebuild at the time of our visit to extend and reconfigure the accommodation. The work was due to be completed by the end of October 2014.

We spent a day in the department and spoke with six parents and three children.

BEH

The A&E department provided emergency assessment and treatment from 8.30am to 5pm, seven days a week, and included a telephone triage service. Outside these hours, patients with urgent eye problems were seen at the BRI's A&E. The department saw approximately 23,000 patients per year, of which approximately 1,500 were children.

Within the report when we refer to A&E we mean the BRI A&E and we specify where we are talking about the BRHC and BEH A&E departments.

The department consisted of a waiting room, including a separate children's area, a small triage room, a treatment room and two doctors' consulting rooms.

We spent two hours in the department and spoke with seven patients and one relative.

Accident and emergency

In all of the departments we 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. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

Summary of findings

Patient safety was a high priority and risks to patients were understood and managed effectively. Patient outcomes were mostly good and there were few serious incidents. Patient feedback was mostly very positive; people told us that staff were kind and compassionate.

Overcrowding was the major risk faced by all of the A&E departments. At the BRI, frequent ambulance queues were a cause for concern. Significant work had been, and was being, undertaken by the trust to increase capacity, improve patient flow and reduce delays and risks to patients. At the BRHC, the physical environment was not large enough or appropriately configured to accommodate and effectively care for the increasing numbers of patients attending the hospital. This was being addressed by a programme of reconfiguration and refurbishment, which was nearing completion, to improve the efficiency of the department, alongside a hospital-wide project to improve patient flow and capacity.

Staffing levels were a concern. There were occasions in all three A&E departments when services were forced to manage without a full complement of nursing staff. This posed risks to safety and responsiveness, although there was a range of safeguards in place to mitigate risks.

At the BRI, we had concerns that the needs of people with mental health problems were not met promptly enough. Also, a lack of staff awareness of the needs of people with dementia posed the risk that they may not have received the specialist care they required.

Despite these concerns, staff in all three departments were highly motivated, engaged and committed. There was a culture in which learning and continuous improvement were encouraged. Staff shared values and aims and worked cohesively to achieve these, supported by strong clinical leadership.

Accident and emergency

Are accident and emergency services safe?

Good



Incidents

- The BRI A&E department's senior team was proud of the fact that there was a high level of incident reporting in the A&E department (the highest in the hospital), indicating an open culture. Despite this, there had been few serious incidents. Two serious incidents were reported by the BRI A&E department in 2013/14. In October 2013, black escalation (critical status declared when the department is unable to provide a safe level of care due to lack of capacity) was enacted due to high levels of emergency patients attending A&E. In February 2014, it was reported that six patients experienced 12-hour waits in A&E, five of whom were on trolleys, with the sixth transferred to a bed. Neither of these incidents resulted in actual patient harm. A further serious incident occurred in July 2014 when a patient with mental health problems was in the BRI A&E department for nearly 20 hours awaiting further mental health assessment and placement by another healthcare provider.
- Similarly, the senior team in the BRHC was encouraged by high levels of incident reporting. There had been no recent serious incidents.
- All serious incidents resulted in a root cause analysis and action plans were put in place to reduce the likelihood of similar events occurring in the future.
- Consultants in the BRI and BRHC A&E departments were designated as the patient safety leads and they had worked together to look at risks associated with overcrowding.
- Staff we spoke with told us that they were encouraged to report incidents and they were given feedback. There was a strong patient safety culture. In the BRI A&E department, safety issues were discussed every day at team briefing meetings. Patient safety briefings often focused on topics that had arisen in response to complaints or adverse incidents. Weekly patient safety messages were delivered by the lead nurse and displayed in prominent places, such as on the back of toilet doors. The message of the week during our visit related to the management of hypoglycaemia.
- Mortality and morbidity (M&M) meetings were held regularly to review the care of patients who had had complications or an unexpected outcome, to share learning and inform future practice. These were usually attended by the relevant inpatient teams. Regular simulation sessions were held to cascade learning following M&M meetings. An example of learning from this forum was shared with us. There had been two deaths arising from undiagnosed aortic dissection. As a result, an education campaign had been run, which was cascaded to other departments, including radiology, the ambulance service and GPs. There had been a noticeable change in practice and 12 aortic dissections had been diagnosed in the department in the last year, which represented a significant improvement.
- The leadership team at the BRI told us that violence and aggression from the public posed a significant risk to staff and patients. A total of 466 incidents involving violence and aggression had occurred in the six months prior to our inspection. The department was trialling a 'tally system' based on research undertaken by the Design Council in 2013, 'Reducing violence and aggression in A&E'. The tally system was designed to improve the level of reporting of incidents of this type and to understand which areas of the department were experiencing the highest levels of violent and aggressive incidents so that these could be better managed.

Cleanliness, infection control and hygiene

- We found that all A&E departments were clean and tidy, although we noted staining on a chair in the corridor outside the BRI majors department.
- Hand washing facilities were readily available and we saw staff wash their hands and use hand gel between patients. Protective clothing such as gloves and aprons were available and the 'bare below the elbow' policy was adhered to.

Environment and equipment

- Overcrowding was an issue at busy times in all three departments. At the BRI, ambulance queues, although decreasing in frequency, continued to occur on most days.
- The BRI A&E department's risk register identified that the department was too hot and that this had adversely affected both patients and staff, resulting in a number of clinical incidents. Temporary air conditioning units had

Accident and emergency

been placed in the department while a permanent solution was being installed. Work was under way during our visit, causing some disruption and lack of privacy for patients in the observation unit

- We were told that the BRHC A&E department was originally built to accommodate 14,000 children but was now seeing more than twice that figure. The department's risk register identified that the current layout of the department made it difficult for staff to maintain an overview due to lack of lines of sight and difficulty with intra-departmental communication. Rebuilding work was under way to address these issues by creating a larger, more flexible open-plan space. In the short term, the risks were heightened by the building work; however, the risks had been assessed and we observed that they were well managed. We were told that the next phase of building work would entail closing four of the eight beds in the observation unit temporarily. There was a detailed plan to manage this and the impact on the rest of the hospital.
- In the BRI and BRHC, there were dedicated ambulance entrances that ensured patients had direct access to the majors and resuscitation areas. There was good restricted access to the helipad that served both hospitals.
- The resuscitation areas were equipped appropriately. In the BRI, there were electronic resuscitation guidelines available for staff.
- The x-ray departments were adjacent to the A&E departments and were easily accessible.
- We checked a range of equipment, including resuscitation equipment, which was accessible and fit for purpose. At the BRI, the shift coordinator was responsible for ensuring that the department remained fully equipped and stocked. Any shortfalls or faulty equipment were recorded on the daily shift coordination sheet and actions taken to remedy the shortfall.
- The risk register for the BEH A&E department identified that examination lamps located in the doctors' consulting rooms were at risk of failing due to their age and condition. The A&E sister told us that a recent capital bid for their replacement had been rejected. We were told that equipment could be borrowed from another department in the event of failure, although this would inevitably result in delays.

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Fridge temperatures were checked regularly and records showed that these were correct.
- In the BRI A&E department, the shift coordinator was responsible for ensuring that stocks of controlled drugs and fluids were maintained. This was recorded on the shift coordination sheet.
- Emergency drugs were accessible.

Records

- Patients' records were in paper format and all healthcare professionals documented care and treatment using the same document, which was later scanned onto an electronic records system.
- At the BRI, the shift coordinator was required to audit six patients' records per shift to ensure that patient observations and interventions were taking place as required. This was not achieved consistently during our visit, particularly during busy shifts.
- We checked a sample of records in the BRI and BRHC departments. They were clear and easy to follow. We saw appropriate assessments recorded, including risk assessments, observations, advice and treatment and a discharge plan.
- An electronic patient system ran alongside paper records and allowed staff to track patients' movement through the department and to highlight any delays.
- A white board in the BRI majors area provided an overview of patient management in the department, showing the allocation of patients to cubicles and staff. Patients' dependency scores and observations were also recorded there. We noticed that these observations were not always updated in line with the paper records, which were more consistently completed. The board also displayed alerts such as the identification of patients with dementia or patients with mental health needs who required close supervision. The shift coordinator was responsible for maintaining this board.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before they were carried out.
- Staff training in consent was provided at induction and refreshed every three years during corporate update

Accident and emergency

training. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment.

- In the BRI A&E department, there were no secure areas where high-risk mental health patients could be accommodated. There was an assessment room used purely for the purpose of undertaking psychiatric assessment and patients were not left there unsupervised. Patients who were at risk of harm or at risk of absconding were cared for in the majors area where they were supervised closely. Staff told us that additional nursing staff or security staff could be called to assist with patient supervision and to prevent them from absconding. Security staff were trained to restrain patients, but most A&E staff were not trained in this. The department's risk register identified that only 26% of staff had received clinical holding (restraint) training. This put staff and patients at risk. Training had been suspended from March 2014; although it had recommenced in August 2014, staff could not be rostered to attend until November 2014.

Safeguarding

- Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- In the BRI, staff had received training in how to identify people at risk of domestic or sexual abuse and specialist advisers were available to support identified patients.
- There were posters displayed in the BRI reminding staff to discuss child welfare with patients attending the department who may have childcare responsibilities.
- In the BRHC, consultants reviewed all patients' records, including the records of all attenders during the night, to check for any safeguarding concerns. A weekly meeting was held to discuss any safeguarding concerns.

Mandatory training

- There was significant disparity between training data provided to us by the trust and data provided by departments.
- At the BRI, most nursing staff were up to date with essential training; however, only 65% of staff were up to date with safeguarding adults training. The trust informed us that it was taking steps to ensure that all staff were up to date with this training by the end of December 2014.

- At the BRHC, 90% of A&E staff were up to date with mandatory training.
- At the BEH, most staff were up to date in essential training, with the exception of hospital life support training and paediatric life support training, where approximately half of the staff were not up to date. The trust informed us that it planned to ensure that all staff were up to date with this training by the end of November 2014.

Assessing and responding to patient risk

- There were triage systems for the initial assessment and management of patients. The trust was consistently exceeding the national standard which requires 95% of patients to be seen and to receive an initial assessment by a registered healthcare professional within 15 minutes.
- At the BRI, self-presenting patients who arrived in the minors area were greeted by a receptionist, who collected basic information. Patients then waited in the waiting area to be called by the triage nurse.
- Data about the trust shows that the A&E department met the 15 minute target within the minors area. However, the escalation and trigger processes to ensure that patients could be assessed as a priority within 15 minutes were not always effective. On one day of our visit to the BRI, when the service was very busy, we found that three patients presenting in the minors area with chest pain were not assessed promptly (one waited over 30 minutes and three over one hour). The risk of delayed triage had not been escalated and acted upon. When we raised this to their attention staff were concerned that this had not happened and described the process of escalation, reporting and recording which should have occurred. The lead consultant told us that exceptional delays of high-risk patients should have been reported and recorded. We discussed this with other medical and nursing staff, who all agreed that the four patients we highlighted should not have waited this length of time for assessment and should have appeared on this record so that the circumstances could be investigated.
- We examined a random sample of 10 records for patients who had attended the department with chest or abdominal pain the previous week. All of these patients had been assessed within 15 minutes. Although

Accident and emergency

records were maintained of when patients had or had not met the triage target, there was not a system of recording how long patients waited to be triaged if they waited longer than 15 minutes.

- We looked at the shift coordination sheet for three days and saw examples when delays in the minors area had been recorded and junior medical staff and/or additional nursing staff had been re-allocated to address these delays. However, staff were not aware of any formal escalation procedure in the event of delays in minors.
- Emergency nurse practitioners (ENPs) were employed in the BRI minors area. These highly trained nurses were able to see, treat and discharge certain categories of patients so that the patients did not have to wait to see a doctor. There were not enough ENPs to ensure cover 24 hours a day, seven days a week, although new staff had been appointed and were due to commence employment shortly. There was also an extended scope physiotherapist who was able to see and treat patients with musculoskeletal injuries.
- The trust's corporate risk register identified that patients on ambulance trolleys queued in the corridor outside the BRI A&E department at regular intervals due to a lack of capacity in the department. The register stated "The condition of these patients is not known and there is a risk of patient deterioration and/or collapse." It was identified that patients could wait up to two hours without assessment, care or treatment and without oxygen or suction.
- In order to mitigate this risk, the department had developed internal escalation plans to restrict the number of patients queueing and a number of systems had been implemented to ensure that patients' vital signs and pain scores were monitored and that they were prioritised appropriately.
- BRI patients who arrived by ambulance were met by the patient flow coordinator. This staff member was easily identified because they wore a pink shirt. The patient flow coordinator registered the patient's arrival on the electronic patient information system. The shift coordinator received a verbal handover from the ambulance crew and allocated the patient to a cubicle and named nurse. The handover was registered on the electronic patient record system. In the event that no cubicle was available, there was a formal process in place between the trust and ambulance service in order that patients in the corridor were safely monitored. The

handover took place at the entrance to the department and the patient would be taken to the corridor outside the department where they would continue to be cared for by the ambulance crew. This care included the recording of regular observations and alerting hospital staff to any deterioration in their patient's condition. The patient flow coordinator and the shift coordinator were jointly responsible for monitoring the ambulance queue.

- We spoke with ambulance crews who were monitoring patients in the ambulance queue. Whilst they acknowledged the delays to patients were frustrating and sometimes caused distress, they assured us that patients were safe. They told us that any concerns about a patient's safety would be responded to promptly by hospital staff. The trust's corporate risk register identified that patients on ambulance trolleys queued in the corridor outside the BRI A&E department at regular intervals due to a lack of capacity in the department. The condition of these patients would be unknown and therefore there was a risk of patient deterioration and/or collapse. It was identified that patients could wait up to two hours without assessment, care or treatment and without oxygen or suction. The department had developed internal escalation plans to restrict the number of patients queueing and a number of measures had been implemented to ensure that patients' vital signs and pain scores were monitored and that they were prioritised appropriately.
- A standing operating procedure (SOP) had been developed by the ambulance service. This procedure was implemented when the ambulance service deemed it necessary to allow its crews to leave their patients and become available for further emergency work. In these circumstances, the hospital allocated nursing staff from other parts of the hospital to work in the A&E department so that queuing patients could be supervised. Appropriate nurses were identified each day and were on 'standby' for this eventuality.
- There were structured handover meetings at each change of shift. Discussions included bed availability, staffing, breaches, incidents, equipment and learning. This ensured that all staff were well informed and aware of risks.

Accident and emergency

- The trust used a recognised early warning tool. Patients in majors were given an initial score and a corresponding observation regime was put in place. All patients received a minimum of hourly observations unless otherwise indicated.
- Patients who were suspected of having had a stroke could be transferred directly from the ambulance to the CT scanner. There was a stroke response team that attended A&E when requested.
- At the BRI and BRHC, patients who required a period of observation but were unlikely to require admission exceeding 24 hours were transferred to the respective observation units.
- At the BRHC, the A&E department used the Manchester triage system, augmented by the measurement of vital signs. Patients were categorised from one to four and prioritised to be seen by a doctor accordingly. A senior doctor and the nurse in charge were notified of any patients categorised as priority one or two. Observation standards and frequency were stipulated for each category of patient. There was an enhanced pathway for patients referred by a GP.

Nursing staffing

- The BRI A&E department was not fully staffed. The department had experienced a high turnover of nurses, including emergency nurse practitioners, and although recruitment was ongoing, there were approximately seven nurse vacancies at the time of our visit. There was regular and frequent use of bank and agency nursing staff. Staff told us that sometimes they were unable to fill vacant shifts but they did not think that staffing levels were unsafe. During the period from 1 September 2014 to 12 September 2014 there were 13 unfilled shifts, three of which were emergency nurse practitioner shifts.
- Department dependency scores were documented every two hours and recorded on the shift coordination sheet so that staffing requirements could be kept under review. We were told that additional temporary staff could be requested if the dependency scores indicated a need. For example, a mental health patient who required one-to-one supervision might have required a registered mental health nurse.
- There were safeguards in place to ensure the safe and appropriate deployment of temporary staff, with most being placed in the observation unit or the majors area where they would be supervised and supported. The shift coordinator was responsible for sourcing

appropriate cover, for staff deployment and for their orientation in the department. There was a checklist completed by temporary staff that evidenced that they had familiarised themselves with the department and their role. Temporary staff on duty during our visit told us they felt well supported and comfortable with their responsibilities.

- At the BRHC, there had been a detailed analysis of the factors that contributed to overcrowding and its impact on safety and quality of patient care. From this and following the centralisation of specialist paediatrics, plans were put in place to reconfigure the department physically and corresponding staffing levels were agreed. Staffing levels had been challenging, but, following significant recruitment, the senior management team was confident that the department would be fully staffed by November 2014 when the newly configured department became operational.
- The BRHC A&E risk register identified a high risk (amber) that major resuscitation events, particularly trauma events, often required more nursing staff than were available on an individual shift. The clinical lead for the department described the safeguards that had been put in place. All staff in the A&E department had received specialist training to respond to a major resuscitation event; this included staff deployed in the observation ward, who would be called upon to assist. Their positions would be backfilled by staff from other areas of the hospital.
- The risk register also identified that the nurse in charge (a band 6 nurse) was counted in the daily staffing numbers and had to combine a supervisory role with clinical care. This situation had contributed to several clinical incidents, which highlighted the need for a supernumerary nurse coordinator. We were told that this position had now been established and would become operational when the reconfigured department opened.

Medical staffing

- In the BRI there was a consultant on the 'shop floor' from 8am to 10.30pm, Monday to Friday, and from 8am to 5pm at weekends. Outside these hours, middle-grade doctors were on duty and consultants provided on-call cover. Junior medical staff told us that they were well supported by senior staff and staffing levels were consistently good, with low use of locum staff.

Accident and emergency

- At the BRHC, the department had recently increased its consultant presence, extending their cover from 8am to midnight, seven days a week. A senior registrar (ST6) was also on duty between 4pm and midnight, which was the busiest time in the department. Outside these hours, a junior-grade doctor was on duty (some were more experienced than others), supported by inpatient registrars who would attend the department if requested. A consultant was always available on call.

Major incident awareness and training

- Staff in the A&E departments were well briefed and prepared for a major incident. They could describe the processes and triggers for escalation. Similarly, they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT). There was a lead consultant and a band 6 nurse in the BRI A&E department who were responsible for briefing and training staff.
- There were good links between the BRI and the BRHC A&E departments and shared procedures were in place in relation to major incident management.
- There were appropriate security arrangements in the A&E departments. Security staff were employed within the BRI 24 hours a day, seven days a week, and could be summoned to support A&E staff. Staff told us that the security staff usually based themselves in the A&E department during the evening.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Patient care was effective. There was evidence that the A&E departments adhered to National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines. All staff were well supported with continuing education and participated in regular audits to ensure that care pathways were followed and treatments were appropriate and effective.

Evidence-based care and treatment

- In the BRI there were up-to-date protocols available based on NICE guidelines for the treatment of different conditions such as sepsis, stroke and myocardial infarction (MI).
- Clinical indicators were audited monthly, including early warning scores, pain relief, treatment of stroke, chest pain, fractured neck of femur and sepsis.
- There was a local audit programme delivered by multidisciplinary teams of doctors, nurses and administrative staff.
- At the BRHC there was a range of procedures and protocols based on national good practice for a trauma centre. The department participated in national audits, such as on pain relief, and local audits, such as on hand hygiene.

Pain relief

- All of the patients we spoke with, except one (BRI), told us that they were offered and/or provided with appropriate pain relief. Patients' records confirmed this.
- Monthly audits took place in the BRI to ensure that clinical guidelines in relation to pain relief were complied with. The department scored well in relation to initial pain scoring, the administration of analgesia and the use of the Abbey Pain Scale system for patients who were unable to articulate their needs. However, the audits showed that there was room for improvement in relation to reassessing pain after one hour for patients with moderate to severe pain.
- A number of complaints had been received at the BRI relating to inadequate pain relief. In response to this, regular reminders were issued to staff via patient safety messages.
- In the BRHC A&E department, audits had identified that patients did not always receive pain relief in a timely way. Staff attributed this to staffing levels and layout issues that would be addressed when the reconfigured department and corresponding staffing levels were operational. Patient group directives had been agreed and it was anticipated that appropriately trained staff would administer certain medicines without the requirement for another member of staff to check this, thus speeding up the process.

Nutrition and hydration

- Patients told us that they were offered food and drink. We saw this recorded in their records.

Accident and emergency

- Monthly audits of clinical indicators relating to dignity and nutrition showed that the BRI A&E department was performing well in relation to offering patients food and drink when they had been in the department for more than two hours.

Patient outcomes

- The trust had participated in 12 out of 16 national CEM audits since 2008 so it could benchmark its practice and performance against best practice and other A&E departments. Audits included asthma (2009), an area in which the trust did not meet nine of the 14 standards.
- The trust performed poorly in the 2012 consultant sign-off audit.
- The trust did not meet any of the CEM standards in the fractured neck of femur audit of 2012. Monthly audits of clinical indicators relating to the treatment of fractured neck of femur showed some improvement, although improvement was still required in relation to evidencing the start of the appropriate treatment pathway. Delayed admission to a ward also remained a concern.
- The trust did not meet 13 of the 14 CEM standards for the treatment of renal colic in the 2012 audit.
- The trust met only one of the 13 CEM standards for the treatment of severe sepsis and septic shock. This area was re-audited in 2013 and performance remained poor. An education campaign, 'sepsis week', had been held in July 2014 and monthly nursing audits were showing significant improvement. Most of the staff we spoke with were familiar with the recognition and treatment protocols for sepsis or knew where to locate them.
- There was a programme of local audits. In the BRI, these included audits of compliance with national guidelines, such as those on fluid prescribing, and audits identified through patient safety incidents, for example, on the use of central lines. In the BRHC, there had been a study of the treatment of wheezing children.
- The BRI A&E department did not meet the national standard relating to the rate of unplanned re-attendances (January 2013 to February 2014) and performed worse than the England average. The department continued to review performance against this and other A&E clinical indicators to understand the reasons for this.

Competent staff

- There was a programme of regular training for staff in the BRI A&E department, with 20 key topics covered on a rolling rota. Medical and nursing staff told us that they felt well supported with training.
- Junior medical staff at the BRHC were well supported and supervised by consultants. All investigation results (blood tests and x-rays) were reviewed by a consultant (the next day if conducted overnight) and all records from overnight attendances were reviewed the following day to ensure that treatment was appropriate and to identify any learning needs.
- The trust scored above the national average in the 2014 National Training Survey (NTS) for handover (BRI and BRHC) but the BRI scored below the national average for induction.
- Staff were appraised regularly. At the BRI A&E, 87% of nursing staff and 86% of medical staff had received a recent appraisal. At the BEH, 80% of nursing staff had received a recent appraisal, while at the BRHC, 84% of nursing staff and 81% of medical staff had received a recent appraisal.
- At the BEH, staff told us that they did not receive regular formal one-to-one supervision, although they were able to ask for support when required. Team meetings were rare and ad hoc because there was little 'down time' in the department. The department sister produced a monthly newsletter that was emailed to all staff.

Multidisciplinary working

- The BRI A&E department was well supported by the radiology department. During our visit we observed that most requested CT scans were performed within one hour. There was a good working relationship between the two departments and regular radiology teaching was provided for A&E medical staff. However, there was limited provision of interventional radiology and several clinicians we spoke with were concerned that this would deteriorate further with the relocation of vascular services to North Bristol NHS Trust. Out of hours provision was ad hoc and fell short of the recommendations of the Royal College of Radiologists.
- There was evidence of good partnership working with the local ambulance service and regular meetings took place. These ensured that the two services worked cooperatively to minimise delays and patient safety risks. A service-level agreement had been developed to

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mitigate the risks associated with ambulance queues.

We observed that hospital and ambulance staff worked seamlessly together and demonstrated understanding and respect for each other.

- The BRI A&E department had introduced multidisciplinary meetings with mental health and community services to formulate management plans for frequent attenders.
- Staff reported that, although the psychiatric liaison service was not always timely in its response, it was supportive and provided advice and teaching.
- There was an alcohol nurse specialist who visited the BRI A&E department each morning to see patients with problems related to alcohol. A&E staff could also arrange for patients to see this specialist on an outpatient basis.
- There was a rapid emergency assessment care team (REACT) based in the BRI A&E department from Monday to Friday. This team, consisting of occupational therapy, physiotherapy and nursing staff, facilitated discharges of vulnerable patients such as older people, people living alone or people with limited mobility. They assessed, for example, people's mobility and equipment needs and made referrals to other services as appropriate to facilitate a safe and speedy discharge.
- There was a service provided by the British Red Cross that helped to facilitate discharge from A&E or a ward when a patient was medically fit but there were non-medical (social) reasons preventing a safe discharge.
- A child and adolescent mental health specialist made daily contact with the BRHC A&E department to support patients as required.

Are accident and emergency services caring?

Good



Patient feedback captured prior to and during our inspection was overwhelmingly positive for all three A&E departments. This was consistent with the high scores achieved in the Friends and Family Test. We observed staff to be caring and compassionate.

Compassionate care

- The A&E departments used the Friends and Family Test to capture patient feedback. They consistently achieved high levels of satisfaction, which were better than the England average.
- Apart from one negative interaction with a patient at the BRI, which we reported to the lead nurse, all of the staff interactions with patients we observed were positive and respectful. All of the patients and relatives we spoke with praised the staff, describing them as “kind”, “understanding” and “polite”.
- Feedback from parents and children at the BRHC was also very positive, with staff described as “brilliant” and “caring”.
- At the BEH, all patients and relatives we spoke with praised the staff, describing them as “reassuring”, “kind”, “respectful”, “helpful” and “cheerful”. We observed many positive and caring interactions.

Patient understanding and involvement

- The BRI A&E department scored 8.3 out of a possible 10 in the 2013 inpatient survey when patients were asked about how much information about their care and treatment was given to them.
- In the BRI, patients saw and interacted with a range of staff during their stay in the department. We heard staff introduce themselves. There were posters displayed in cubicles that identified different staff groups by the colour of their uniform, and each cubicle was staffed by a named nurse whose name was displayed. We noted, however, that staff name badges were not always visible or prominent, and patients were not always able to identify the staff caring for them. One patient told us that they had seen four different doctors and they didn't know “who was who”.
- Patients and relatives told us that their care and treatment options were explained to them in way they could understand. One patient commented: “I have been treated like an intelligent human being.”
- In the BRI and the BEH there was no information given to people about waiting times. There was a notice in the BEH advising people that at busy times they may have to wait up to four hours. In the BRI, a receptionist told us that they advised people about waiting times only if they asked, because they did not want to raise people's expectations.

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- In the BEH, patients we spoke with were very satisfied that their treatment had been clearly explained to them. Friends and Family Test results for July 2014 showed that 97% were extremely likely or likely to recommend the service.

Emotional support

- Staff told us that there were good links to sources of specialist support, such as counselling and chaplaincy services. In the BRHC, the chaplain visited the A&E department every day.

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

Requires improvement



The trust had failed to consistently meet all of the core A&E access targets, notably in the BRI, the time patients spent in the department and the time to treatment. Although most patients were promptly assessed on arrival, some patients arriving by ambulance were forced to queue in the corridor outside A&E because the department had no capacity. This compromised patient experience and put them at increased risk.

Patients who required a mental health assessment waited too long in the BRI's A&E department and were not adequately supported by suitably trained or skilled staff. The department was taking steps to improve this by extending the psychiatric liaison service out of hours.

Service planning and delivery to meet the needs of local people

- At the BRI, twice-daily patient flow meetings were held on weekdays (once at weekends) and more frequently if the escalation status was increasing. A series of action cards outlined responsibilities for all divisions, according to current status. These included action cards for emergency department flow and role-specific action cards that set out individual responsibilities.
- A neighbour trust (North Bristol NHS Trust) had centralised A&E services on one site in May 2014, changing the profile of A&E attendance across Bristol, as

well as reducing overall bed numbers. There were regular meetings with community partners to ensure that demand and performance were monitored, understood and managed jointly.

- The A&E risk register for the BEH identified that, although the department was staffed to the funded establishment for nursing staff, this did not take into account increasing attendances, shorter opening hours or that staff had to support primary care clinics. Temporary staff were not used to cover gaps and the department relied on existing staff to provide extra shifts. Staff told us the department regularly operated with insufficient nursing staff and expressed concern that they were often rushed and that patient waiting times were too long. We were told that on each shift there should be a staff member staffing the telephone triage service. When the department was short-staffed, the telephone was not answered. On the day of our visit, the sister was triaging patients attending the department, as well as providing telephone triage. We were told that this was a regular occurrence. We requested further information to illustrate this problem.
- Attendance at the BRHC had increased following the centralisation of specialist paediatrics (CSP) The CSP project had increased the overall size of the department footprint with the addition of a new observation ward, freeing up the old observation area for use in A&E. The second part of the project was to optimise the use of this space; this work was currently under way and due to be completed at the end of October 2014.

Access and flow

- The trust was not consistently meeting all of the five core A&E access targets.
- In the first quarter of 2014/15, the trust failed to meet the standard requiring 95% of patients to be discharged, admitted or transferred within four hours of arrival in A&E. At 94.7%, the year-to-date performance was marginally above the year-to-date position the previous year. The target was achieved in June 2014 for the first time since November 2013.
- The BRHC and the BEH were consistently meeting this standard.
- The trust performed worse than the England average in respect of the percentage of patients waiting four to 12 hours from decision to admit to admission, although performance was improving.

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- The trust did not meet the target (5%) as at June 2014 in respect of unplanned readmissions to the A&E departments.
- The trust performed better than the England average in respect of patients leaving A&E without being seen (as at June 2014).
- The trust was meeting the standard requiring 95% of patients to be assessed by a healthcare professional within 15 minutes of arrival. However, at the BRI, lengthy ambulance waiting times were a concern and continued to occur regularly when the department was full to capacity, usually due to a lack of bed capacity in the hospital and in the wider health community. This was recognised by the leadership team as the biggest challenge faced by the department. It was reported at the A&E management meeting that the department was in the top third in England for patients queueing on ambulance trolleys.
- The BRI and BRHC had escalation plans to ensure that patient flow was managed throughout the hospital and that patients could access appropriate care and treatment in a timely fashion.
- At the BRI, twice-daily patient flow meetings were held on weekdays (once at weekends) and more frequently if the escalation status was increasing. A series of action cards outlined responsibilities for all divisions, according to current status. These included action cards for emergency department flow and role-specific action cards that set out individual responsibilities, including those of the A&E department shift coordinator and the A&E consultant of the day. There were also protocols for managing delays in ambulance handovers and for caring for patients queueing in the corridor.
- On the first day of our visit, the BRI A&E department had declared 'red escalation' due to a deficit of 49 beds across the hospital. It was reported at 11.30am that one patient had been in the A&E department for 13 hours and was still waiting for a bed. There were ambulance queues (up to three at a time) throughout the afternoon, evening and night. The observation unit was full in the evening, which resulted in two patients awaiting investigations being kept in the A&E department overnight.
- Daily 'operational grip' meetings were held in the A&E department to discuss patient flow issues and performance with clinical site managers and coordinators for the medical and surgical admissions units.
- A consultant was on the 'shop floor' from 8am to 10.30pm and, in conjunction with the nurse in charge, they maintained an overview of the issues affecting the department at any one time.
- There was a range of urgent pathways into the BRI that did not require specified patients to attend A&E; instead, they could be admitted directly to certain wards. The A&E department had close working relationships with these departments and had developed shared professional standards to ensure the optimal use of beds and resources. However, a lack of bed capacity meant that, on occasion, expected patients could not be accommodated on patient wards and were redirected to the A&E department. These patients were usually cared for in the minors area, thus disrupting the fast flow through this department.
- The BRHC's risk register identified overcrowding in A&E impacted on its ability to meet access targets. The department and the hospital as a whole had experienced unprecedented numbers of emergencies associated with respiratory illnesses during the winter of 2013. Following this, a hospital-wide project was established to examine, anticipate and manage blockages to patient flow and capacity in readiness for the coming winter.
- Steps taken included extending the presence of senior medical staff (decision makers) in the department. The consultant on the 'shop floor', in conjunction with the nurse in charge, maintained an overview of the issues affecting the department at any one time. They also worked closely with general and specialty paediatric teams, the clinical site team and outreach nurses. There was an escalation policy which enabled them to request help from these teams.
- The BRHC A&E department provided telephone advice to GPs so that some emergencies could be managed outside of the hospital.
- The BEH A&E department consistently met its access targets, with patients being assessed promptly and seen and discharged within four hours. Staff told us that the department was often very busy, the waiting room was overcrowded and patients experienced long waits. Staff told us that this was the main subject of complaints, although the service received very few formal complaints.

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Meeting people's individual needs

- A high proportion of patients attending the BRI's A&E presented with mental health needs, some associated with drug or alcohol misuse. The clinical leadership team told us that the management of this patient group was one of their biggest challenges. Patients often waited in the department for too long for psychiatric assessment.
- Staff expressed concern, frustration and anxiety about managing this patient group, both in terms of their ability to provide a responsive and appropriate service to these patients and the effect that their often protracted presence had on other patients and on patient flow.
- The department used a mental health assessment tool to assess patients' mental health and the risk they posed to themselves or to others. Some staff told us that they had received training to use this tool but did not feel that the training to manage patients with mental health needs was adequate. Mental health patients were categorised as high, medium or low risk and referred to the psychiatric liaison service as required. High-risk patients would be cared for on a one-to-one basis in the majors department. During our visit we observed that a high-risk patient was in a cubicle in the majors area for approximately 12 hours. This person was waiting for assessment, detention and admission to a psychiatric hospital. During this 12-hour period there were numerous patients queueing in the corridor due to a lack of cubicles and the delays impacted on an already busy department and other patients.
- Many mental health patients were cared for in the observation unit. One staff member told us that most of the time 50% of the patients occupying the observation unit had mental health needs. This was the case during our visit. Some staff expressed concern that this was difficult to manage with the current ratio of one nurse to four patients.
- The A&E department was supported by a psychiatric liaison service. Clinical nurse specialists were employed between 9am and 5pm, Monday to Friday. Between 5pm and 9pm there was a junior doctor (psychiatry) on call and from 9pm onwards support was provided by the community-based intensive service provided by other providers and agencies. Managers and staff told us that this service did not have the capacity to provide a responsive service and delays were frequent. This caused distress to patients and affected patient flow in the department.
- A study undertaken by a staff member in July 2014 showed that in a two-week period the average response time from referral to assessment by the psychiatric liaison service between 9am and 5pm was 91 minutes. The average response time out of hours was 313 minutes. This meant that overall 87% of referrals were not responded to within the target of one hour set by the Royal College of Psychiatrists.
- The department had identified that demand for psychiatric support had increased by 21.6% in 2013/14 compared with 2012/13. Most delayed psychiatric assessments took place out of hours. In response to this, the department was about to extend the psychiatric liaison service in October 2014 to provide cover from 8am to 10pm, seven days a week.
- The A&E risk register (BRI) showed that there was no identified person to deliver training in dementia awareness; this posed a risk of suboptimal care for patients living with dementia. In response to this the department had recently identified a lead nurse in dementia awareness who was trained to train and support staff to care for people living with dementia.
- The department had recently introduced 'forget me not' magnets, which were used to identify people living with dementia on the patient allocation white board. We saw these in use, although during our visit we identified three patients with known dementia who had not been identified or assessed as requiring additional support. There were plans to introduce 'forget me not' stickers that would be affixed to patients' notes.
- A booklet, 'This is me', was available to help staff understand people's individual needs although we did not see this used. Guidance entitled 'Top ten tips when caring for people with dementia' had been shared with staff.
- In the BRI, two independent domestic and sexual violence advisers, funded by Public Health England, provided support to patients referred to them by A&E staff. Working seven days a week, the service provided a package of intensive support to victims of abuse, including liaison with the police and social services. The team also provided training to A&E staff to support them in identifying and referring appropriate patients.

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- People whose first language was not English were supported by the availability of a translation book and telephone interpreter services.
 - The department had taken steps to protect people's dignity; however the BRI A&E department scored worse than the England average in response to questions about privacy in A&E in the 2013 national inpatient survey. The management team believed that patients queuing on ambulance trolleys in the corridor and the compact space in minors may have been contributing factors.
 - In the BRI there was a glass privacy screen in the minors reception area; patients were requested to queue behind this in order to protect the privacy of the person checking in. However, we observed that patients were not using the screen as directed. A notice at the reception desk reassured patients that if their problem was personal, they did not have to discuss it with the receptionist and microphones were in place so that patients could speak quietly and be heard by the receptionist but not by others in the department.
 - We saw staff draw curtains to promote patients' privacy during examination and treatment, although conversations could be overheard. Two patients in the BRI commented to us about this.
 - In the BRI observation unit, there were eight cubicles (two rows of four along a corridor, separated by a door). Each row was served by a toilet and a shower. The lead nurse told us that these cubicles were operated to ensure they provided same-sex accommodation. We did not observe this to be the case and saw male and female patients occupying the same areas. Three staff told us that the accommodation was routinely used in this way. Although this was not a concern for the five patients we spoke with, this arrangement did not comply with the standards set out by the Department of Health's Chief Nursing Officer in 2009.
 - A room for breastfeeding mothers was available in the BRHC.
 - The A&E department at the BRI was not well signposted. The department was located on level three of the hospital, one floor above street level, and could be accessed on foot by stairs or by lift from the main entrance. Signage from the newly refurbished hospital main entrance was not prominent. During the day there were numerous staff and volunteers available to direct patients and visitors but this was not the case in the evening. Reception staff told us that patients sometimes complained that the department was difficult to locate. Similarly, the BRHC A&E department was not easy to locate for people who arrived independently.
 - Lack of parking was a common complaint for people attending all three A&E departments. Patients arriving by car could be dropped off outside the departments and there were short-term (15 minutes) parking bays at street level, but otherwise patients and visitors relied on public transport or the free hospital bus service or used public car parks. One patient we spoke with told us that they had travelled by bus, despite feeling very unwell, because they knew they would not be able to park close to the hospital.
 - In the BEH, staff told us that the pharmacy, previously located in the same building, had recently been relocated to the main entrance of the BRI and this required patients to cross a busy road to collect prescriptions. Staff told us that many patients were regular attenders and they were very unhappy about this move. They told us that they could make special arrangements to collect prescriptions for elderly or infirm patients who found the access arrangements difficult.
 - We noted that the entrance to the BRI's A&E department reception area was difficult for patients who used a wheelchair to access. For this reason, the door, which was a fire door, was kept propped open, posing a risk in the event of a fire.
 - Building work in the BRHC caused noise and disruption to the service. For example, builders routinely had to walk through the plaster room. Risk assessments had been completed and detailed temporary protocols had been put in place to ensure children's safety. We observed that these were complied with and disruption was minimised.
 - In the BRHC, there were facilities for parents to stay overnight and play facilities for children. There was also a quiet room for parents' use in the resuscitation area.
 - In the BEH, the triage room was not large enough to accommodate people who used wheelchairs. Staff told us that they would arrange for patients using a wheelchair to be seen in an alternative consulting room.
- ## Learning from complaints and concerns
- Staff we spoke with in the BRI had not received training in how to handle complaints, although they could access the trust's complaints procedure on the intranet

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or refer people to the trust's Patient Support and Complaints Team. There were leaflets about this service available in the department. A receptionist told us that they would always refer people who wished to complain to this service, even if they asked to speak with the person in charge. This was not consistent with NHS guidance, which encourages local resolution of complaints as being preferable and more effective.

- In the BRHC, staff were familiar with the complaints procedure and told us they would try to resolve complaints at the time where possible.
- A receptionist in the BRI A&E department told us that the two most common complaints they received related to waiting times and the uninviting environment in the waiting room. We saw no initiatives to tackle these two issues.
- There was evidence of learning from complaints. One staff member (BRI) told us that following a number of complaints regarding the administration of pain relief, there had been a recent safety briefing, reminding staff about the importance of reassessing pain. At the BRHC, a complaint from a relative had resulted in them being invited to participate in the planning and design of a new parents' quiet room.

Are accident and emergency services well-led?

Good



Staff working in A&E were enthusiastic, committed and engaged. They demonstrated a sense of pride in what they did well and determination and optimism about overcoming some of the major challenges they faced. Clinical and departmental leadership was strong and evident in all departments. However, staff at the BEH complained about poor communication and felt unsupported by senior and board-level managers.

Vision and strategy for this service

- There was a clear shared vision in the A&E departments. Staff demonstrated a good understanding of what their departments did well and how they could improve. Their views mirrored the views of the management team.

- The staff in the BRHC were proud of their service and excited about its reconfiguration. They shared a vision of becoming the best paediatric trauma centre in the country.

Governance, risk management and quality measurement

- Quality and performance issues were regularly discussed and risks understood and managed. In the BRI A&E department, there were fortnightly management meetings, attended by senior medical and nursing staff. A standing agenda covered performance, safety, staffing, complaints, teaching and training, patient feedback, audit and IT issues. There was evidence that when there was an unexpected outcome for a patient, reflection occurred and action was taken to improve. For example, if a risk was highlighted as a result of a mortality and morbidity meeting, simulation sessions were run in order to improve care provided to patients.
- At the BRHC, there were clear reporting procedures with departmental and specialty meetings reporting through to divisional and ultimately, trust level. There was evidence of good teamwork within the hospital and division as a whole.
- Departmental risk registers were reviewed regularly. Risks were appropriately identified, effectively managed and escalated to divisional and trust level.
- Concerns were expressed by staff at the BEH about an apparent lack of succession planning. The age profile of the current workforce was such that a significant proportion of experienced staff was due to retire in the near future and there were concerns that they would be replaced by less experienced staff. The trust advised that a workforce review had been undertaken and that consideration was being given to using lower graded staff to undertake some duties currently undertaken by practitioners. We were assured that this was to be kept under review.

Leadership of service

- In the BRI and the BRHC, staff told us that they felt well supported by senior medical and nursing staff, and by site management, who were visible and accessible. Consultants at the BRI were described as "dynamic" and "enthusiastic".
- In the BEH, staff told us that they felt well supported by the department sister. However, more senior managers,

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including board-level executives, were not regarded as visible or supportive. There was uncertainty and anxiety expressed about the future of the service and this had affected staff morale.

- Staff in the BRHC told us that the centralisation of specialist paediatrics had been managed well and they had received additional training to equip them in specialist areas.

Culture within the service

- Staff in the BRI described a “good team ethic” and “excellent working relationships between doctors and nurses” and a team “where everybody pulls together”.
- Staff felt valued and supported. There was a ‘star of the week’ scheme operated in the BRI A&E department, where nursing staff nominated colleagues for exceptional performance.
- Staff told us that there was an open culture in which mistakes were openly discussed so that learning could take place.
- Staff felt able to speak out if they had concerns. They were psychologically and emotionally supported. Two

staff in the BRI told us that they had experienced bullying and had reported this. They felt their concerns had been listened to and acted upon and they had received appropriate support.

- Staff in the BRHC showed resilience and professionalism, working in a challenging physical environment.







Public and staff engagement

- Staff were well informed and engaged.
- All patients were encouraged to take part in the Friends and Family Test. Results were displayed in departments.

Innovation, improvement and sustainability

- The trust had signed up to the ‘Southwest STAR’ project to test two innovations designed to improve patient safety in emergency care systems as part of the Shine programme supported by the Health Foundation. The project was focused in the BRI A&E department and comprised a safety checklist that encompassed safety, assessment and triage and an information technology innovation to help the clinical site team place inpatients in the most appropriate bed. The checklist was about to be piloted.

Medical care (including older people's care)

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

Information about the service

University Hospitals Bristol's main site provided inpatient medical services. There were approximately 381 medical beds. There were nine medical wards, a medical assessment unit and a discharge lounge in the Bristol Royal Infirmary. The Bristol Heart Institute had one ward for medical patients, another ward for both medical and surgical patients, and a coronary care unit. The Bristol Haematology and Oncology Centre had an oncology day unit, one clinical oncology ward with teenagers' and young adults' facilities, and a clinical haematology ward.

We visited the following areas: medical assessment unit (MAU); older person's assessment unit (wards 4 and 12); care of the elderly wards (wards 7 and 23); respiratory wards (wards 10 and 54); hepatology ward (ward 11); acute stroke unit (ward 15); gastroenterology ward (ward 26); the discharge lounge, all located within the Bristol Royal Infirmary; cardiology wards (wards 51 and 53); coronary care unit (CCU); cardiac catheter laboratory, all located within the Bristol Heart Institute; oncology day unit; clinical oncology and teenagers' and young adults' ward (ward 61); clinical haematology ward (ward 62), all located within the Bristol Haematology and Oncology Centre.

We spoke with over 50 members of staff, including nurses, doctors, pharmacists, therapists, administrators and housekeepers. We spoke with 39 patients and 10 relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

We inspected the histopathology department to review the service now following concerns in the past about the service. We previously inspected this in 2011 and reviewed our findings again in 2012. This service did not impact on our rating for medical care.

Medical care (including older people's care)

Summary of findings

Patients received compassionate care and we witnessed positive interactions between patients and staff. All staff spoke highly about working at the trust.

We saw good facilities in the teenagers' and young adults' ward. We saw staff using the 'This is me' tool for people with dementia to tailor the care they delivered.

Safety in medicine was compromised. We found prescription medicines that were not stored appropriately; shortfalls in staffing numbers for nursing; and resuscitation trolleys were not checked appropriately.

We found examples of the trust working positively in conjunction with partners across community services.

There was poor patient flow in the trust and we found medically fit patients across the medicine division awaiting social care packages or social service assessment.

We found the service was working in line with the Royal College of Pathologists Guidelines 2012. However, the trust had recognised the histopathology service was not meeting all of their targets for processing specimens due to low staffing levels for histopathologists. Not all staff felt their views were listened to by the executive team about the proposed changes to the service.

Are medical care services safe?

Requires improvement



Medicine safety was compromised.

On two wards we found prescription medicines that were not stored appropriately, one medicine fridge that had not consistently met the recommended temperature since January 2014, and out-of-date nutritional products on two wards. We found out-of-date equipment on two wards and single-use equipment that had not been disposed of as required.

For five out of the eight resuscitation trolleys we inspected, staff had not documented daily equipment testing to ensure that the equipment was fit for purpose. One trolley had outstanding actions to make it compliant and another had out-of-date equipment.

Staff in the medicine division were 67% compliant with mandatory training and compliance for annual resuscitation training was 59%. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.

There were staff shortages for nurses and histopathologists. The divisional risk register highlighted the limited medical cover available out of hours and at weekends, which could lead to patients not receiving a timely review.

There had been no environmental audits in 2014 across the division and some wards had completed no audits since 2011. This meant that there was no quality assurance to ensure that wards met infection control standards.

Each ward had a five-minute daily 'safety briefing' to highlight any safety issues resulting from incidents ranging from those at ward level to those occurring trust-wide.

Incidents

- Medicine specialties had 33 serious incidents between April 2013 and March 2014. This accounted for 23% of the trust total. Falls accounted for 42% of the incidents in medicine, followed by grade 3 pressure ulcers, which accounted for 30%. Both incidents featured on the divisional risk register.
- A single risk report had been started in 2012 in order to reduce the number of patients who fall and to reduce the risk of harm. This was ongoing. Ward managers were

Medical care (including older people's care)

encouraged to take a 'zero tolerance' approach to falls and there were monthly divisional meetings. A pilot programme called 'Eyes on Legs' that aimed to reduce falls had commenced on ward 7; the performance dashboard showed that the number of falls had decreased from eight to two between March and June 2014.

- Half of the staff in the division had received training in patient slips, trips and falls and pressure ulcer prevention training. We saw patients wearing non-slip socks to prevent falls.
- There had been 17 hypoglycaemic incidents reported in the trust between September 2013 and September 2014. The diabetes specialist nurses told us that as a result of these incidents they provided staff training to address and improve knowledge about the prevention and management of hypoglycaemia.
- There had been two incidents reported by the trust in April and May 2014 where staff had been exposed to chemotherapy. However, nursing staff on the chemotherapy day unit told us that this was a regular occurrence due to the chemotherapy administration equipment changing to a non-sealed system. The sister on the ward told us that equipment was being investigated to establish whether safer systems could be used, but that this was taking a long time. One nurse told us that: "The other day chemotherapy splashed in my face, I washed it off but I didn't have time to seek occupational health advice as I was too busy."
- All the staff we spoke with said that they were aware of how to report incidents. The NHS staff survey 2013 showed that the trust had improved on the number of staff reporting errors, near misses or incidents witnessed. However, the trust was 1% worse than the national average.
- Some staff told us that they did not receive feedback from incidents. We spoke to the ward sisters for wards 51 and 53, and both were able to tell us about the incident-reporting tool they used. On ward 53, they showed us how they fed back any learning to staff. One of the ways in which they did this was via an internal ward newsletter. We were shown a copy of one of these that detailed the learning that was needed from a specific incident.

- The cardiac catheter laboratory also shared any incidents and learning from incidents via their mortality and morbidity meetings and audit meetings. These meetings included all members of the multidisciplinary team.
- Each ward had a five-minute daily 'safety briefing' to highlight any safety issues resulting from incidents ranging from those on ward level to those occurring trust-wide. All staff on the ward were encouraged to attend. We saw staff sign the safety briefing agenda to acknowledge that they had attended the briefing and understood the information.

Safety Thermometer

- The NHS Safety Thermometer information showed that results for harm-free care between September 2013 and May 2014 had worsened within respiratory medicine and hepatology, from 100% to 85%. However, harm-free care had improved to 100% for both geriatric medicine (from 79%) and gastroenterology (from 95%). The national average was 96% for this period.
- Pressure ulcer prevalence rates had reduced across the trust over the past year. Geriatric medicine and gastroenterology had no new pressure ulcers reported since December 2013 and October 2013 respectively.
- Cardiology, clinical oncology and gastroenterology had no new venous thromboembolisms (VTEs) between September 2013 and May 2014. Compliance for VTE training was 51% for the division.
- NHS Safety Thermometer information was clearly displayed on boards on some wards. For example, the cardiac wards 51 and 53 both had details of the results from their August Safety Thermometers on display. The results included percentages for the following: cleanliness, hand hygiene, infections, pressure ulcers and falls. Both wards had been flagged on dashboards as red or amber for their falls for five or more months in the last eight. Ward 53 had three falls for the month of August 2014. Staff explained that all three related to the same patient. The noticeboard also listed 'What we did' following the increase in falls. Where patients had been identified as being at risk of falls, a member of staff was permanently based in that bay. In addition, all patients were assessed and a plan of care was put in place within six hours of admission.

Cleanliness, infection control and hygiene

- Staff followed the trust's infection control policy. Staff were 'bare below the elbow', used hand gel between

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patients and used personal protective equipment (PPE). However, compliance with infection prevention and control training was at 71% for the division and the NHS staff survey 2013 showed that only 51% of staff said that hand-washing materials were always available; this was worse than the national average of 59%.

- Staff told us that if patients had an infection they would aim to barrier nurse the patient within a side room to prevent the spread of infection. One patient on the teenagers' and young adults' inpatient unit (TYA) told us that staff always used PPE and, if patients had an infection, equipment such as blood pressure monitors would stay in the patient's room so that the infection did not spread.
- We asked the trust for environmental and infection control audits for the medicine division. However, they reported that they had not conducted recent audits on medical wards due to the ward moves taking place. The trust provided information to show that there had been no environmental audits in 2014 across the division, and wards 10, 11, and 12 plus CCU and MAU had not had an infection control audit since 2011. This meant that there was no quality assurance to ensure that wards met infection control standards.
- Wards 51 and 53 had their results in relation to hand hygiene, cleanliness and infection rates for the previous month on display. Both wards had a high percentage of compliance in these areas and no hospital associated infections.
- We were unable to visit ward 22, which had eight medical beds, as it was closed due to norovirus.

Environment and equipment

- The wards were well lit, clean and tidy.
- Equipment was clean and functional. Items were labelled with the last service date and some equipment had decontamination status labels that identified when equipment had been cleaned.
- We found three open equipment storerooms or cupboards on three wards (stroke, TYA and ward 61). This meant that equipment such as syringes and dressing packs were not stored safely and securely to prevent theft, damage or misuse.
- We found out-of-date equipment, including microfine insulin syringes and Steritex transfer sets, on two wards (wards 23 and 61). We reported these to nursing staff, who told us that they knew they needed to check equipment but had not had time to do it.

- We saw two single-use enteral syringes (a syringe used to administer nourishment and medication via a feeding tube) that had been used and left in their packaging on patients' bedside tables on the acute stroke unit. These should have been disposed of in clinical waste bins. We reported these to staff and they were disposed of. On ward 10 (respiratory) we found that enteral syringes were disposed of in a bucket on patients' bedside tables. These should have been disposed of in clinical waste bins rather than being left on patients' bedside tables.
- We inspected eight resuscitation trolleys and saw that they were centrally located and clean and that defibrillators had been serviced. However, for five out of eight trolleys, staff had not documented daily equipment testing to ensure that the equipment was fit for purpose.
- The resuscitation trolley outside TYA had been documented since 28 August 2014 as 'needs paper replacing', but this had not been done.
- The resuscitation trolley in the oncology day unit had one piece of equipment, a SCOTSMAN™ suction catheter, that had expired in May 2013. The last documented date when the equipment had been checked was 1 August 2014; it had been noted that the 'Cardiac arrest drugs expires 29/08/2014'. We reported this to the sister and checked the cardiac arrest drugs, which were in date but the checklist had not been updated.

Medicines

- Staff in the medicine division were overall 53% compliant with medicine management training.
- We found prescription medicines on two wards (TYA and ward 61) were not appropriately stored in locked facilities. On the stroke unit prescription medicines were in a locked room but the door was left open during our visit.
- On ward 11 (hepatology), we found that the medicine fridge had been consistently between 9°C and 19°C since January 2014, despite the medications' recommended storage temperature of 2°C to 8°C. This had been documented on the fridge checklist but had not been addressed. We raised this with staff who then reported the fridge to the estates department. On the acute stroke unit, we found that the fridge had not been checked each day and in the last 10 days was missing six

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checks. This meant that ward fridge temperatures were not checked regularly or reported if they were found to be outside the accepted range required to ensure the efficacy of the medicines the fridges contained.

- Each ward had a 'hypo box' to treat patients with hypoglycaemia. These had been introduced at the end of 2013 and the diabetes specialist nurses told us that each box included a chart on which ward staff could record its use. The specialist nurses planned to audit the use of the boxes at the end of 2014.
- We found five out-of-date nutritional products on two wards (MAU and ward 23). We reported these to staff, who told us that there was no system in place to check the use-by dates of nutritional products stored on the ward. This meant that patients were at risk of consuming out-of-date products.

Records

- Most patient care plans were up to date.
- We asked one qualified nurse on the acute stroke unit about assessments of patient falls. They did not know what the ticks and crosses meant on the previous completed assessment and therefore could not interpret the assessment sheets.
- On ward 53 we saw the records of one patient in relation to food and fluid intake and output. We found that the fluid charts for the 12 hours of daytime on 9 and 10 September 2014 had only one entry – 'OTT (out to the toilet)' – and there were no measurements. Fluid intake had not been calculated at the end of each 12-hour period.
- Computers were left unattended on ward 10 (respiratory) and displayed patient information such as a chest x-ray and biochemistry results. This meant that there was a risk of breaching patient confidentiality and of unauthorised personnel having access to the computer systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nurses on MAU told us that mental capacity assessments were a doctor's responsibility.
- On wards 51 and 53 (cardiology), the sisters could explain how they assessed mental capacity and Deprivation of Liberty Safeguards (DoLS). However, two other nurses on ward 54 could not explain this. A nurse on MAU and another on ward 23 were not aware of the mental capacity assessment tool used in the trust.

- On ward 23 (care of the elderly), we saw a DoLS assessment completed and an associated action plan for discharge in place. The sister demonstrated knowledge of the DoLS legislation.
- The trust had completed an audit of people with cognitive impairment in August 2014; this showed that 109 out of 124 patients had a completed Abbreviated Mental Test Score (AMTS). Compliance across the trust had improved by 9% compared with the 2012 audit, which meant that 88% of patients with cognitive impairment received a best practice AMTS assessment.

Safeguarding

- Safeguarding training at level 1 had 83% attendance and at level 2 had 83% attendance by staff within the medicine division.
- Nursing staff were aware of what to do if they had a safeguarding concern.
- Allied health professionals (AHPs) told us that they knew what to do if they had a safeguarding concern and if safeguarding was discussed on ward rounds. They felt that they had a good relationship with the safeguarding team. One commented that: "Safeguarding is everyone's responsibility."

Mandatory training

- Staff in the medicine division were 67% compliant with mandatory training. Training in clinical record keeping, consent, health and safety, trust induction, local induction, manual handling, medical devices and patient safety all had a compliance rate below 80% within the division.
- In September 2014, annual resuscitation training had 59% staff compliance. This meant that a significant number of staff had not received any life support training in the last 12 months. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.
- Ward sisters for wards 51 and 53 (cardiology) said that they did not have any figures for staff who had attended mandatory training but that all staff were booked to attend the relevant courses and ward 51 would be up to date by the end of the year.

Histopathology

- One incident had taken place in July 2014. An investigation into this had been completed. Learning

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from this resulted in some changes to the service provision that were implemented prior to our inspection. For example, they had changed the form used when requesting a certain test on a sample.

- A policy and procedure were in place for managing discrepancies and raising concerns about standards in cellular pathology.
- There was a shortage of histopathologists that had been recognised by the trust, which had been working to find a solution to address this issue. Locums had been employed to help.
- Staff told us that they did not have time for training due to staffing issues and workload pressures. They said that they did not complete the mandatory training until it showed as 'red' on the department training programme. Some newer members of staff said that they had completed the mandatory training during their induction, which was less than three years ago and so was still in date.
- We were told that some of the equipment used was hired and not owned by the trust and that a maintenance contract was in place. An engineer was visiting on one of the days of our inspection to service and maintain some of the equipment.
- For equipment that was owned by the trust, some items had stickers showing when they were due to be serviced. However, we found one machine that had a sticker stating that it was due for service in 2012. One of the quality managers told us that the trust's medical engineering department was due to visit to log and check all equipment owned by them shortly.
- The staffing levels for biomedical staff and laboratory assistants were in line with their allocated budget as there was no national guidance to follow. The head of service told us that they had recently had an increase in their workload due to another hospital no longer undertaking dermatology work. Staff told us that they worked very hard to make sure all their work was completed but they were under pressure.

Assessing and responding to patient risk

- There was 89% compliance in conflict resolution awareness training for all staff in the medicine division. However, the compliance rate was 68% for clinical and frontline staff working in the medicine division.

- The staff on ward 11 (hepatology) told us that they were working closely with security to provide clinical restraint training sessions for ward staff. This was to minimise staff and patient risk when there was challenging behaviour on the ward.
- Staff on ward 23 (care of the elderly) told us about an elderly patient who suffered from vascular dementia who had tried to leave the ward and had become distressed; a nurse had called security to restrain the patient. There was no evidence of a mental capacity assessment or DoLS in the medical notes regarding their capacity to make a decision about leaving the ward. The patient was given lorazepam, a drug used to treat anxiety and to sedate patients; this is not best practice for patients with dementia and increases the risk of falls. Later in the day, the patient was given haloperidol, an antipsychotic drug that is sometimes used to reduce severe agitation. The patient later complained of pain in the shoulder where they had been restrained by security but no injury was found by doctors. The sister told us that they had tried to get agency staff to provide one-to-one supervision for the patient but that they were unable to recruit staff. This meant that the patient did not receive the recommended one-to-one care to prevent them from becoming distressed.
- The sister on the oncology day unit told us that they could admit patients who deteriorated during treatment, primarily within the Bristol Haematology and Oncology Centre (BHOC), but if there were no beds they could access resources at the main hospital.

Nursing staffing

- We spoke with the duty matron for medicine who told us that there were between 20 and 30 nursing vacancies across the division for which they were struggling to recruit staff. They told us that the average shortfall for most shifts was five to six registered nurses and five to six nursing assistants. They relied on agency staff and staff doing overtime. Despite students being supernumerary, they acknowledged that students often did a lot of nursing staff work. They tried to manage risk by distributing more staff to higher dependency wards but accepted that this was not always possible.
- There were staffing issues in the BHOC. The matron for cancer services told us that there had been several occasions when the ward had unsafe staffing levels and that, despite much effort, it continued to be difficult to recruit trained staff for the BHOC wards.

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- We looked at the off-duty rota. For a three-day period that week, agency staff had covered seven qualified nurse and one nursing assistant shifts, plus staff had worked overtime. On one occasion during the three days, the shifts fell below the agreed staffing level.
- The sister on ward 61 (oncology) told us that the ward consistently struggled to fill nursing shifts and that it took a significant period of time out of their day to arrange cover, taking them away from patient care and ward development. When we visited, the sister was awaiting contact from a nursing agency to confirm whether they could supply qualified nurses for the late shift and night shift that day. The sister was working on the ward to cover a nursing shift, which meant that there was no supervisory person.
- One patient in the TYA chat room told us that "There is no supervision and sometimes there's nobody about to ask things" and "The staff are brilliant but there's not enough". We waited on the ward for 24 minutes before a nurse came out of a patient room and became available at the nursing station that had a view of the chat room, a room where patients socialised and had access to activities. During this time, syringes and medical notes were left out at the nursing station.
- TYA was allocated one qualified nurse and one nursing assistant. On the two occasions we visited TYA there was a qualified nurse from ward 61 covering the ward as the usual TYA nurse was sick. The nurse covering TYA did not know the location of the nearest resuscitation trolley. There was no nursing assistant each time we visited the ward. We asked the sister for TYA and ward 61 about this. They told us that the nursing assistant often works between TYA and ward 61 depending on pressures. This meant that required staffing levels were not met for TYA.
- To administer chemotherapy to patients on TYA, the nurse had to go to ward 61 to find another nurse to double-check the prescription. This meant that the nurse went off the ward, leaving no qualified nurse in the area. If there was no nursing assistant, there were no nurses in the area at all.
- On ward 10 (respiratory), they were two nursing assistants short of the agreed staffing level. We saw that there were two trained nurses looking after four patients requiring non-invasive ventilation (NIV) plus two other respiratory patients. This failed to meet British Thoracic Society staffing guidance.
- Staff on MAU told us that they had vacancies for seven registered nurses and two nursing assistants. They told us that recruiting enough staff for shifts was difficult despite using agency staff and the substantive use of overtime.
- Some staff from the cardiac wards had been moved to the CCU due to staff shortages on one of our inspection days. A senior member of staff from one of the cardiac wards told us that they often sent staff from their ward to work within this unit when other areas were low on staffing numbers. We were told during the bed meeting that agency staff were used to cover any gaps in the rotas.
- The sister from ward 53, who normally had a supervisory role, was working as part of the ward numbers due to reduced staffing levels. Ward 53 had recently had a review of its staffing and had been allocated an extra nursing assistant. Agency staff were being used to fill this post while recruitment was under way.
- Wards 51 and 53 (cardiology) both reduced their staffing levels at weekends, including at night. This was because they had no elective patients. Both had one fewer qualified nurse on Saturday evening and Sunday shifts. Ward 53 had one fewer nursing assistant for weekend nights.

Medical staffing

- We spoke with a stroke consultant who told us that thrombolysis was administered by consultants during the day and by trained registrars at night. The service was part of a regional telemedicine on-call consultant system that ensured that the decision to thrombolyse a patient was taken by a trained consultant.
- The divisional risk register highlighted the limited medical cover available out of hours and at weekends and the difficulty of directly matching medical availability with clinical need, which could lead to patients not receiving a timely review. We spoke with one registrar working in BHOC who had concerns about the medical staffing provisions at night. They told us that, although the registrar and consultant were on call, one senior house officer (SHO) was on duty for the whole centre and if a patient deteriorated the SHO would have to spend the majority of their shift with that patient, neglecting other patient needs.
- The cardiac catheter laboratory operated an elective service five days a week and an on-call out-of-hours service outside these times. It also treated patients from

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other trusts outside Bristol out of hours. Patients were admitted directly from the ambulance service if they were diagnosed as requiring treatment for a specific cardiac event. Out of hours, these patients were admitted directly to CCU before treatment.

- Out-of-hours medical support for the cardiology unit was shared with the medical division. A cardiologist reviewed all new and ill patients at weekends. A cardiology registrar was included in the on-call numbers during the week. In the medical division and cardiology, registrars covered 60 to 70 beds over the weekend, with low numbers of junior doctors to support them.
- If patients required an echocardiogram at weekends, this was performed by the registrar on call using a portable machine. There was no routine out-of-hours service for echocardiograms.

Major incident awareness and training

- The trust had a major incident plan.
- We spoke with two ward sisters who told us that they knew where they could access the plans for a major incident if one was to take place and understood what their roles would be.
- AHPs told us that they knew their role if a major incident was declared. They knew where the major incident room or command centre was in trust headquarters and gave an example of a recent local fire when some AHPs were on call in case the incident escalated.
- Ward 22 had eight beds for flexible medical capacity during periods of high bed pressure.

Are medical care services effective?

Good



The trust participated in a number of national audits.

The trust performed better than the national average in the Myocardial Ischaemia National Audit Project (MINAP) 2012/13, but fell below the national average for the Sentinel Stroke National Audit Programme (SSNAP) for January to March 2014 despite meeting scan and thrombolysis targets.

We found that patients had adequate pain relief and there was evidence in all records seen of completed care plans and pain assessments. However, trust audits showed that patients with cognitive impairment or with behavioural and psychological symptoms, who were unable to

communicate their needs did not always have an Abbey Pain Scale assessment tool completed. This meant that staff may fail to identify pain in patients unable to communicate; there was an action plan in place to increase the use of the tool.

There were provisions in place to promote the intake of adequate nutrition and fluids for patients.

Staff were competent to carry out their roles. Clinical competencies and training were available for staff to develop. There was good multidisciplinary working within the acute stroke unit and most services were actively working towards seven-day working to meet patient needs.

Evidence-based care and treatment

- The trust participated in a number of national clinical audits.
- From November 2013 to April 2014, 54% of chemotherapy patients presenting with potential neutropenic sepsis received antibiotics within one hour, which met the National Chemotherapy Advisory Group 2009 guidelines. For the remaining patients, 15% did not receive antibiotics within one hour and the data for 31% of patients were unknown.
- We spoke with a stroke research nurse who told us that they were taking part in six national studies; some were commercial in order to generate income. They told us that patient recruitment was good and that the research and development service was supportive.
- We spoke with a nurse who provided a service for patients who had suffered a transient ischaemic attack (TIA). This service ran from Monday to Friday, 8.30am to 4.30pm. If patients had symptom onset during service times, staff were able to see them within 24 hours for specialist assessments and investigations; this was in line with the 2008 National Institute for Health and Care Excellence (NICE) stroke guidance. Outside these times, patients would have to be admitted or have to go to North Bristol NHS Trust for treatment.

Pain relief

- No patients that we spoke with reported being in pain and there was evidence all records seen of completed care plans and pain assessments. The August 2014 trust audit of people with cognitive impairment showed a 29% compliance rate for staff using the Abbey Pain Scale assessment tool (an easy-to-use pain scale for people with end or late stage dementia who were unable to articulate their needs) and 32% compliance for patients

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with behavioural and psychological symptoms. Compliance had deteriorated since the 2012 audit. This meant that not all patients received appropriate assessments to aid pain management.

Nutrition and hydration

- There were protected meal times on medical wards.
- Red trays and jugs were in use for patients who needed assistance with their food and drink to promote the intake of adequate nutrition and fluids.
- Cold snacks were available for patients outside meal times and within the discharge lounge.
- Eight patients told us that they enjoyed the food provided. They felt the portion sizes were good and they were offered enough choice. All commented that the food was hot when they received it. One patient commented that "The food is nice", but another told us "The food is the main problem in the hospital, it's awful".
- Dieticians we spoke with told us that each ward had a 'nutrition champion' and that there was a nutrition steering group that included dieticians, catering staff and nurses that aimed to ensure that nutrition in the hospital met patient needs. The group produced a 'Nutrition Bites' newsletter to update staff trust-wide about the latest nutritional and menu changes.
- We were told by the matron for cancer services that the BHOC hosted the only wards in the trust that could now provide patients with a cooked breakfast, for those requiring a higher protein diet.

Patient outcomes

- The overall trust score for the SSNAP between January and March 2014 was a 'D', where 'A' was the best and 'E' the worst. The trust performed better than the national average for patients accessing scans within one and 12 hours of the clock starting and for patients being given thrombolysis. More patients were assessed within 24 hours of clock start by a stroke specialist consultant and a nurse trained in stroke management than the national average. This meant that within the first 24 hours of treatment, patients were receiving care in line with national guidance. However, the trust was worse than average for admitting patients directly to the acute stroke unit within four hours; and for having rehabilitation goals in place within the agreed target times. The sister on the ward told us that there were plans in place to improve these results.
- The trust performed better than the national average in the heart failure audit 2012/13, with 100% of patients

having input from a specialist compared with the national average of 78%. Of these, 96% had input from a cardiologist, compared with the national average of 57%.

- According to the 2012/13 MINAP, 94% of non-ST-elevation myocardial infarction (nSTEMI) patients saw a cardiologist or a member of their team. But only 46% were transferred to a cardiac ward or unit; the national average was 53%. Patients were admitted directly to the cardiac catheter laboratory to promote swift treatment.
- The trust was in the bottom 20% of respondents for 18 out of 21 patient related questions in NaDIA. The results indicated issues regarding medication errors, lack of foot care and staff awareness of diabetes. The diabetes specialist nurses told us that there was no podiatry service commissioned for inpatients with diabetes who required specialist foot care. They said that if patients urgently required foot care, they would refer them to the podiatrist providing the outpatient service, but there was no guarantee that the patient would be seen. The diabetes specialist nurses told us that there was no action plan in place to improve results. However, the trust had completed a single risk report for the diabetic foot service provision stating that the CCG was undertaking a foot service review across Bristol with the intention of supporting an inpatient service at the trust.
- The diabetes specialist nurses told us that they provided Commissioning for Quality and Innovation (CQUIN) structured education sessions for qualified nurses and formal education sessions for junior doctors about diabetes and that they would do on-the-spot teaching as required on the wards. They reported that the funding for the e-learning NHS diabetes module had been stopped and they were researching a new e-learning package to ensure that staff could access training.
- The diabetes specialist nurses told us that their response time to patient referrals was within 24 hours; however, they had no data or evidence to support this.
- The August 2014 audit of people with cognitive impairment showed that 51% of appropriate patients had been screened for delirium using the Confusion Assessment Method within 72 hours of admission as per the National Dementia CQUIN. This had improved by 33% since the 2012 audit, but still meant that 49% were not screened in line with targets. There were plans in place to improve results.

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- The standardised relative risk of readmission rates for 2013/14 were better than the trust average in the BHOC, but worse than average in gastroenterology and cardiology. We saw no shared learning to improve results.

Competent staff

- The diabetes specialist nurses told us that within their team senior nurses provided supervision for junior nurses and would undertake joint patient assessments to provide learning opportunities. They had weekly team meetings with clinical supervision.
- The dementia project nurse told us that there was a segment on dementia in staff induction and for established staff there was a one-hour dementia refresher training session. They told us that the trust had approximately 140 dementia champions and that these roles received no extra formal training but would be invited to optional champion days.
- The training and development nurse for BHOC told us that they provided new staff with three months of supervision, along with a chemotherapy workbook to complete, and then assessed staff competencies to ensure that staff were safe. There was annual chemotherapy training for established nurses and a workbook to complete. They told us that new competency sessions had been developed in January 2014, such as blood transfusion competencies. We saw that each member of staff had a competencies folder and that training dates were recorded on an electronic spreadsheet. The nurse told us that the aim was to ensure that all staff were up to date with competencies by January 2015.
- Some doctors told us that they had good clinical support and educational opportunities in cardiology. They also felt that there was "Good teamwork".
- Physiotherapists told us that they received supervision and could attend journal clubs but that these were often compromised if the service was too busy. Occupational therapists told us that they had monthly clinical reasoning sessions to discuss patient care but that there was currently no dedicated service training.
- Some AHPs told us that they had to self-fund study days. One commented that: "My manager told me not to bother putting in a study leave application because we can't fund it." Another commented: "We are not gaining new skills."

Multidisciplinary working

- We saw the multidisciplinary team (MDT) working well within the acute stroke unit, where there were daily MDT meetings to share information.
- The diabetes specialist nurses told us that they had a weekly MDT education meeting where each team member took turns to present a relevant topic for others to learn. However, they felt that the service was "Fragmented", as the diabetes doctors and nurses had separate bases within the trust and therefore it was more difficult to have informal conversations about patient care and treatment. This was reflected in the 'Clinical nurse specialist (diabetes) report April 2014' with a recommendation that it should be addressed in the new building.

Seven-day services

- AHPs told us that they were actively working towards seven-day working.
- Physiotherapy provided a seven-day service and an out-of-hours on-call service for urgent patients, for example patients requiring urgent chest physiotherapy.
- The occupational therapy service provided a Saturday service for priority patients and the dietetic service was starting Saturday working. Both services were aiming for seven-day working within the coming year.
- Speech and language therapy was completing a scoping exercise to assess the workforce required to extend its service.
- The cancer clinical nurse specialists and the diabetes specialist nurses provided a service from Monday to Friday, 9am to 5pm; there were no plans for seven-day working. The National Cancer Patient Experience Survey 2013 showed that 66% of patients found it easy to contact their clinical nurse specialist; the trust was in the bottom 20% of all trusts for this question. There were guidelines for the out-of-hours management of minimally symptomatic adults with newly diagnosed type 1 diabetes on the intranet for staff to refer to when the diabetes specialist nurses were not in the trust.
- This discharge lounge was open to facilitate patient discharges from 8.30am to 8pm, Monday to Friday; 10am to 3pm on Saturday; and 11am to 4pm on Sunday.

Histopathology

- The histopathology service operated during office hours from Monday to Friday and there was an on-call system in place outside these hours.

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- The service manager told us that consultant histopathologists were not routinely on call but if a specific emergency arose for their specialty they would contact them for advice and support.
- The appraisal rate for the histopathology department was 96.8%, which exceeded the 85% target. One member of staff was on long-term sick leave.
- Competency assessments were devised from guidelines from the Clinical Pathology Accreditation (CPA). We saw some staff forms and noted that they were due in July 2014 but had not been completed. Staff said that they felt these were a paper exercise. A quality manager told us that new standards to meet the ISO 1519 United Kingdom Accreditation Service will be phased in by 2016.
- Over 90% of cancer MDT meetings attended by a consultant histopathologist.
- The service was not meeting its targets for the turnaround of small specimens to report or for large or complex cases to report. We were told by the service manager of the laboratory that the shortage of histopathologists was impacting on the reporting times.
- Biomedical and laboratory assistants said that they did not have time to be with the histopathologists reviewing slides for their own personal development due to workload pressures.

Are medical care services caring?

Good



Patients received compassionate care and we witnessed positive interactions between patients and staff.

Patients told us “The nurses are fantastic” and “I’ve had excellent care”. Patients told us that staff were supportive, although they could be busy at times and this affected their availability to support patients.

The NHS Friends and Family Test showed that the majority of respondents between June 2013 and June 2014 said they were likely or extremely likely to recommend the trust to friends and family.

We saw the acute stroke team ensure that patients and their families were up to date with current care and treatment plans. Staff highlighted concerns patients and family members had raised with them and amended the plan accordingly.

Compassionate care

- Patients told us: “The nurses are fantastic”; “Lovely nurses”; and “I’ve had excellent care”. Three patients commented that staff were: “Very busy”.
- We received comment cards stating: “Most of the staff were polite and caring”; and “The radiotherapy suite is busy and crowded, but people are friendly”. One relative told us: “Staff could not be better.”
- We saw the housekeeper on the acute stroke unit patiently discussing the menu options to a patient who had a visual impairment and could not read the menu. They ensured that the patient was happy with the food they had chosen and asked if there was anything else they could do to make the patient more comfortable. The patient later commented that they had received “Excellent care”.
- We looked at whether patients had their call bell within reach on several wards. We found six out of 16 patients audited on ward 10 (respiratory) and 10 out of 16 patients on the acute stroke unit were unable to reach their call bell. However, in ward 7 (care of the elderly) all but one of the 12 patients audited had call bells within reach.
- We looked at whether patients had a drink within their reach on several wards. We found for patients who could drink orally, 15 out of 17 patients audited on ward 10 (respiratory), seven out of 12 patients on the acute stroke unit and 12 patients out of 13 on ward 7 (care of the elderly) had drinks within reach.
- The NHS Friends and Family Test was being carried out. The results showed that the majority of respondents between June 2013 and June 2014 said they were likely or extremely likely to recommend the trust to friends and family

Patient understanding and involvement

- The National Inpatient Survey 2013 showed patients scored the trust an eight out of ten for their involvement in decisions and for enough information provided about their condition and treatment. This mirrored the national average scores.

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- The acute stroke team had a 'board round' MDT meeting each weekday to discuss the care and treatment of patients who had had a stroke. The team members checked with each other that the patients and their families were up to date with current care and treatment plans. They highlighted concerns patients and family members had raised with them and amended the plan accordingly.
- We saw staff explaining to patients the treatment and care they were delivering. We heard doctors discussing treatment options with patients behind curtains and asking if they had any questions.
- The National Cancer Patient Experience Survey 2013 showed that 70% patients completely understood the explanation of what was wrong; the trust was in the bottom 20% of all trusts for this question.
- We spoke with one relative who was making a formal complaint regarding the care of their partner and the lack of information they received.

Emotional support

- The National Inpatient Survey 2013 showed patients scored the trust a six out of ten for having someone on the hospital staff to talk to about any worries and fears, and a seven out of ten for receiving enough emotional support from hospital staff. These results were in line with the national average.
- However, patients told us that staff were supportive, although they could be busy at times and this affected their availability to support patients. One patient on the chemotherapy day case told us that "The most important thing is that they [staff] do listen, including the consultants" and that "Staff are always respectful".
- The National Cancer Patient Experience Survey 2013 showed that 83% of patients felt that they were told sensitively that they had cancer. One patient on ward 61 (oncology) told us that they had been given a cancer diagnosis with no family or nurse present. They told us: "The doctor walked off and I had a cry by myself".

Are medical care services responsive?

Requires improvement



There were high levels of bed occupancy and poor patient flow in the trust. We found medically fit patients across medicine awaiting social care packages or social service assessment.

We observed the daily teleconference between the trust and local organisations that aimed to support health and social care teams to deliver safer patient care and that discussed the availability of beds, the flow of patient treatment and what could be changed to support discharge. This was an example of all relevant organisations working in partnership to deliver efficient and safe patient care.

We saw good facilities in the teenagers' and young adults' ward. We saw staff using the 'This is me' tool for people with dementia to tailor the care they delivered.

We found areas on two wards that had mixed-sex beds or facilities in the same clinical area. This breached single-sex recommendations.

Service planning and delivery to meet the needs of local people

- We observed the daily teleconference between the trust, North Bristol NHS Trust, Bristol City Council, the clinical commissioning group (CCG), the **South Western Ambulance Service** NHS Foundation Trust and local community services including a rehabilitation centre and nursing homes. They aimed to support health and social care teams to deliver safer patient care and discussed the availability of beds, the flow of patient treatment and what could be changed to support discharge. This was an example of all relevant organisations working in partnership to deliver efficient and safe patient care.
- We observed a trust bed management meeting; these happened three times a day. Staff were able to use an electronic bed flow system to establish real-time data. We saw that immediate decisions were made to manage the bed situation across the trust.

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Access and flow

- Processes for ensuring a timely discharge from hospital for patients requiring social care support were not effective. The divisional risk register showed that delays in the transfer of patients to community services was considered high risk.
- There was a 'reverse triage' colour-coded system on the medical wards to identify patients medically fit for discharge. For example, patients who were categorised as red were medically unwell, amber were awaiting investigation, light green were awaiting therapy and dark green were awaiting social care packages or social service assessment.
- We found four patients on ward 10 (respiratory) who were medically fit for discharge awaiting social care packages. One patient on ward 61 (oncology) had been waiting to be transferred to Weston General Hospital for six days but there had been no bed available.
- On ward 23 (care of the elderly), 15 out of 24 patients were medically fit and awaiting social care packages. This was partly due to trust delays referring patients to social services, for example we found one patient on the ward who had been waiting for a social services referral from the trust for four days. But also due to the delayed response from social services, for example one patient had waited 22 days after a social services referral to be allocated a social worker; and another had waited eight days for an allocated social worker.
- Despite some discharge process efficiency planning, elderly patients had a longer length of stay within the trust (15 days on average) compared with the national average of 10 days.
- We observed the acute stroke team 'board round' meeting and noted that planned discharge dates were predicted for each patient to encourage patient flow across the ward. Six patients were identified as medically fit for discharge but were waiting for social care packages to be arranged.
- The sister on the acute stroke unit told us that they tried to keep a bed available overnight to admit emergency stroke patients. However, the bed was often used by patients admitted earlier in the day. When we visited, the bed was being used by a medical outlier (a medical patient from another medical ward). A stroke consultant told us that stroke beds were often taken by medical outliers. We spoke with divisional directors who acknowledged that access to the stroke unit was difficult.
- The trust was not meeting the national cancer target of the 62-day wait for first treatment following an urgent GP referral. Overall, the trust was 3.5% worse than the national target between April and June 2014. The main specialties failing to meet the target were upper gastrointestinal, lower gastrointestinal, lung and urological cancer services. Cancer services that met 100% of the patient 62-day targets were brain, breast, sarcoma and skin services. The lead clinical nurse specialist for cancer services told us how plans were being implemented to improve performance. There was a trust cancer performance action plan in place that aimed to improve results; eight out of the 16 actions related to the surgical division.
- There was an acute oncology unit that could accommodate four patients. There was a 24-hour helpline and triage system in place to assess oncology, haematology and radiotherapy patients who were having difficulties. Patients who needed to be admitted could bypass A&E to be admitted directly to the unit in the BHOC. The unit was staffed by a nurse practitioner from Monday to Friday, 9am to 7pm. The unit was staffed by ward 61 nurses 'out of hours' and staff told us that this put pressure on the ward staffing levels.
- The discharge lounge allowed patients to wait for discharge in a safe environment while making inpatient beds available. Staff told us that pharmacy should respond within two hours of requests for medication to take home and that they also had a drug stock to speed up the process. Staff reported that transport caused delays as there was a four-hour target within which to collect patients, but often the wait could be longer.
- Cardiology was not meeting the 18-week referral-to-treatment time. An action plan had been devised and actions had started to be put in place to address this. These included an additional (fourth) cardiac catheter laboratory and occasional extra waiting lists at weekends for elective patients requiring an angiogram.
- Wards 51 and 53 (cardiology) had had bed occupancy rates of over 97% for eight of the last nine months. This meant that managing beds was often difficult.
- The Heart Institute had bed meetings each weekday morning attended by members of senior staff from each ward or unit. They discussed how many beds were required for elective patients and how many they

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needed for emergency admissions. They also discussed any outliers needing to be transferred to their specialty and whether patients needed to be transferred to and from other hospitals.

Meeting people's individual needs

- We found areas on two wards (wards 10 and 11) that were mixed sex. On ward 26 (gastroenterology), there was a male bay with a side room within it. The sister told us that this room was occasionally occupied by a female patient who would share the bathroom with male patients and have to walk through the male bay to enter and leave the ward. This breached single-sex recommendations and the matron was unaware of these examples when we asked. There was no evidence that these breaches had been declared to the Department of Health.
- There were two 'downstream' wards for the care of the elderly (wards 7 and 23). This meant that patients were often transferred via A&E to the elderly care assessment unit and then to the downstream wards. We found four patients who had experienced three bed moves and AHPs told us that this was a regular occurrence, even for patients with dementia. One commented: "It has negative consequences for meeting therapy targets." Another told us: "Relatives are not told that the patient has been moved, which causes distress." One relative of a patient with dementia told us they had concerns about the patient being moved from ward 12 after 15 days and felt that this had caused the patient to be more confused and that there was a lack of information regarding their care. The 2013 Future Hospital Commission's vision for hospital services acknowledged that multiple bed moves resulted in poor care and poor patient experience and increased the length of stay. Therefore, moves between beds and wards should be minimised and happen only when necessary for clinical care.
- There were no activities arranged for patients with dementia and no evidence of dementia-friendly colour schemes. Staff on ward 23 (care of the elderly) told us that they had recently appointed a dementia coordinator post to provide dementia-friendly activities for patients.
- We found evidence of staff using the 'This is me' tool for people with dementia to tell staff about patient needs, preferences, likes, dislikes and interests. One relative who had completed the tool on behalf of a relative stated on a comment card: "I have had feedback and thanks from nursing, physiotherapy and housekeeping staff on the comprehensive detail I have provided ... I commend staff on their ability and compassion in meeting the needs of dementia sufferers."
- Another relative told us how pleased they were as staff had made allowances to enable a patient to have flowers on the ward after reading the patients 'This is me' booklet, which had described how the patient liked flowers. They commented: "This had a positive effect on my [relative]."
- On the haematology ward there were exercise bikes and arm pedals available for some patients within their rooms. The nurse told us that these encouraged patients to exercise during their inpatient stay, especially when they were isolated and restricted to their rooms.
- TYA opened in March 2014 and had five patient rooms, a chat room, a snug and a quiet room. There were kitchen facilities for patients and their families to prepare food and drinks at any time. There was appropriate storage for patients to bring in their own food, and snacks provided by the charity, Friends of BHOC, were available 24 hours a day to encourage patients to eat regular meals. These options provided a variety of choice. There were televisions, computer games, board games, a pool table, books and a juke box for patients to use.
- We spoke with one patient on TYA who had stayed on the ward several times. They told us that the ward hosted social nights for patients such as film nights or pool tournaments, and that both in- and outpatients could attend. They told us that this provided peer support between patients and families. They told us staff hosted weekly facilitated sessions to discuss topics such as nutrition, chemotherapy and carer advice, which empowered them.
- They told us that on their birthday staff arranged a party for them. They felt like they had "more freedom" on the ward compared with the adult ward.
- The TYA patient we spoke with was a wheelchair user. They told us that: "I cannot open the doors on the ward because they are too heavy"; and "I have to press the buzzer and wait for a nurse to let me out of the chat room." There were no electrically operated door facilities for wheelchair users to press to open the doors. They also told us that, although there were most

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facilities in the bathroom for people with physical disabilities, there was no shower seat so they found having a shower difficult. Yet, on other wards, such as the acute stroke unit, seats in showers were available.

- On TYA and the acute stroke unit there were facilities for family members to stay overnight.
- The stroke team told us that for patients who had a stroke but were not on the acute stroke unit, the specialist team would go to where the patient was to treat them. We found evidence of two patients, one in the cardiology ward and the other on ward 23, who were being treated for other health problems but were also seen by the stroke specialist team for treatment.
- One acute stroke unit staff member raised concerns that patients were not always positioned correctly as directed by care plans. They highlighted that one patient required a foot splint but that this was not always fitted as prescribed; this meant that the patient had to receive Botox to treat the issue. We looked at the care plan, which advised that the foot splint should be fitted for two hours on and then two hours off. We found that in the previous 10 days the splint was fitted for a total of 19 hours 40 minutes, with fitting times ranging from 10 minutes to almost four hours. This was not in line with the care plan. We asked nursing staff about this and they told us that the patient strongly disliked the splint; however, this was not documented in the medical notes.
- The diabetes specialist nurses told us that they had implemented a helpline to provide advice for patients and local GPs. They took calls from 9am to 12pm, Monday to Friday.
- The trust had cultural menu options to meet the cultural needs of the hospital population, including halal, kosher, vegan and Afro-Caribbean options. We spoke with two Afro-Caribbean patients. One patient did not know about the cultural menu. The other patient told us that they did not always get the cultural menu in order to choose from the Afro-Caribbean options. They told us that "The menu lacked imagination" and "Nobody has been to talk to me about what I would like to eat".
- There were many patient leaflets available on wards providing information about different clinical conditions.
- We spoke with two people working as volunteers on behalf of the Royal Voluntary Service. They told us that they provided a service three to four times per week, depending on the number of volunteers available. They

went to as many wards as they could with their mobile shopping trolley to sell confectionary, magazines and personal hygiene products to patients while they were in hospital.

- Translation services were available both by phone and in person.

Learning from complaints and concerns

- We saw literature about the complaints procedure and information about the Patient Advice and Liaison Service (PALS) on display on most wards.
- AHPs and nurses told us that they try to resolve patient complaints and concerns as patients raise them. They were aware that PALS was on hand if required.
- Divisional directors told us that complaints were discussed monthly at divisional meetings.

Are medical care services well-led?

Requires improvement



All staff spoke highly about working at the trust. They told us that they had good peer support. Yet, we found minimal trust engagement with staff.

The trust had Recognising Success awards to celebrate the staff who transformed care every day across the trust and staff gave positive feedback about these.

Some staff had concerns about their restricted ability to complete audits or projects and to attend study days due to lack of funding and staffing. There was a lack of innovative practice.

Risks were recognised but failed to take constraint effective action.

Vision and strategy for this service

- Staff told us that they liked having trust visions and values but felt that the training had been too corporate.
- Divisional directors told us that there was further work to do on succession planning for the division but there was no action plan to achieve this.
- The diabetes specialist nurses told us that they had staffing problems within their team and that they needed to look at succession planning as senior staff were due to retire in the coming years. The 'Clinical nurse specialist (diabetes) report April 2014' stated that the service was 33% below establishment due to

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long-term sickness. There was one nurse for the inpatient medical division and they reviewed less than 30% of inpatients with diabetes. There was an increase of 5% in inpatients with diabetes compared with the previous year and the team recognised that this was unsustainable without an increase in the workforce. However, there was no service strategy to manage this.

Governance, risk management and quality measurement

- The medicine division had monthly quality and patient safety group meetings. The agendas covered the monthly dashboard data; feedback from specialty clinical areas, governance, and mortality and morbidity meetings; quality and patient safety reports; and education and training needs.
- Risks that affected the delivery of safe care were clearly identified on the division's risk register. Staff told us that they could add risks to the risk register at any time. The risks were then assessed by the patient safety lead and categorised into departmental, divisional or trust risks. However, the divisional risk register did not describe the actions that were required to reduce risk and therefore it was not clear if and how risks were being managed.
- Ward sisters told us that they had weekly meetings with the divisional nurse to discuss patient safety risks.

Histopathology

- We saw the preliminary result from internal audits undertaken between 11 March 2014 and 11 September 2014. Supplementary reports had been undertaken on 47 cases; this was where a number of slides were reviewed as part of quality assurance testing. This had resulted in only very minor changes to the reports.
- Staff told us that they had very high volumes of work but wanted to provide the best care for patients. They felt well supported by their management team and that often managers would come to help them when they were very busy.

Leadership of service

- AHPs told us that there was a lack of management for maternity leave and often there was no cover provided. They told us that staff shortages caused increased pressure on staff to perform and that they were unable to collect accurate patient contact data because they did not have enough time after treating patients.
- Some AHPs commented: "We worry about taking annual leave and sick leave because of the pressure it puts on

the team"; "We are scared to go off sick because you get disciplined"; and "We're just firefighting". We looked at the Supporting Attendance Policy, which appeared to follow the Bradford Factor scoring system used in human resource management.

- Biomedical scientists told us that they received an annual appraisal. However, they felt that the emphasis of the appraisal was now on the trust rather than on individual development. One commented: "It's a paper exercise." Managers told us that: "It is difficult to implement the appraisal plan due to time and money." The NHS staff survey 2013 showed that 34% of staff felt that they had had a well-structured appraisal in the last 12 months; this was below the national average of 38%.
- Biomedical scientists told us that they found it difficult getting new equipment despite submitting business cases. They did not understand why it took so long for the trust to make a decision and felt that there was a lack of communication from divisional managers to department staff.
- Histopathologists told us that they felt they were not being listened to by the senior management of the service and at trust level regarding some proposed new changes to the service provided.
- Registrars and junior doctors we spoke with told us that consultants were supportive and they could access supervision if they wanted. However, some chose not to on a regular basis.

Culture within the service

- Staff told us that the trust was a friendly place in which to work and they liked coming to work. They told us that they would bring their friends and family to the trust for care.
- Some staff told us that they had been working for the trust for over 10 years and some staff commuted long distances to work there.
- Staff commented that patients come first.
- We spoke with the matron for cancer services who told us that they were proud of staff working in the BHOC because of their commitment. They commented: "Staff go over and above for patients"; and "It's a privilege to work in a place where people try their hardest."
- Staff told us that they had good peer support. The NHS staff survey 2013 showed that 40% of staff had been suffering from work-related stress in the last 12 months; this was worse than the national average (37%) and an increase on the previous year.

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Public and staff engagement

- Histopathologists told us that they did not feel engaged with the trust regarding the ongoing discussions about where the service would be located in the future.

Innovation, improvement and sustainability

- The trust had Recognising Success awards to celebrate the staff who transformed care every day across the trust. For example, a BHOC receptionist had received the Patient Champion award in 2013.
- The housekeeper on the acute stroke unit had won the Unsung Hero award and told us about how touching it was to have their work recognised. Although most ward staff expressed the importance of the housekeeping role, there was no cover in place for periods of leave.
- Nurses told us that the trust celebrated the annual national Nurses' Day. The trust had Nursing and Midwifery Recognition Awards to recognise individuals for their hard work and dedication to patient care and for going beyond what was expected of them. For medicine, in 2014 the tissue viability lead nurse and a nursing assistant on MAU had both won awards.
- Divisional directors told us that they acknowledged that innovation projects were limited by financial constraints. If a project was cost-neutral or cost-saving, it would be supported.
- AHPs told us that they lacked time to complete audits and research. One commented: "If you want to do audits or research, you have to do this in your own time."
- The diabetes specialist nurses told us that they received emails sent via the clinical portal to notify them when 'frequent flyers' had been admitted via A&E. This meant they were aware of patients early within the admission pathway and helped nurses prioritise their caseloads. They were also working with information technology to implement a tracking system for all patients with diabetes, so that they could identify patients with diabetes within the trust and prioritise accordingly.
- On ward 53 (cardiology), the sister told us that she was involved in a number of pilot schemes. These included the electronic prescribing scheme, which will be rolled out across the trust, and manual observation competencies. These will form part of the early warning scheme already in place for deteriorating patients.

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

Information about the service

Surgery services at University Hospitals Bristol NHS Foundation Trust are provided at St Michael's Hospital, Bristol Eye Hospital (BEH), Bristol Heart Institute, Bristol Royal Infirmary (BRI), The University of Bristol Dental Hospital, Bristol Royal Hospital for Children (BRHC) and South Bristol Community Hospital. Surgical services for children, provided at the Bristol Hospital for Children, are incorporated within the Children and Young People section of this report. Surgical services provided at South Bristol Community Hospital are detailed within the separate report.

Theatre distribution and specialties using them are detailed below:

Site

Bristol Royal Infirmary (Queens Building), Hey Groves theatres

- Number of theatres: 10
- Number of recovery bays: 8
- Specialties:
 - Cardiac
 - Thoracic
 - Upper gastrointestinal
 - Lower gastrointestinal
 - Vascular (at the time of inspection)
 - Maxillo facial
 - Trauma including limb reconstruction
 - Emergency (CEPOD)

Bristol Royal Infirmary (Queens Building), Queens Unit theatres

- Number of theatres: 2 plus 4 endoscopy rooms
- Number of recovery bays: 4 plus 19 recovery trolleys
- Specialties:
 - ENT
 - Upper gastrointestinal
 - Maxillo facial
 - Thoracic (minimally invasive procedures)

St Michael's Hospital

- Number of theatres: 5 (including 2 dedicated obstetric theatres)
- Number of recovery bays: 10 plus 12 trolleys within the surgical day case unit
- Specialties:
 - Obstetrics
 - Gynaecology
 - ENT
 - Dental
 - Upper gastrointestinal
 - Maxillo facial

Bristol Eye Hospital

- Number of theatres: 4
- Number of recovery bays: 2 adult and 2 paediatric
- Specialties:
 - Ophthalmology

There were surgical wards in the BRI, Bristol Heart Institute, St Michael's Hospital and the BEH. The BRI also housed a preoperative assessment area, surgical admissions lounge

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and a discharge lounge. The BRHC and The University of Bristol Dental Hospital provided surgical procedures only for children and are contained within the Children and Young People section of this report.

The hospital performed around 49% of surgery as day case admissions, 27% as emergency surgery and 24% as elective (planned) surgery.

During this inspection, we visited the Hey Grove and Queens Unit theatres, those in St Michael's Hospital and the BEH and their relevant post-anaesthetic care units (recovery rooms). We visited the day surgery unit at St Michael's Hospital, the preoperative assessment unit, surgical admissions unit and discharge lounge. We visited the nine wards across all hospital sites. We spoke with 88 staff, including: theatre managers; matrons; ward sisters; consultants; doctors; junior doctors; and nurses from all the different grades. We also talked with ward clerks, housekeepers, healthcare assistants, pharmacy staff, physiotherapists and occupational therapists and members of the hotel services staff. We spoke with 19 patients and their friends and relatives. We observed care and looked at 31 sets of patient records. We also reviewed data provided in advance of the inspection.

Summary of findings

Overall, surgery services at the University Hospitals Bristol Main Site require improvement. While care was seen to be caring and compassionate across all areas, improvement is required in order to make the service safe, effective, responsive and well led.

Incidents were reported and investigated and there was evidence of learning from them. There had been five never events within surgery since June 2013. There was evidence that action had been put in place following these. Compliance with the World Health Organization (WHO) surgical safety checklist was good. Wards, theatres and departments were clean. However, not all staff observed good infection control practices. Medicines were not always given on time and the principles of safe medicines administration were not always followed.

Staffing in theatres fell below recognised guidelines and wards were not always fully staffed to their establishment if bank or agency staff could not be recruited. Ward 700 had an increased activity due to the provision of a treatment room, when compared to ward 800. Despite this it was not reflected in the staffing numbers. Staffing levels on the surgical and trauma assessment unit were such that at times patients did not receive one-to-one care when required.

Patient outcomes were below the England average for hip fractures. Fewer patients than the England average received surgery within 48 hours or were seen by an orthogeriatrician. The standardised relative risk of readmission rate was significantly higher for both elective and non-elective cases in upper gastrointestinal surgery.

The beginning of the patients' pathway was good, with good access and provision of care at the preoperative stage. However, bed occupancy was high and patients were not being cared for in designated areas. Patients often went to theatre without an allocated bed available post-operatively. As a result, patients often stayed in the recovery area overnight and some even went home from there. Patients were kept 'nil by mouth' for long periods of time and cancellations often occurred late in

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the day. Patients also remained in hospital for longer than the England average. While there was good access to translators, written information was provided only in English.

While services were reported as being well led on wards and in departments, there was little visibility of the divisional management team. Plans had been made for a major reconfiguration of services, with some specialties moving to another provider. Managers told us that this would allow a protected bed base and increase their capacity to undertake elective and emergency work in a more timely manner. However, until reconfiguration occurred, issues with patient flow and access remained. There was little evidence that actions were being taken to address the issues relating to discharge.

Are surgery services safe?

Requires improvement



Safety at the University Hospitals Bristol Main Site requires improvement.

Incidents were reported and investigated. However, there was a large number that were not managed in a timely manner. There had been four never events within surgery since June 2013. There was evidence that action had been put in place following these. Compliance with the WHO surgical safety checklist was good. Wards, theatres and departments were clean. However, not all staff observed good infection control practices.

Medicines were not always given on time and the principles of safe medicines administration were not always followed.

Patients were assessed for risk and were monitored for changes in their condition. Concerns were escalated appropriately although actions were not always put in place immediately.

Staffing in theatres did not meet the guidelines from the Association for Perioperative Practice (AfPP), which state that operating theatres should be staffed with two scrub nurses and one nurse circulating. Wards were not always fully staffed to their establishment if bank or agency staff could not be recruited. The increase in activity by the provision of a treatment room on ward 700 was not reflected in the staffing numbers. Staffing levels on the surgical and trauma assessment unit was not sufficient to meet people's needs all of the time.

Incidents

- Staff reported incidents via an electronic incident-reporting system. Many staff we spoke with described having reported an incident themselves. However, this was less the case among healthcare assistants, student nurses and hotel services staff, who said they would inform the nurse in charge of the patient.
- The ward sister and matron received reports of all incidents within their area. They were responsible for reviewing the incident, undertaking investigations and providing feedback to staff.
- The number of patient safety incidents reported was monitored on ward dashboards, and collectively within

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the division of surgery, head and neck governance meetings. These reported on the number of incidents per month, the type of incident and the grade of incident. For example, within the division during the month of July 2014 there was a total of 293 patient safety incidents reported, with the most common category of incident being falls followed by communication failure within the team.

- The number of incidents described as ‘unmanaged’ was also reported monthly at the division of surgery, head and neck governance meetings. These are incidents that either have yet to be investigated or to have action taken. It was noted that, at the end of July 2014, there was a total of 334 incidents reported, of which 42 remained unmanaged despite being reported prior to January 2014.
- Staff reported receiving feedback on incidents within emails and newsletters. Learning from incidents on the wards was also included in ward safety briefings.
- There had been a total of five never events reported by the trust since June 2013. Never events are serious, largely preventable patient safety incidents. These should not occur if the available, preventable measures have been implemented. Two of these incidents occurred in the Heygrove theatres; one in the Bristol Dental Hospital and two occurred in South Bristol Community Hospital and as such are reported within that report. The trust believed one at South Bristol Community Hospital not to be a never event, although investigation was ongoing at the time of our inspection. All five incidents had been thoroughly investigated and an action plan and lessons learned produced. The action plans had been implemented and associated learning had been shared with relevant hospital staff.
- Within surgery there was a total of nine incidents reported to the Strategic Executive Information System (STEIS) between 1 April 2013 and 31 March 2014. Six were categorised as being due to falls, one was a grade 3 pressure ulcer, one categorised as delayed diagnosis and one an allegation of abuse.
- There was evidence of learning from incidents. For example, following the never events, the method of recording the WHO surgical safety checklist had been changed from paper to a white board; it was felt that this had had the effect of focusing staff on the purpose and content of the checklist.
- There was also evidence of action taken as a result of incident reporting. Within the ear, nose and throat (ENT)

theatres, a nerve monitor was required more than twice a week. This was being borrowed from the BRHC and relied upon it not being required during that time. As a result of this being raised as an incident, a request for a new nerve monitor had been made through the capital bids process.

- Mortality and morbidity were reviewed and discussed. However, the outcomes of these meetings did not feed into the divisional governance processes, therefore we were unable to determine whether the division was notified of actions or learning, or whether anything had improved as a result.

Safety Thermometer

- Wards undertook the Safety Thermometer and these results were published both on the ward (on noticeboards at the entrance to each ward) and on the ward performance dashboard. At the time of the inspection, several wards had changed in their configuration. For example, wards 5b and 6 had recently combined to become the newly opened ward 700. This meant that there had been insufficient time elapsed since the merger to record data for the new wards. However, data was available for the wards in their pre-existing locations and was reported on the performance dashboards. Plans were in place to record the data for September.

Cleanliness, infection control and hygiene

- Theatre complexes in all the hospitals were clean, with good storage of equipment. Cleaning rotas were seen and the cleaning of theatres was subject to weekly audits. For example, within day theatres, the cleaning audit reported 95% compliance. However, staff reported not receiving feedback on issues identified.
- Surgical equipment could be tracked and traced. There was a system for determining which patients had been operated on using specific surgical sets. Evidence of decontamination was also placed in patients’ notes following procedures such as nasal endoscopy.
- Within theatres, staff wore surgical ‘scrubs’. However, during the inspection two staff members from theatre were noted to be in the main hospital entrance wearing their theatre scrubs, hats and clogs.
- Year-to-date audits showed there to be 95% compliance with hand hygiene for theatres overall, with compliance ranging from 93% to 99% within the BEH.
- Ward areas were also seen to be clean. Patients we spoke with told us that they found the wards,

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bathrooms and toilet areas to be clean. Wards had hand gel dispensers located at the entrances and there were signs displayed encouraging staff and visitors to use them.

- While skips for soiled linen were seen in use, this was not a consistent practice seen in all areas. We saw one nurse hold clearly soiled sheets and carry them through a bay of patients, out into a corridor. The nurse was wearing gloves but was not wearing an apron at the time.
- We observed staff on wards adhering to the trust infection control policy and the 'five moments of hand hygiene'. Staff were 'bare below the elbows' and were seen using alcohol gel, washing hands, wearing aprons that were changed between patients and ensuring that doors were shut in rooms that required barrier nursing.
- The newly opened wards consisted of 24 side rooms, all of which were en suite, and two four-bedded bays. This allowed for barrier nursing if required. Where this was occurring, we saw signs in place alerting staff and visitors and personal protective equipment to hand.
- Infection control statistics were reported monthly to the divisional governance meeting. The Trust's *Clostridium difficile* (*C. difficile*) and methicillin-sensitive *Staphylococcus aureus* (MSSA) rates for 2013/14 were in line with the national average. Rates for the year 2014-15 to date were higher than England averages. Within the surgery, head and neck division, there had been no cases of methicillin-resistant *Staphylococcus aureus* (MRSA) and six cases of *C. difficile* since April 2014.
- MRSA screening was undertaken preoperatively for all elective theatre cases. This was subject to audit and showed 100% compliance. Compliance with screening for all emergency cases ranged from 92.2% in July 2013 to 96.2% in April 2014.
- Where cases of *C. difficile* occurred, we saw that they had been reviewed and learning points actioned for the wards. This was reported and monitored within the divisional governance meetings.
- We reviewed the cleaning checklist in the patients' kitchen on ward 700 and noted that this had not been completed since 25 August 2014 – a period of 16 days. We inspected the microwaves in this kitchen and found them to be dirty. The ward sister was informed of this at the time. We visited the ward the following day and noted that the microwaves had been cleaned.

Environment and equipment

- At the time of the inspection, a large amount of building work was nearing completion. Four wards (wards 5a and 6 and wards 5b and part of ward 18) had been relocated and combined to form wards 700 and 800. These wards were bright and spacious, with each consisting of 24 cubicles, all with en-suite bathroom facilities, and two four-bedded bays (ward 700 also had the addition of a treatment room). Building work was still in progress both on and adjacent to the wards. A large room in the centre of both ward 700 and ward 800 was being completed to house specialist nurses and secretaries. Building equipment was left in there unattended. The door was not locked. However, there was an alarm that sounded when the room was accessed.
- Eight beds remained open on ward 18 for general surgery. In contrast, wards 14 and the surgical and trauma assessment unit (ward 2) were cramped. Trolleys and chairs were seen in the corridors, restricting access, particularly at times of increased activity such as meal times.
- Medical equipment such as pumps and monitors were maintained by the Medical Equipment Management Organisation (MEMO). MEMO held an asset register for all equipment in circulation (approximately 55,000 items). In addition, it also maintained a record of all equipment that had been disposed of or decommissioned. The electronic system generated a planned preventative management (PPM) schedule that was based on the risk and maintenance needs of each item. Where specific skills were required (such as the validation of electronic weighing equipment), service-level agreements were held with the manufacturers or suppliers. We spoke with staff from MEMO who told us that there had been a backlog in PPM due to restricted access to some areas while building work was being carried out. This was noted on the divisional risk register and scored 9, identifying it as a moderate risk. We reviewed equipment in both wards and theatres and found only one item to be overdue its maintenance check.
- Staff we spoke with on the wards described the process for reporting faults in medical equipment. These were actioned quickly. MEMO staff confirmed that incidents were reported via the electronic incident-reporting system, which ensured that they were notified of all medical device-related incidents.

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- Battery-operated equipment such as pumps and monitors were seen plugged into the mains electricity to ensure a full battery if needed.
- There had been two serious incidents of power failures at the end of 2013, both of which had impacted on patient care and safety. These had occurred as a result of work being carried out 'upstream' of the trust by the electricity provider. As a result of this, the trust had worked with the company to ensure that the same issue could not occur again.
- The operating environments were secure and well laid out to support the movement of patients through the department. The recovery area in the Hey Grove suite was small. We did not see it full but staff told us that it had the capacity to accommodate eight patients.
- Resuscitation equipment was stored correctly. While it was checked on most days, there were some gaps in daily checking on the surgical and trauma assessment unit and ward 700.
- Availability of equipment was taken into account during theatre scheduling, which occurred on a weekly basis. This ensured that there was sufficient 'turnaround time' to re-sterilise specific equipment between cases.
- Staff were able to access specialist equipment for patients, for example air mattresses for patients at risk of developing pressure ulcers or bariatric equipment for larger patients.
- We saw a computerised stock control system for lenses within the BEH. This allowed for patient traceability and also automatic reordering. This ensured that there were always sufficient quantities of different lenses available.

Medicines

- Medicine trolleys were kept locked and securely attached to the walls on wards. At the time of the inspection, ward 700 had only one chain point attached to the wall for the medicine trolley; therefore, in order to maintain safety, staff kept the second trolley securely locked in a cupboard until the works had been carried out. We visited ward 700 during the unannounced inspection and saw that this had happened and the second trolley was securely chained to the wall.
- Medicines were stored appropriately, with fridges used where appropriate. Fridge temperatures were monitored and recorded and records were seen.
- Two open 50ml bottles of Xylocaine spray (a local anaesthetic) were found on a trolley within the treatment room on ward 700. This room was unlocked

and accessible to patients and members of the public. In addition, the bottles were not dated to indicate when they had been opened and therefore when the contents should be discarded.

- We visited the surgical and trauma assessment unit during both the announced and unannounced inspections. During the unannounced inspection we were told that 8am medicines were administered late due to a shortage of staff. We reviewed the prescription charts for two of the patients in that bay. The late administration was not reflected on the prescription chart. We left the ward at 12.55pm. At that time, the 12pm medication administration had not commenced.
- Compliance with the policy on administration of antibiotics was audited each month and was reported on the ward dashboards. However, from the governance papers seen it was not evident what actions had been taken as a result of the findings. For example, ward 78 showed a drop in compliance from 100% in April 2014 to approximately 45% in May 2014, with an improvement to 80% in June 2014. Reasons for the drop and actions to address this were not described.

Records

- Medical records were stored in secure trolleys at the nurses' stations within all wards. Nursing records were held at the bed end or in the doorway of each cubicle. Medical records accompanied patients to and from theatre.
- Records reviewed contained risk assessments and plans of care. Some of these had been updated following changes, although not all. Enhanced recovery pathways were present in several of the notes reviewed, though again not always completed.
- Preoperative records were seen in both day theatre and the Hey Grove Suite. Records contained completed preoperative assessment forms.
- An inter-hospital transfer form was completed when patients transferred from ward to ward.
- Large stickers were placed in the medical records on Fridays to indicate the plan of care for patients over the weekend. These were easily identified and seen in records reviewed

Surgical safety

- We observed use of the WHO surgical safety checklist in all theatres. This is a process recommended by the National Patient Safety Agency to be used for every patient undergoing any surgical procedure and involves

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a number of safety checks designed to ensure that staff avoid errors. We observed the process being completed effectively and in line with trust policy and best practice, and compliance was subject to audit. The Trust told us they monitored WHO checklist compliance as reported on the Medway Patient Administration System which had shown compliance of above 99% since October 2012. We reviewed the results of audits undertaken by clinicians during one week in July and one week in September 2014. The audit imposed some local requirements (e.g. “surgeon in attendance in anaesthetic room”) which were above national requirements. Between audits, there had been an awareness campaign and WHO surgical safety checklists had been placed on the walls. The September 2014 audit showed 97% compliance with trust policy, an improvement from 78% in July 2014.

- As well as looking at the completeness of the checklist, the audit also reviewed the quality of completion and found a large improvement in the level of attention and compliance with all aspects. Compliance with the checklist was subject to ongoing monthly audits that were reported on the performance dashboards.

Safeguarding

- Staff we spoke with were aware of the safeguarding processes within the organisation. We reviewed compliance by random selection of both staff files and statistics held by the ward manager. All staff files we reviewed showed that staff were up to date with their training. When we looked at the statistics held by the ward sister, we saw that those staff whose training was out of date had dates booked for upcoming courses.

Mandatory training

- Records of compliance with mandatory training were held centrally for all wards and departments. However, during the inspection, ward sisters told us that they often kept records of mandatory training within their own area because they believed the central records did not reflect the current status of compliance with attendance. Training records supplied by the trust in advance of the inspection showed a wide variance across surgical wards and departments. For example, compliance with infection prevention and control training among registered nurses ranged from 35% in vascular surgery to 75% in thoracic surgery. All staff we spoke with reported being ‘up to date’ with the mandatory training requirements.

- Access to mandatory training was reported as being good among all grades of staff.

Assessing and responding to patient risk

- Patients for elective surgery attended a preoperative assessment clinic. This had nine rooms and, while the clinic was nurse-led, there were two anaesthetists present. All patients attending were assessed under the American Society of Anesthesiologists (ASA) physical status classification system. The ASA system is a way of assessing the fitness of cases before surgery. Any patient scoring three or more was seen by an anaesthetist. Patients were given one-hour appointments that ensured there was sufficient time for their risks to be fully evaluated.
- On admission, all patients had an assessment for the risk of venous thrombosis. We saw evidence of the action taken where risks were identified. For example, we saw patients had been prescribed anticoagulants or were wearing anti-embolism stockings.
- Assessments were undertaken in relation to falls, pressure ulcer risk and nutritional screening. These were complete in all the patient records we reviewed.
- Staff used an early warning system (EWS) to monitor patients’ observations. We reviewed staff responses to elevated early warning scores and saw that actions had been taken in line with their policy. For example, where there had been scores of two or three, observations were repeated within 30 minutes. Where a patient triggered an early warning score above four, junior medical help was summoned. Staff we spoke with told us that there had been an outreach team to provide support with the deteriorating patient; however, this service had ceased. Ward staff said that they felt this put a lot of pressure on the junior doctor who was covering all of surgery at weekends.
- We saw evidence of the use of Situation, Background, Assessment, Recommendation (SBAR) on ward 14. SBAR is a recognised communication tool to ensure that the appropriate information is handed over verbally and an adequate response received.
- At weekends, medical staff made plans of care on large stickers that were placed in the medical notes and enabled on-call staff to see the plan of care in their absence. Where patients had remained in the hospital over several weekends, we saw that these stickers continued to be used.

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- Patient procedures were cancelled if there were any concerns about clinical risks. For example, we saw a patient who presented for day surgery but was unfit for the anaesthetic. The procedure was postponed and a full explanation given to the patient.
- Patients at risk of falling were identified with 'falling' stars. These were to be put on drug charts to alert pharmacy and to aid identification of medicines that could contribute to the risk of a fall. Toilet and bath-time assessments had been introduced to identify night-time needs which were then carried out during intentional rounding overnight. This had been actioned following an investigation into a patient fall at night.
- A trauma coordinator was in post to review all trauma patients who were not on the designated trauma ward (ward 14). We saw how they visited each ward area to ensure that physiotherapy and occupational therapy needs were being met and that discharge processes were being managed.
- We saw a pressure mattress on one ward that was waiting to be put on a bed. We saw that the patient was sitting in a chair, not on a pressure-relieving cushion. The patient had a grade 2 pressure ulcer. We reviewed the records, which described the patient as being at high risk. We brought this to the attention of the nurse at the time as there was a delay in providing the pressure-relieving care to the patient.
- Where there were shortfalls in staff, bank and agency shifts were sought, although these were not always filled. Bank and agency usage was reported on the performance dashboards. The trust figure of 5.2% is below the England average of 6.1% for bank and agency usage. However, the number of unfilled shifts was not recorded or reviewed. Staff we spoke with told us that it was not unusual to have shifts unfilled. We reviewed one week's staffing levels on ward 700 and noted that there had been unfilled shifts for three long day shifts, one early shift and one night shift.
- We spoke with one bank nurse who told us that they often worked on the same ward. They described feeling welcomed and felt they were fully informed of their patients' needs.
- Overall, staff sickness rates were in line with national rates; however, some wards reported high levels of sickness. For example, ward 78 had an average sickness rate of 9.5% and ward 5b 6.9% over the past nine months compared with the England average of 4% for nursing staff.
- Ward 700 had a treatment room for ENT referrals from GPs and walk-in centres that patients could attend for specialist review, assessment and treatment seven days a week. Nurse cover for this room fell to the ward coordinator. Activity through the room was unpredictable as far as numbers were concerned, and patients could arrive at any time as there was no formal closing time for referrals. We reviewed the attendance register back to 1 September 2014 and saw that this room had been used every day for between two and six patients. When patients attended the treatment room, the coordinating nurse was required to attend and assist the doctor where necessary. This took them away from other nurses and patients on the main ward. Staff we spoke with told us that this concerned them, particularly at the weekends when the numbers of nurses on the ward were reduced, and they were planning to submit an application for increased staffing to mitigate the risk. We saw that this was present on the risk register, scoring as a medium-level risk.
- Staffing in theatres did not meet the guidelines from the Association for Perioperative Practice (AfPP), which state that operating theatres should be staffed with two scrub nurses and one nurse circulating. Several theatres in the Hey Grove suite were noted on the allocation list as having only two theatre personnel per list (excluding anaesthetic support). During the inspection we judged

Nursing staffing

- Ward staff had undertaken a review of acuity during the month of August, although this had stopped at the time of the inspection. Staff told us that they thought it was too soon for this to be launched electronically across the trust. Some areas told us they continued to monitor acuity as they felt their staffing needs were not being met.
- Each ward had a board at the entrance detailing what staff should be on duty that day and what the actual staffing was. Expected levels and actual levels were the same on the days of the announced inspection. However, staff reported a large use of bank and agency staff. We reviewed the number of shifts requested to be filled by bank and agency staff on wards 700 and 800 and saw that there had been several occasions in the preceding week when a vacant shift had not been filled. This meant that staffing levels had been below the optimum level.

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that staffing within theatres was not sufficient. Staff described this as being the norm but reported feeling that it was very stressful and difficult at times. Staff turnover in theatres was reported as 14.7% for the year to date (16.5% for July 2014).

- Staffing in the surgical and trauma assessment unit was not sufficient to meet people's needs all of the time. During the unannounced inspection, the ward clerk was on annual leave. There was no provision to cover this post during periods of absence. On the day we visited there were four registered nurses and three healthcare assistants on duty. We saw that one patient with dementia had been receiving one-to-one support. However, this was unavailable as an additional staff member (bank or agency) could not be found. Family members were with that person at the time of the inspection. Staff told us that, when family members were present, the patient was usually calm. There was also no staff member designated to care for patients in the eight assessment chairs. Therefore, as well as undertaking the roles of coordinator and ward clerk, the coordinator was fulfilling this role. There were four patients in the assessment area. A reduction in the numbers of staff at night occurred at 7.30pm, but the assessment area did not close until 8pm. Patients could remain in there for considerably longer awaiting review. Staff we spoke with said that this was not unusual and at times all eight chairs could be occupied beyond 8pm, when they were cared for by the night staff.
- The surgical and trauma assessment unit was a very busy ward during both visits. All beds were full. We saw that one patient had gone to theatre directly from the assessment area and another was awaiting theatre. One patient was receiving intravenous medication and another was awaiting medical review. These were all receiving care from the nurse in charge who was acting as the coordinator. One nurse was providing care for four patients in a bay and two side rooms. Three of the four patients in the bay had cognitive impairment. We saw one patient attempt to get out of bed and they required significant input to calm them and then subsequently to support them onto a commode and change their soiled bed. Meanwhile, another patient was clearly distressed and was attempting to remove the cannula in their hand that was supplying intravenous fluids. We notified the nurse at the time of our concerns for this patient's safety and welfare.

- Whenever patients were transferred from the surgical and trauma assessment unit they were accompanied by a member of the ward staff in order to settle them into their new ward area and to provide a handover to the new ward in addition to the completed inter-hospital transfer form. This had the effect of reducing nursing staff numbers on the ward while they were undertaking this.
- Statistics provided by the trust prior to the inspection showed that vacancy rates among nursing staff ranged from 0% to 16% (16% being within the ENT specialty).
- Staff had handovers and a safety briefing around a large board at the beginning of each shift. These boards indicated details of each patient, such as their falls or pressure ulcer risk and whether they were nil by mouth.

Surgical staffing

- The hospital had consultant-led cover out of hours and at weekends and emergency surgery was consultant-led. Anaesthetists were described as very supportive to staff when there were concerns regarding a patient's condition on the wards. Junior doctors confirmed that there was 24-hour consultant presence in the hospital for advice, guidance and attendance.
- Where required, locum cover was provided. Staff did not report any issues with regards to obtaining locum cover.
- We observed a ward round on one of the surgical wards. This was attended by the whole specialty team, it involved a review of each patient, and a detailed plan of onward care was made.

Major incident awareness and training

Staff were aware of the trust-wide major incident policy. All those we asked knew where to obtain information relating to their role in a major incident. Staff were able to describe the processes for moving patients and mobilising staff.

Are surgery services effective?

Requires improvement



In order to be effective, surgical services at the University Hospitals Bristol Main Site require improvement.

Patient outcomes were below the England average for hip fractures. Fewer patients than the England average

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received surgery within 48 hours or were seen by an orthogeriatrician. The standardised relative risk of readmission rate was significantly higher for both elective and non-elective cases in upper gastrointestinal surgery.

Evidence-based care and treatment

- Policies were based on National Institute for Health and Care Excellence (NICE) and Royal College guidelines. For example, monitoring and responding to patient observations were in line with NICE clinical guideline 50 ('Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital').
- The trust participated in national audits. These included surgical-site infection (for NICE), hip fractures (for the National Hip Fracture Database or NHFD) and the national bowel cancer audit, as well as the national Cardiac Benchmarking Collaborative.

Pain relief

- There was a dedicated pain team employed to support the provision of appropriate pain relief for patients.
- Some patients needed epidural analgesia for post-operative pain relief. This required nurses to undertake additional training and competency assessments before they could provide care to these patients. We were told that this meant there were some wards to which patients could not return post-operatively.
- The Visual Analogue Scale (VAS) was used to assess pain and the effectiveness of analgesia. The Abbey Pain Scale was used for patients with cognitive impairment.
- We spoke to several patients about their pain management. While most felt that this had been satisfactory, one patient did not. They were a drug user who had notified staff of this fact. Despite a high tolerance threshold, the patient reported that it took five days for the dose of analgesia to be increased sufficiently to provide adequate pain relief.
- We spoke with one patient who described the late administration of their intravenous pain relief. This was prescribed to be administered at 10pm, but was not administered until 12.45am. We reviewed the drug chart and noted that the administration was recorded as 10pm. This meant that there was a risk of further doses being given without an adequate time delay between them.

Nutrition and hydration

- Patients were offered water up to two hours prior to surgery in day theatres. This was not the case in all areas across the trust. We spoke to two patients, one of whom had been kept 'nil by mouth' for three days while awaiting surgery (with a meal allowed in the evening only once it was evident that surgery would not take place) and another for two days.
- Meals were varied and drinks supplied regularly by the hotel services staff. We saw a variety of cold drinks offered to patients on ward 700. Staff explained that this reduced the risk of nose bleeds that could occur to patients who had hot drinks (following nasal procedures).
- Patients' nutritional scores were assessed and dieticians accessed when required. Most fluid charts were maintained, although several were not evaluated. Dietetic input was available preoperatively to patients undergoing surgery to create a stoma.
- Patients returning to the ward following day surgery were given drinks and biscuits. We saw patients in the day surgical unit at St Michael's offered sandwiches and yoghurts. The housekeeper informed us that they reviewed the content to ensure that items were suitable for diabetics. We also saw the housekeeper access sandwiches without butter at the request of one patient.

Patient outcomes

- Performance in national audits varied. According to the hip fracture audit for 2013, the number of patients receiving surgery within 48 hours was 72.2%, below the England average of 87.3%. The number of patients developing pressure ulcers was greater at 6.2% compared with the England average of 3.5%, and the mean total length of stay significantly greater at 27.8 days compared with the England average of 19.2 days. Within cardiac surgery, the average length of stay following a coronary artery bypass graft from admittance from home to discharge home was 10.8 days, below the benchmark of 11.9 days.
- The standardised relative risk of readmission rate was noted to be significantly higher for both elective and non-elective cases in upper gastrointestinal surgery. We reviewed the process for managing patients presenting with acute cholecystitis (inflammation of the gall bladder). Emergency surgery cover within the trust was rotated weekly between upper gastrointestinal and colorectal surgeons. If patients presented with acute

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cholecystitis during the week when emergency cover was provided by upper gastrointestinal surgeons, staff said that those patients were more likely to be stabilised and discharged to return for elective surgery. This may not have been the case when the week's cover was provided by the colorectal surgeons. We spoke with one patient awaiting collection from the discharge lounge. They told us that they were going home following their third admission in 13 days to await elective surgery in approximately six weeks' time. Their first admission had been for one night, the second for three nights and the third for four nights. Each admission was as a result of pain caused by acute cholecystitis.

- The trust undertook 49% of all surgical cases as day surgery, 24% were elective and 27% emergency.

Competent staff

- Workforce appraisal compliance was monitored through the ward performance dashboards. For most areas, this met the trust targets.
- Consultants we spoke with described the revalidation process and felt that this was being well managed.
- We spoke with several new staff members. They described the induction processes and felt that they were well supported into their roles.
- Staff in more senior nursing roles described having one-to-one sessions with their line managers.
- Prior to the merger of wards to form wards 700 and 800, staff from all wards spent time working shifts on the opposite ward. Some additional training had been provided. However, some staff said that they felt more training was needed in order to give them the skills to feel confident in providing care to the different groups of patients they now cared for.
- We spoke with student nurses who described their experiences as mainly positive. They felt supported by their mentors and other ward staff and felt that there were good opportunities to learn within surgery.

Multidisciplinary working

- There was good multidisciplinary working. For example, trauma cases were discussed each morning, involving medical, nursing and theatre staff. There was a multidisciplinary outlier team of a nurse, physiotherapists and occupational therapists who worked together to ensure that the needs of trauma patients who were not on the designated trauma ward were met.

- Wards were visited by physiotherapists, occupational therapists, pharmacists, dieticians and specialist nurses.
- Patients attending preoperative assessment prior to surgery to create a stoma were seen by the stoma nurse and dietician.
- There was no hospital-based social worker. However, following referral to social services, patients were seen by the social worker on the ward.
- Staff spoke of good working relationships and easy access to other specialist advice where required.

Seven-day services

- Services were available both out of hours and at weekends. Physiotherapists provided cover at weekends. However, this did not cover routine assessments. There was access to the pharmacy team via an on-call system. Staff said that medicine stocks were usually satisfactory.
- There was access to imaging services out of hours and at weekends. This included magnetic resonance imaging (MRI) scanners, x-rays, CT scanner, ultrasound and theatre fluoroscopy services. There was one theatre manned 24 hours a day, seven days a week in the Hey Grove suite.
- Consultants did ward rounds daily and saw all patients.

Are surgery services caring?

Good



Surgical services at the University Hospitals Bristol Main Site were caring.

Staff were kind and gave compassionate care to patients and relatives. Patients had a good understanding of the care they were receiving. Emotional support was seen to be good.

Compassionate care

- We saw patients and relatives treated with kindness and compassion. One patient told us via a comment card: "I am left humbled by the extraordinary skills and endless compassion and care I have been so very fortunate to receive." Another told us "the staff are marvellous – they keep you cheerful", while a third said that "you really can't fault the staff".
- Friends and Family Test results were included in ward performance dashboards. The average response rate for

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the trust was 35%, above the England average of 30%. Ward 5a had a consistently higher response rate. This ward now formed part of ward 700. We spoke to the housekeeper on the ward who told us how they ensured that there were sufficient pens to help patients complete the questionnaires. They told us they had seen an increase in response rates following this and that this was something they took pride in. Most patients who responded said that they were either 'extremely likely' or 'likely' to recommend the ward to their family and friends.

Patient understanding and involvement

- The hospital performed mostly 'about the same' as other trusts in the 2013 inpatient survey, including when asked if patients were involved as much as they wanted to be in decisions about their care and treatment.
- There was a wide variety of patient information leaflets available and we saw that these were given to patients during the preoperative phase and also post-operatively in the Queens day unit. We saw them given to patients in the preoperative assessment area, where staff took time to discuss issues within them.
- We spoke to two patients who were awaiting surgery. Both felt that they had been given clear information and were aware of the procedures and processes that were to take place.

Emotional support

- Staff could access occupational health for support. However, there were no counselling services available for patients or relatives.
- We reviewed the notes of one patient who was awaiting discharge but was homeless. They therefore had nowhere to go once they left hospital. There had been concerns regarding their emotional health and as a result they had been referred for psychiatric assessment, which had been carried out.
- Clinical nurse specialists were available to provide emotional support to patients undergoing life-changing procedures such as the creation of a stoma. These patients were seen in the preoperative clinic by the stoma nurse and again regularly on the ward post-operatively to provide advice, support and teaching.

Requires improvement



Surgical services require improvement in order to provide a responsive service.

The beginning of the patients' pathway was good, with good access and provision of care at the preoperative stage. However, bed occupancy was high and patients were not being cared for in designated areas. Patients often went to theatre without an allocated bed available post-operatively. As a result, patients often stayed in the recovery area overnight where there was a lack of provision to ensure their privacy and dignity could be maintained and some even went home from there. If patients left theatre for their designated ward at a time that the surgical admissions unit was closed, they did not have access to personal possessions, which remained in the surgical admissions unit overnight.

Discharge planning did not commence in a timely manner, often only starting once people were medically fit for discharge. Patients also remained in hospital for longer than the England average.

The percentage of patients whose operation was cancelled and who were not treated within 28 days was consistently higher than the England average. Inpatients awaiting surgery were kept 'nil by mouth' for long periods of time and cancellations often occurred late in the day.

While there was good access to translators, written information was provided only in English.

There were issues with overall capacity. Bed occupancy rate was 90.3%. Decisions were made to admit patients for surgery in the absence of a dedicated bed for them to go to post operatively. Some patients were moved late at night, disturbing their sleep and that of other patients in the areas they were moved both from and to. Patients medically fit for discharge remained on specialist wards whilst patients with specialist nursing needs were cared for as 'outliers' on other surgical wards.

Are surgery services responsive?

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Service planning and delivery to meet the needs of local people

- Preoperative assessment appointments were given to patients in outpatient clinics. However, some patients were offered 'one stop' or 'same day' assessment where their cases were urgent or they had travelled particularly long distances.
- Patients are admitted to the Surgical Assessment Suite (SAS) prior to surgery. Their belongings remained there while they went to theatre. From theatre, they went to their bed on a ward. It was not always known where the patient would go post-operatively, and therefore belongings remained in the surgical admissions unit until ward staff retrieved them. As this was closed overnight, this meant belongings could not be retrieved out of hours.

Access and flow

- Bed occupancy was consistently higher than the England average. For example, data for quarter one in the year 2014/15 (April to July 2014) showed an occupancy rate of 90.3%. Research has indicated that bed occupancy rates of over 85% increase the risk of harm to patients.
- The average length of stay across all areas was four days for elective cases (the England average is three days) and six days for non-elective cases (the England average is five days). There was wide variation across specialties. For example, within elective thoracic surgery, the average length of stay was three days (the England average is five days). However, for trauma and orthopaedics (non-elective) it was 12 days (the England average is eight days).
- The percentage of patients whose operation was cancelled and who were not treated within 28 days was consistently higher than the England average.
- The trust was meeting referral-to-treatment times in all specialties apart from oral surgery and cardiothoracic surgery.
- Cancellation rates on the day of surgery for elective procedures were 1.5% for quarter one in the year 2014/15. The majority of these fell within thoracic surgery (average 15%). Staff told us this was mainly caused by the change in surgical procedure, which whilst resulting in the patient remaining in hospital for period of time, the procedure took longer time to complete in theatres. As a result, surgeons were only able to undertake two before running out of allotted theatre time, when they

had prior to the change in procedure they had been able to undertake three procedures in the allotted theatre time. Theatre lists continued to be booked for three patients despite this change in operating practice and the third person on the theatre list was cancelled. There was a plan to lengthen the theatre allocation time for these procedures as a three month trial. However this had yet to commence and continued to be one of the causes of cancellations on the day of surgery. Figures given to us during the inspection showed that thoracic surgery cancellations made up 11.5% of all cancellations on the day of surgery in August 2014. The main cause of thoracic cancellations was clinical prioritisation of other cases; the second biggest cause was cancellation due to lack of HDU bed.

- The surgical and trauma assessment unit (ward 2) had a total of 20 beds in a mixture of bays (four to six beds) and side rooms. In addition, it also had a small room housing eight chairs with two small examination rooms attached. The assessment room was small and at the time of visiting had four patients present. With relatives and friends, the room was crowded. Patients in the assessment room were waiting to be reviewed by medical staff, receiving intravenous medicine infusions or were waiting to go to theatre. There were several patients identified as having dementia or cognitive disorders. The ward was noisy and busy, as well as cramped and cluttered, all of which could cause added confusion, make concentration difficult and increase anxiety.
- Single-sex bays and toileting facilities were evident on all wards we visited. However, the assessment area on the surgical and trauma assessment unit was mixed sex. When needed, people attending the assessment area used toilet facilities on the main ward.
- Patients were admitted directly into the assessment area on the surgical and trauma assessment unit. Others were transferred there from the emergency department if there was no bed. One consultant we spoke with told us that they had been unable to examine a patient the preceding day as both examination rooms were occupied and there was no other bed available.
- Staff told us that patients often went to theatre without an allocated bed having been identified. At times they were required to remain in the recovery area overnight. This area had the capacity for eight patients although it would be very cramped if fully occupied. The recovery

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area was a mixed sex area. Privacy could be provided only by screens, some of which were low in height. There were no toilet facilities in this area. Patients who needed to use the toilet had to use a commode obtained from a neighbouring ward. Data reviewed showed that the recovery area had been used overnight for a total of 139 patients in the six months preceding the inspection. During the unannounced inspection, one patient had gone to theatre directly from the surgical and trauma assessment unit. They did not have a bed to return to post-operatively. Staff told us that they would go to the recovery area to discharge the patient from there as recovery staff were less familiar with the discharge processes.

- Some patients were moved late at night. This disturbed their sleep, disturbed others in the areas they were moved both from and to, and increased the risk of falls and patient safety incidents as a result of disorientation and confusion on waking. We spoke to one elderly patient who described being moved at 1am. They had been woken and, although they described the nursing staff as kind and apologetic, they had been disorientated and confused regarding their whereabouts on waking the next morning. Another patient told us that they had been given sleeping tablets and were then also informed that they would be moving wards. They told us they did not immediately take the sleeping tablets but awaited the move so that they would be awake. The move occurred at 1.30am, following which they took their medication. Night-time moves were not reported as clinical incidents and staff were not recording the numbers of night-time moves that occurred on the site.
- Patients could be discharged directly from the wards or could go to the discharge lounge to await transport. We visited the discharge lounge, which was bright and spacious. Patients sat in chairs and could access drinks if needed. While the majority of patients in the discharge lounge came from medical wards and the oncology centre, data we were provided with showed that 30% of the usage of the discharge lounge was by the surgery, head and neck division.
- Ward 14 was the designated trauma and orthopaedic ward. This had 30 beds. We visited the ward and noted that there were 10 patients who were deemed fit for discharge. However, they remained on the ward as there was no discharge destination identified. For some there was a need for ongoing packages of social care and

others were unable to return to their normal home. At that time there was a total of 19 'outliers' (trauma and orthopaedic patients who were not being cared for on a designated trauma and orthopaedic ward). This meant that nursing staff on ward 14, with specialist trauma and orthopaedic nursing skills, were providing ongoing care to patients who no longer needed their specialist skills. Meanwhile, other patients were being cared for on general surgical and other specialist surgical wards, such as thoracic and ENT surgical wards, that lacked specialist trauma and orthopaedic nursing skills.

- The management of emergency surgery lists meant that procedures were often cancelled or patients had delayed access to theatres. We spoke to three people who were awaiting surgery. One patient told us: "I'm second reserve emergency." They added: "I've been on constant standby for two and a half days.. Because I'm not scheduled I don't show on a waiting list." The second patient with abdominal pain had been cancelled for theatre three times. The third patient had been cancelled and sent home the preceding day, having been 'nil by mouth' for over 18 hours. They had returned that morning for theatre. They were accompanied by a family member who said: "I'm scared to death he'll be cancelled again." At this point they had been 'nil by mouth' for 12 hours.
- Processes for ensuring a timely discharge from hospital for patients requiring social care support on discharge were not always effective. We reviewed the notes for a patient on the surgical and trauma assessment unit. They had been medically fit for discharge for nine days but, despite living with dementia, remained in a busy assessment ward awaiting a community healthcare funding assessment. We reviewed the referral processes and saw that these had not been undertaken correctly by hospital staff, which had added to the delay.
- We reviewed the referral processes for patients requiring social worker assessment on ward 14 and noted that this was commenced only when the patient was deemed medically fit for discharge. This meant that patients remained in hospital longer, awaiting assessment.

Meeting people's individual needs

- Access to translation services was good. Translators could be booked via a bank for elective patients and in

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preparation for ward rounds and specialty reviews. We saw from the notes how a translator had attended key reviews by psychiatrists and social workers for one patient.

- There was a wide variety of information leaflets for patients. However, the only available leaflets we saw were in English and all signage was in English.
- Separate dental surgery lists were held for patients with learning disabilities.
- Staff on surgical wards used the 'This is me' document on dementia care, produced by the Alzheimer's Society. One-to-one nursing support could be requested for patients with cognitive impairment such as dementia, although we saw that this had not been provided for two patients due to an inability to find additional staff. Carers and relatives were encouraged to visit to provide advice and support.
- Meals were available to meet all dietary needs such as vegetarian and Halal.

Learning from complaints and concerns

- Staff knew of the complaints policy and how patients could make a complaint or raise a concern. While they were able to describe changes that had occurred as a result of incidents, they were not able to describe any learning that had arisen as a result of complaints. The number of complaints per ward was not reported on the performance dashboards, although the numbers were reported in the divisional governance minutes.

Are surgery services well-led?

Requires improvement



Surgical services require improvement in order to be well led.

While services were reported as being well led on wards and in departments, there was little visibility of the divisional management team. Plans had been made for a major reconfiguration of services, with some specialties moving to another provider. Managers told us that this would allow a protected bed base and increase capacity to undertake elective and emergency work in a more timely manner. However, until reconfiguration occurred, serious

issues with patient flow and access remained and there were not effective measures in place to deal with these issues. There was little evidence that actions were being taken to address the issues relating to discharge.

Vision and strategy for this service

- The services were undergoing major changes with services moved to and from other providers, wards reconfigured, and sub-specialties joining together. Staff we spoke with were aware of these changes within their work areas.
- Staff were aware of the trust vision.

Governance, risk management and quality measurement

- Ward performance dashboards showed individual performances. These were reviewed with senior nursing staff. Medical staff, particularly junior medical staff, were less aware of the content of the dashboards.
- The surgery, head and neck division held a monthly governance meeting, the minutes of which we saw.
- Other than a trust wide newsletter emailed to all staff there was no structured process for staff to receive feedback. Instead, staff across the surgery, head and neck division received information in an ad hoc manner. Some wards and areas had ward specific newsletters to update staff, on others we were told that staff were informed of pertinent issues during the safety briefings, and other messages were communicated via group email.
- Meeting minutes and other information had previously been placed in the staff room on ward 14 but this had been removed at the request of staff who wished to have 'time away from work' during their breaks.
- Wards and departments had their own risk registers that fed into the divisional and corporate registers. Staff were aware of the risk registers and how to raise a risk to be included.
- While the risk to patients through lack of staff on ward 700 was identified on the risk register, actions had not been put in place to mitigate the risk.
- The lack of dedicated staff in the assessment area in the evenings on the surgical and trauma assessment unit had been risk assessed and controls identified. The provision of additional staffing into that area after 19.30 hrs was dependent upon additional staff being found. Staff on the ward told us they often cared for people in the assessment unit without additional resource..

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- While ward performance was reported on dashboards, poor performance on some indicators continued. For example ‘antibiotic compliance’ on ward 5b had been below the accepted threshold when audited for eight of the last nine months reported. On ward 78, when auditing the completion of food charts, five of the last nine months reported fell below the trust’s accepted threshold; for three further months, details had not been recorded.

Leadership of service

- Staff were aware of their immediate managers, who were described as visible and approachable. Ward sisters worked in a supervisory manner. Prior to the merger of wards to form wards 700 and 800, ward sisters were able to access a leadership course in order to prepare them for managing a much larger ward and a workforce with experience of two different sub-specialties.
- Matrons were visible and staff told us that they often visited the wards and departments. Matrons told us that they had good support from the divisional head of nursing and met with her regularly. However, most ward- and department-level staff did not know the members of the surgery, head and neck division management team. Nursing staff we spoke with told us that the management team did not attend the wards.

Culture within the service

- Staff described an open culture where they were encouraged to raise incidents, complaints and concerns with managers. Although feedback from these was not structured across the division, staff felt that they received feedback and were kept informed.
- All staff we spoke with were able to tell us about the trust’s whistle-blowing policy.

Public and staff engagement

- The trust told us that patient views were sought in a variety of ways. There was a corporate (trust-wide) service-user feedback programme that provided the Divisions with feedback about their services. This programme comprised a number of feedback channels, including: the Friends and Family Test, comments cards, a monthly post-discharge inpatient experience survey and a bi-monthly programme of face-to-face interviews conducted with patients whilst they are on our wards.
- Staff were able to participate in the staff survey and 52% had taken part (above the England average of 49%).

- Staff told us that the merger of wards had been well managed. They felt that their concerns had been listened to. As a result, they had been given the opportunity to work in other areas and to visit the new wards prior to opening.

Innovation, improvement and sustainability







- It had been identified through audit that cases were often switched on theatre schedules. This meant that staff on the wards were unaware of which case was first and therefore the patient was often not ready. As a result, theatre and clinical staff now identify a ‘golden case’. This is the first case on the operating list. Ward staff therefore know to prepare the patient in order that theatre lists can commence promptly.
- Video-assisted thoracotomies (VATs) were now being undertaken routinely. As a result, the length of stay post-operatively had fallen by approximately 2.5 days. However, this surgical technique took longer. Staff had identified that they often ran out of time to perform the third case of the day (a major contributor to the ‘on the day’ cancellation rate). As a result, a longer theatre day was about to commence on a three-month trial.
- The division had identified that there were issues regarding access and flow which resulted in cancellation of elective surgical activity and delayed access to theatre for some non-elective surgery (such as fractured neck of femur repairs, which fell below national best practice). As a result, services were in the process of being reconfigured. Some services were moving to another provider; it was felt that this would free beds in other areas and there was to be a surgical floor within the new building where services would be co-located.
- The division had plans for a managed beds programme and the establishment of an emergency floor on level 6. However, until the plans had been completed, capacity and flow remained a major risk within the division. The division has undertaken capacity planning to ensure bed and theatre capacity was aligned and in the right place. However, patients were often admitted for surgery without the availability of a bed, and at times this led to cancellation of their surgery. Ward sisters did not have prior knowledge of who was to be admitted to the ward. This meant that they were unable to adjust staffing or access equipment to meet the patient’s needs in advance of their admission onto the ward.
- While many problems with flow related to discharge, there was little evidence of innovation to manage this by

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the trust. Blockages with flow were described as occurring due to the lack of social care in the

community. However, we observed blockages in patient flow that could have been managed and resolved by the trust. This would have increased capacity and therefore reduced pressure on bed occupancy.

Critical care

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

Information about the service

University Hospitals Bristol Main Site provides up to 44 adult critical care beds. Within the critical section of this report we will report on the safety, effectiveness, responsiveness and management of the 13 beds on ward 3, the seven beds on ward 99 (these wards will be referred to as the critical care unit) and 24 beds on the cardiac intensive care unit (CICU). The trust also provided other high-dependency and intensive care beds; these are reported in the children and young people and maternity sections of this report. The opening of the new 21-bed critical care unit (ward 600) had been postponed at the time of our inspection and was due to open in December 2014.

Ward 3 was the critical care unit and was known as the intensive care unit. It provided 13 level 3 beds for both medical and surgical patients. Ward 99 provided seven level 2 beds. Wards 3 and 99 take both medical and surgical patients admitted both from the accident and emergency department and from other wards or departments within the hospital. Wards 3 and 99 will close when the new critical care unit (ward 600) opens. The CICU provided 13 level 3 beds and 11 level 2 beds for patients who had had cardiac surgery. Intensive care consultants covered wards 3 and 99 from 8am to 10pm seven days a week. From 10pm a registrar was available within the hospital with one consultant on call. A rota of consultant anaesthetists covered CICU with one consultant anaesthetist available each day. Wards 3 and 99 admitted 1,880 patients and CICU admitted 1,692 patients between September 2013 and August 2014.

We visited wards 3 and 99, the CICU and the new critical care unit, although it was not open for patient admissions. We talked with seven patients, nine relatives and 39 staff: nurses, doctors, physiotherapists, domestic staff and managers. We observed care and treatment and looked at the records of 10 patients who were receiving or had recently received care within the critical care wards. Before the inspection we reviewed performance information about the hospital.

Critical care

Summary of findings

Critical care services were judged to be good in the safe, effective, caring and well-led domains. The responsive domain required improvement.

The trust's adult critical care services had a good patient safety record and performed better than other comparable trusts. We saw that there was a culture of learning from incidents and complaints. Risks were being managed appropriately. Staff were encouraged and supported to be involved in quality improvement projects and we were shown several examples of innovation. Arrangements for medicines were generally appropriate, but some improvements were needed.

Patients and relatives told us that staff were mostly caring and compassionate. There was appropriate medical cover for critical care wards and CICU. The imminent plan to recruit more experienced nurses will give greater assurance of the ongoing safety in both critical care and CICU.

Changes within the last 12 months to the leadership of both the critical care unit and CICU had been positive and were leading to improved opportunities for staff and an improved skill mix for nurses, which will enhance patient care. Clinical leadership from consultants within critical care was also seen to be good. However, there was a lack of clarity around governance arrangements from CICU consultants.

The forthcoming opening of the new critical care unit (ward 600) will provide both staff and patients with an improved care and working environment. There will be improved facilities for visitors and additional quiet rooms, which will afford greater privacy for distressed and grieving relatives. The new unit will provide one additional bed compared with current availability. It is highly likely that problems will continue relating to access to critical care beds, resulting in cancelled operations and delays in transfer to critical care due to the lack of available suitable beds.

Are critical care services safe?

Good



Overall, we found that critical care services were safe. The trust's adult critical care services had a good patient safety record compared with other similar trusts. We saw that there was a culture of learning from incidents and complaints and risks were being managed appropriately.

There were appropriate systems in place to highlight the deteriorating health of patients; the records we looked at evidenced this. We found that the new computerised patient record system, which alerted the consultant and nurses if the patient's safety and wellbeing were compromised, was an excellent innovation.

The trust had no adult critical care outreach service. A critical care outreach service provides support to ward staff if a patient might be deteriorating and can also follow up on patients discharged from critical care to ensure that their recovery continues. We did not identify any safety issues in relation to the lack of availability of this service during our inspection.

The environment was clean and hygienic. Arrangements for medicines were generally appropriate although some improvements were required. There was also a need for additional pharmacists or pharmacy support to provide medicines and advice to staff and to release the night nurse in charge from the nightly ordering of medication. A need for additional supernumerary nurses to support staff and to supervise patient care was being addressed.

Incidents

- There had been four serious harm incidents associated with the adult critical care department and the CICU that were reported to the National Reporting and Learning System (NRLS). These incidents related to three grade 3 pressure ulcers and an equipment failure between April 2013 and March 2014.
- We looked at the root cause analysis investigations for those incidents and for another, more recent, serious incident. All were comprehensively investigated and identified learning and actions required to reduce the risk of similar incidents in the future. We also saw that required actions had been addressed or were in place.

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- All staff we spoke with said that they were encouraged to report incidents and received feedback of the actions taken. Staff gave us examples of actions that had been taken to reduce the risk of similar incidents occurring and how patient safety had been improved, for example how pressure ulcers had been reduced.

Safety Thermometer

- NHS Safety Thermometer information was displayed on information boards on each ward or unit we visited. This included information about whether there were any infections such as methicillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile*. It also included information about the most recent pressure ulcers. The unit was performing as expected for these indicators.
- Risk assessments for patients for pressure ulcers and venous thromboembolisms (VTEs) were being completed appropriately on admission.
- The department safety information, which was updated monthly, showed that both critical care unit and CICU were performing as expected for the safety indicators.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment. There was an identified cleaning programme, which had been completed correctly. Tags were added to equipment when they were cleaned; however, we saw that these tags were not available consistently.
- The cleanliness of the critical care unit and CICU was audited monthly. The critical care unit had scored 100% and the CICU 93% when audited by an independent manager. Results of monthly compliance of staff with hand-washing and hand hygiene audits identified that the critical care unit department had scored 100% and CICU 98% compliance. Staff followed the trust policy on infection control. The 'bare below the elbow' policy was adhered to, and hygienic hand-washing facilities and protective personal equipment were readily available and used appropriately by staff.
- Disinfectant hand gel was available at the entrance to the department, although the hand gel inside ward 99 was some distance away and behind a chair, which meant that there was a risk that staff and visitors might not use it. However, hand gel was also available throughout the unit and at the end of every bed. Signs were visible throughout the units to remind staff and visitors about the importance of hand washing.

- There were effective arrangements for the safe disposal of sharps (anything that can puncture the skin) and contaminated items.
- The critical care unit supplied its patient data and outcomes to ICNARC, which evaluated the unit against similar departments nationally. ICNARC data for infection rates showed that *Clostridium difficile* and MRSA infection rates from April 2013 to March 2014 for the trust were better than in other, similar trusts.

Environment and equipment

- It was evident that there was limited space available on wards 3 and 99, which could impact on both patient and staff safety. Wards 3 and 99 were cluttered and there was a lack of suitable storage for furniture such as armchairs. Ward 3 also appeared dark, with windows that had limited light because of the new building work outside. Ward 600 (the new critical care unit) is both light and spacious, with more storage space, so this will address the current difficulties.
- The fire exit in the corridor by the clean utility on ward 3 was blocked by equipment.
- We were told that staff teaching for the use of equipment was mostly undertaken by senior nursing staff within the unit. Maintenance or repair of equipment was mostly undertaken away from the unit.
- A technician was available within the CICU to ensure the maintenance of equipment. Staff on wards 3 and 99 (critical care unit) said that they would be able to use their equipment more efficiently if they had access to a technician to log equipment and undertake minor maintenance such as replacing batteries.
- The critical care unit used a computerised patient monitoring system that had been developed within the unit. Patient information was displayed on plasma screens available at strategic points on both wards 3 and 99 and on a hand-held computer. Alerts were also sent to consultants' phones. The alerts highlighted to staff patient results and observations that were outside safe limits and also when patients required a change in their position. This equipment was not available in the CICU and staff did not know whether it would be available in CICU in the future.
- To ensure patient safety, appropriate safety checks on equipment were undertaken. For example, we observed checks to portable capnography, which is used to check the location of breathing tubes by monitoring the levels of carbon dioxide in expired breath.

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- We saw that the resuscitation equipment was checked regularly and restocked when needed. There was a record of when this had been done and who had undertaken the check.
- A buzzer system was used to enter critical care, with a camera to identify visitors and staff.

Medicines

- All controlled and high-risk medication and associated paperwork were stored appropriately and safely.
- On the CICU (the high-dependency unit), the controlled drug safe was not compliant with legislation (it had only one lock whereas it was designed to have two locks due to its height). We also noted that there were crossings out within the controlled drugs register; this does not meet the organisation's required practice.
- On ward 600 (which was not yet open to patients during our inspection), the controlled drugs cupboard was not secured to the wall in line with the pharmacy department guidance. This was not in line with good practice.
- Wards 3, 99 and CICU used prefilled syringes of potassium chloride injection. The National Patient Safety Agency highlighted in 2007 that patient safety may be improved by the wider availability of only licensed ready-to-administer or ready-to-use injectable medicines are procured and supplied. The trust may wish to consider the wider availability of prefilled syringes within critical care and the trust.
- There was access for staff to e-medicines databases (the Medusa IV guide), which provided up-to-date information about medicines.
- There was a lack of sufficient storage facilities for intravenous fluids and fluids required for haemofiltration (filtering of a patient's blood to remove waste products) on ward 99. We saw that the storage cupboard was so full that the door could not be closed, and boxes were stacked up against the door. The lack of space also put staff at risk when they needed to remove fluids from the storage room. There will be additional storage available when ward 99 moves to the new unit; however, the location of the store was not appropriate and meant that pallets of fluids would be transported across the unit.
- Medicines were all stored securely in lockable cupboards. Within the CICU, there were lockable glass-fronted cabinets that enabled staff to easily identify in which cabinet required medicines were stored.
- Intravenous fluids were being stored in unlocked rooms on wards 3 and 99. However, this was being addressed.
- Medical gas cylinders were being stored in an appropriate rack on ward 99. However, the rack was full and in-use cylinders were not segregated from empty cylinders. This could be problematic in an emergency if a used cylinder were selected.
- The medicines fridge temperatures, including the minimum and maximum temperatures, were recorded daily. The trust may wish to consider that for the whole of the previous month (August) the medication fridge on ward 99 was at 8°C, which is the maximum safe temperature. This meant that should there be any temperature increase the safety and effectiveness of medicines stored within the fridge may be affected.
- The temperature of the room where medicines were stored was not recorded within the wards or units we visited. A regular check on temperature provides assurance that medicines are stored safely and that their effectiveness is not adversely affected.
- The critical care unit and CICU did not meet best practice guidance for the availability of a senior pharmacist (band 8a). Good practice guidelines identify: "pharmacy services are often overlooked despite clear evidence they improve the safe and effective use of medicines in critical care patients".

Records

- Wards 3 and 99 had a new computerised patient records and observations recording system that had been developed by staff within the critical care unit. All patient records were filed in an identical way, which meant that information could be found easily.
- Patient records on the CICU were both electronic and paper-based and recorded required information.
- Nursing documentation was computerised, with staff at each bed space completing all required records electronically. Observations were checked and recorded at the required frequency.
- The records used innovative smartphone software to enable to highlight to the nurse in charge of the critical care unit and the patient's consultant via their mobile phone or hand held tablet computer, any deterioration

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in observations, results such as the patient's breathing in response to the ventilator, and whether flow rates required changing or if the patient required a change in their position. This had the benefit of both ensuring that the patient had appropriate care to keep them safe and promoting their recovery.

- All professionals involved with a patient during their admission to the unit added their notes to the same records. This ensured continuity and a team approach to care delivery.
- There were clear records of the treatment patients had received and any further treatment or follow-up they required.

Consent and Mental Capacity Act

- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes. Frequently within critical care, patients were unconscious or not able to provide their consent. Staff were able to provide examples of patients who did not have capacity to consent and how they acted in the patient's best interests and, whenever possible, consulted with their relatives. The Mental Capacity Act 2005 was adhered to appropriately.

Safeguarding

- Staff confirmed that they had received safeguarding awareness training and confirmed actions that would be undertaken to keep people safe.
- Staff on ward 99 told us of how they had raised safeguarding concerns about a patient to ensure that they would be safe and protected from harm when they were discharged home.

Mandatory training

- There were satisfactory management arrangements in the department to ensure that staff attended all required mandatory training. Records we saw prior to our inspection identified that compliance with mandatory training was low. Staff told us that this was not correct and was due to a change in the way in which training was recorded and in the areas covered during the mandatory training.
- Staff confirmed that they received annual mandatory training in areas such as infection control, moving and handling and resuscitation. All staff training and attendance was monitored by both the team leader and the matron. The critical care matron and CICU matron

showed us the systems that were used to monitor the training undertaken by staff. We found that there were appropriate arrangements in place to ensure that staff received annual mandatory training.

Assessing and responding to patient risk

- There were at least two consultants available from 8am to 10pm and one consultant on call overnight to provide advice to staff on any deteriorating patient either within wards 3 and 99 or elsewhere within the adult wards of the trust. A registrar or middle-grade doctor with intensive care experience was available within the hospital between 10pm and 8am.
- Staff on some wards told us that sometimes there was a delay while medical registrars escalated concerns to the intensive care doctors and then for the intensive care consultant to agree the patient's admission to the critical care unit. However, the records we looked at during the inspection showed that ward staff had made timely contact with intensive care doctors and that there was an appropriate and timely response to ensure the patient's timely admission to critical care.
- The early warning score (EWS) escalation process for the management of acutely unwell adult patients was used to identify patients who were deteriorating. In addition, the critical care unit had a system that generated alerts in relation to the deteriorating patient. This ensured early and appropriate treatment from staff.
- Nursing staff working within both the critical care unit and CICU said that they did not experience any difficulties contacting doctors when a patient's condition deteriorated.
- The trust does not have an adult critical care outreach team. A critical care outreach service provides support to ward staff if a patient might be deteriorating and can also check on patients discharged from critical care to ensure that their recovery continues. There were no incident reports made by staff of the failure to promptly escalate any deteriorating patient. We did not find any safety concerns in relation to this type of service not being in place.
- Nursing and medical handovers occurred twice a day, during which staff were updated on all patients' conditions. During the handovers, patient safety information and awareness of the 'safety brief' for both the trust and the division were discussed; this is good practice.

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- Visiting professionals to the units, for example a physiotherapist or speech and language therapist, were also updated on a patient's condition and progress before giving any treatment.

Nursing staffing

- On all critical care wards, all level 3 patients were nursed on a one-to-one basis, and all level 2 patients were cared for by at least one nurse to two patients. This meets best practice guidelines identified within Core Standards for Intensive Care Units 2013. There was usually one healthcare assistant per day shift and a housekeeper available from Monday to Friday.
- If staffing levels were not met from the wards' own staff working their contracted hours, staff were able to work and be paid overtime. In addition, both critical care and CICU used agency or bank staff (staff who may already work for the trust and had received induction and ongoing mandatory training from the trust) to cover absences. There was a regular group of bank and agency staff, most of whom had had experience of working on the units before.
- All shifts within both the critical care unit and CICU had at least one supernumerary senior nurse (band 7). The matron was also supernumerary when on shift. Nurses we spoke with recognised that current arrangements for supernumerary nurses who had a supervisory role were insufficient. Senior nurses who were supernumerary agreed that they spent the majority of their time with bed management. One nurse we spoke with said: "They are really busy – they spend their time on bed management so aren't really available."
- There was no pharmacy support for ordering stock medicines within the unit. The supernumerary nurse on night duty also had a responsibility to check and order medicines for the next day. This took this nurse away from supervising and supporting staff and managing the unit or took other staff away from patient care.
- The supernumerary band 7 nurse for the CICU was responsible for the care of up to 24 patients. This does not meet best practice guidelines for the availability of up to three supernumerary nurses for between 21 and 30 patients.
- We found that frequently just one supernumerary nurse was available on both units. Best practice guidelines (Core Standards for Intensive Care Units 2013) identify that, for units of between 11 and 20 beds, an additional supernumerary nurse should be available. The critical

care supernumerary nurse was 'in charge' of both wards 3 and 99 (up to 20 patients) and also had responsibility for overseeing patient care and patient flow within the recovery unit (which may have up to eight patients at any time). This meant that this nurse was checking on the care provided within three separate units over three floors, which could include up to 28 beds. This was being addressed with an agreement to recruit additional band 7 nurses when ward 600 opens. There was also a plan for recovery nurses to be managed by senior nurses in theatres.

Medical staffing

- Medical care in the critical care unit was led by a team of 13 consultants who were qualified in intensive care. Three intensive care consultants were present on the unit from 8am to 5pm seven days a week. There were two consultants who worked between 5pm and 10pm seven days a week. This meets national recommendations of no more than 14 patients to each consultant.
- Within the CICU, an intensive care consultant provided medical cover for the 13 level 3 beds and for six beds in the high-dependency unit. Cardiac surgeons provided medical care to the other five beds in the high-dependency unit of the CICU. Activity in the unit meant that there were usually only nine intensive care patients. If the activity increased to 13 intensive care patients then operations would be cancelled and consultant anaesthetists would be redeployed to provide care in the unit. This met best practice guidance.
- The consultants on both critical care and CICU undertook ward rounds twice daily. This meant that patients' health and recovery were assessed regularly to ensure that they received appropriate and timely treatment.
- All potential admissions to both the critical care and CICU were discussed with a consultant and all new admissions were reviewed by a consultant within 12 hours of admission. This met best practice guidance.
- There were appropriate arrangements for medical cover for both units overnight. A registrar or middle-grade doctor with intensive care experience was on duty between 10pm and 8am for both critical care and CICU. In addition, one consultant was on call from home for critical care and another consultant was on call for CICU.

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Major incident awareness and training

- The trust had a major incident plan and business continuity plan. The major incident plan identified different types and levels of incidents and responses required by the hospital's staff. Staff we spoke with were familiar with their role within the major incident plan.

Are critical care services effective?

Good



The unit had a clinical audit programme to monitor adherence to guidance. All staff were involved in quality improvement projects and audits. Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in their notes.

The nursing skill mix for both units had been reviewed and had identified a need for additional experienced nurses. The plan to recruit these nurses was already in place. The availability of additional experienced nurses will provide improved support, supervision and development for less experienced nurses.

Seven-day working was in place for all medical and nursing staff and for most other staff disciplines. There were also appropriate arrangements in place for weekend, evening and night cover.

Evidence-based care and treatment

- Data given to the Intensive Care National Audit and Research Centre (ICNARC) showed that the trust had fewer deaths within adult critical care when compared with other, similar critical care departments. The data also showed that the critical care unit performed better than comparable units for patient harm, including infection rates.
- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment it provided. Local policies were written in line with this.
- There were care pathways in place that met NICE guidelines to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.

- The unit had an identified clinical audit programme to monitor adherence to guidance, and staff were delegated responsibility to carry out audits such as hand hygiene and cleanliness audits. We saw that the results of these audits were displayed prominently on noticeboards on each ward we visited and showed good compliance rates.
- The unit had implemented quality improvement initiatives. Examples included the use of full-face shields to prevent pressure ulcers to the nose when using non-invasive ventilation, and changes to how patients were positioned and moved when they needed to be cared for face down. This had also reduced the incidence of pressure ulcers.

Pain relief

- A pain assessment score for patients who were unconscious or were unable to express pain was used by staff. The pain control nurse had worked closely with critical care staff to implement this tool and to ensure that patients had appropriate pain relief. The assessment included a check on non-verbal responses or changes to the patient's observations and detailed that pain relief was required.
- The records we looked at confirmed that patients had regular pain relief. Patients we spoke with told us that staff ensured they had the pain relief they needed and were kept comfortable.

Nutrition and hydration

- Patients' nutritional needs were assessed and a risk assessment completed that identified whether they were at risk of poor diet or nutrition or fluid intake. We saw that there were appropriate arrangements in place to highlight and address these risks.
- Dietetic advice was sought when required.

Patient outcomes

- The unit contributed to the ICNARC database. The data demonstrated that the trust's critical care units performed better in most outcomes assessed (such as lower patient deaths, infection rates and unplanned readmissions) than other, similar trusts.

Competent staff

- The critical care unit and CICU both met the required standard of at least 50% of nursing staff with a post-registration award in critical care nursing.
- Qualified nurses on wards 3 and 99 told us that for some time nurses who wished to undertake a

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post-registration qualification in critical care had paid their own course fees. Nurses said that there was no provision by the trust to contribute towards course fees, although some paid study leave was provided by the trust. The matron for critical care told us that, although there was a budget for professional development training within the trust, there was no clearly identified budget for critical care nurses. The matron said that the lack of this information made access to funding difficult.

- The General Medical Council National Training Scheme Survey 2013 reported positively on the training, support and supervision provided by the critical care department.
- Nursing staff had an induction period during which they were supernumerary for at least four weeks, although this could be extended for nurses who had not previously worked in critical care.
- All nurse competencies were checked by nurses against standards identified by the National Competency Framework for Adult Critical Care Units. Nursing staff worked in teams led by groups of band 7 nurses who provided support to staff in each group.
- The critical care unit had a clinical care practice development nurse who worked 30 hours a week to provide teaching to enhance clinical skills, supervision and support to all unit staff. We spoke with the nurse who said: "I am one person providing support to 150 staff." The critical care matron confirmed that agreement had been given to recruit an additional nurse for 37.5 hours a week. The increase in hours for this role and support for nursing staff will meet best practice guidelines.
- The critical care matron told us about the nurse training plan that she had identified since she had been in post and that had been agreed by the board. The plan included the extension of the existing induction programme from four to a minimum of six weeks. There would also be an ongoing training and development plan with further competency assessments for all qualified nurses, which would lead on to the postgraduate qualification in critical care.
- We spoke with doctors who said that they felt supported and were observed to have an excellent rapport with patients and other staff.
- Staff we spoke with confirmed that they had received an annual appraisal. Information supplied by the trust also confirmed that over 85% of staff had received an annual appraisal.

Multidisciplinary working

- There was a daily ward round with input from nursing and physiotherapy. Multidisciplinary team members such as the pharmacist, microbiologist and speech and language therapist had a handover every time they visited the unit.
- There was a weekly multidisciplinary meeting on the unit that had input from medical, nursing, pharmacy, speech and language therapy and physiotherapy.
- Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in their notes.
- The unit had a dedicated team of physiotherapists.
- There was a dedicated critical care and CICU pharmacist, although the current pharmacist's availability did not meet best practice guidance.
- All patients with a tracheostomy were assessed by a speech and language therapist. In addition, a dietician provided support to the units.
- Medical staff reported that the critical care unit provided effective care because of strong "team working".

Seven-day services

- There were at least two intensive care consultants present in the critical department from 8am to 10pm seven days a week.
- One consultant anaesthetist provided medical cover for the 13 intensive care and six HDU beds in the CICU during the day. The same consultant would cover a 24-hour period and would be available on call overnight to ensure patient continuity.
- On each unit a registrar was on duty overnight and a consultant was on call from home. Staff we spoke with said that, when needed, the consultant would attend the units within 30 minutes. This meets best practice guidance.
- Ward rounds took place twice a day, seven days a week.
- All potential admissions were discussed with a consultant, who reviewed the patient within 12 hours of admission.
- A physiotherapist was on duty at weekends.
- Radiology services were led by a consultant who was available for urgent x-rays and scans.
- There was access to pharmacy services seven days a week. During the evening and overnight, a senior nurse was able to request an on-call pharmacist to ensure that patients had all the required medicines.

Critical care

Are critical care services caring?

Good



Patients and their relatives we spoke with said that staff were caring and compassionate. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way.

Patients and relatives were given good emotional support, and throughout our inspection we saw patients treated with compassion, dignity and respect.

Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients we spoke with were highly complimentary about all the staff in both critical care and CICU. Relatives told us that staff were mostly caring.
- There were appropriate arrangements in place to maintain patients' privacy and dignity. There were privacy screens or curtains around each bed space with a note to remind staff to ask before they entered. We also observed staff trying to maintain the dignity of a confused and agitated patient by ensuring that they were covered by bedding and their hospital gown.
- Both units took part in the Friends and Family Test. The Friends and Family Test is an independent survey that asks patients on discharge how they rated the ward or department and if they would recommend the ward or department. It is unusual for patients to be discharged directly from either the critical care unit or the CICU. However, three out of three patients who received care on the CICU said that they were likely to recommend the unit.

Patient understanding and involvement

- The nature of the care provided in a critical care unit means that patients cannot always be involved in decisions about their care. However, whenever possible the views and preferences of patients were taken into account.
- Critical care staff worked closely with the organ donation team. This enabled them to discuss loved ones' wishes in relation to organ and tissue donation

with their relatives. Staff we spoke with told us that, as a result of these close working relationships, they were able to discuss organ donation with a greater number of relatives than they had done previously.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support. For example, one patient had written to the local newspaper describing their experiences and praising staff within the critical care unit.
- The trust had developed support groups for patients and relatives. Staff invited patients to the ICU Steps meetings, which provided a support group for patients who had been in critical care. Patients were able to speak about their experiences and discuss unpleasant ongoing symptoms such as hallucinations. Staff told us that this group had identified the value of emotional support and discussing problems.
- The units had support groups for bereaved relatives. A chaplaincy service was also available and provided valuable support to patients and relatives.
- After admission, the consultant covering the unit would arrange to meet with relatives to update them on the patient's progress. When necessary, further face-to-face meetings were organised.
- The relatives we spoke with said that they had mostly been updated and had opportunities to have all their questions answered.

Are critical care services responsive?

Requires improvement



The critical care services required improvement to more fully meet patients' needs. While staff did their best to ensure that patients who required a critical care bed received one as soon as possible, the lack of available beds meant that there were sometimes delays. There should be sufficient critical care capacity available to ensure that patients receive timely care in the critical care unit and to reduce the number of cancelled operations. The challenges

Critical care

of capacity will not be addressed along by the opening of ward 600 unless the issues of patient flow and discharge are addressed.. The imminent opening of ward 600 will provide improved facilities for visitors.

Service planning and delivery to meet the needs of local people

- We observed a trust bed management meeting; these happened three times a day. We saw that decisions were made to manage the beds across the trust and included the availability of critical care beds. We saw that staff prioritised the patients whose needs were greatest but sometimes, due to a lack of suitable beds, planned operations had to be cancelled or postponed.
- Ward 600, the new critical care ward, was planned to provide improved facilities for critically ill patients and their relatives, such as overnight accommodation for relatives and an improved waiting area.
- The current critical care unit has an occupancy rate of 98% and frequently struggles to meet the demand for critical care beds. The new critical unit has one additional bed, which may mean that the trust will not have sufficient critical care beds for local people.
- The hospital provides cardiac surgery for people within the Bristol area and also in the South West. Staff told us that CICU had increased the number of level 3 (intensive care) beds from 10 to 13 to meet the increased needs of cardiac surgery patients who required care within the CICU. We were told that there was a need to further increase the number of level 3 beds to meet the increasing demands for cardiac surgery; however, this requirement could not be met at the present time due to medical cover. The trust told us that no decision had been made to further increase the number of level 3 beds in CICU. However, that it recognised that there would need to be an increase in the medical cover if these beds were commissioned.

Access and flow

- Between 1 September 2013 and 31 August 2014, figures showed that the combined bed occupancy for the trust's critical care beds was 98%. This is higher than the national average bed occupancy rate for critical care of 86%. The bed occupancy is also above the Royal College of Anaesthetists' recommended critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests that a unit is too small, and occupancy of 80% or more is likely to result in non-clinical transfers that carry associated risks.

- ICNARC data showed that non-clinical transfers from critical care were better than the national average.
- ICNARC data showed that the critical care unit performed worse than the national average for out-of-hours discharges.
- Between April 2013 and August 2014, 153 operations were cancelled due to the lack of available critical care beds (this may include the intensive therapy unit (ITU), the high-dependency unit and CICU).
- ICNARC data showed that the critical care unit performed worse than other comparable units for patients whose discharge from the unit was delayed for more than four hours due to beds not being available on either surgical or medical wards. This meant that other patients could not be admitted to the unit.
- Between March 2014 and August 2014, 139 patients were accommodated in the theatre recovery unit because there was no bed or no specialised bed (this would include a critical care bed). While the recovery unit had experienced staff and specialist equipment, it was not a suitable area in which to accommodate patients for more than a few hours due to the lack of basic facilities such as privacy curtains or sufficient privacy screens and toilet and washing facilities.
- Patients who were discharged home from the unit were aware of their discharge plans and had appropriate records or information given to them or to those providing ongoing care.
- All professionals involved with a patient during their admission to the unit contributed to the plan for their discharge.
- We observed that the nurse in charge actively ensured that admission was given to the patients in greatest need and prioritised patients who needed surgery and a period of critical care nursing.

Meeting people's individual needs

- The critical care units provided care to people with complex needs. Staff told us that additional support was made available if they had a patient with additional needs, such as a learning disability or mental health difficulties, or a patient living with dementia. We observed this during our visit and additional arrangements were also made to support ward staff before one patient was discharged to the ward.
- Translation services were available both by phone and in person.

Critical care

- Staff demonstrated a good understanding of people's social and cultural needs and explained to them how they could raise concerns or make a complaint.
- Relatives were encouraged to visit. There were identified visiting hours to enable patients to rest. Flexible visiting times were at the discretion of the nurse in charge for new admissions and patients who were at the end of life.
- A noticeboard was observed during our inspection in the relatives' waiting room that allowed them to add suggestions. In the CICU, a patient had told staff that the pressure-relieving mattress was very uncomfortable; as a result of this feedback, the unit now offers an alternative mattress.
- There were three visitors' rooms available within the critical care wards: one for ward 3, one for ward 99 and one for the CICU. During the two days of our inspection we observed distressed and grieving visitors sitting on chairs in the corridor outside ward 99 as the visitors' room was already in use. The matron explained that, sadly, they had had more than one patient death and the visitors' room was already in use when the second family attended each day. The matron said that families were reluctant to go away from the unit as they wanted to be close if there was any change in their loved one's condition.
- Another relative told us that they had been unable to get a drink as the tea- and coffee-making facilities were in the visitors' room, which they had been unable to access for the previous two days.
- When we visited ward 600, we observed that there were improved facilities for visitors that would afford them greater privacy and comfort, with drinks if required.

Learning from complaints and concerns

- There had been 12 complaints between April 2013 and March 2014. We saw that complaints were investigated and the outcome of the complaint recorded with any learning identified. The matrons told us that complaints were discussed across divisions to ensure that learning could be shared across the hospital.
- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the shift leader. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.

- Complaints posters were displayed within both the critical care unit and CICU and information leaflets were available.

Are critical care services well-led?

Good



The matrons for critical care and the CICU had both been in post for less than 12 months. Both matrons, although new to the post, had identified areas for improving and developing the services they managed. Clinical leadership from consultants within critical care was also seen to be good. However, there was a lack of clarity around governance arrangement from CICU consultants. The leadership team ensured that there was shared learning in the team and support for staff. ICNARC data showed that mortality rates were lower than those in comparable units.

We saw that there was a culture of learning from incidents and complaints that was facilitated by robust management arrangements.

There was insufficient bed capacity for the number of patients requiring a critical care or CICU bed. Operations were being cancelled and some patients cared for outside the critical care units due to the bed shortfall.

Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty were the expectation for unit staff and encouraged at all levels. Staff were also encouraged to complete incident forms or raise concerns. Staff worked well together and there was obvious respect for everyone working in the unit. Risks were being managed appropriately. Staff were encouraged and supported to be involved in quality improvement projects and we were shown several examples of innovation.

Vision and strategy for this service

- The organisation's values were discussed with the staff teams. Staff were asked to reflect on how behaviours met, or did not meet, the values. The organisation's values were also sent to prospective staff members as a reminder of the expectations of the organisation.
- A review of the skill mix for both critical care and CICU was in place and recruitment of additional and more experienced nurses had started.

Critical care

- Capacity issues for the service were identified. A new critical care unit was due to open. However, the new unit capacity was just one more bed than current capacity. There were no effective plans to deal with the patient flow and discharge issues.

Governance, risk management and quality measurement

- The division held monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were fed back to staff.
- The critical care and CICU managers encouraged staff to report incidents and staff confirmed that they received feedback on the incidents they reported.
- Critical care consultants were motivated and committed to improving the quality of the service that critical care provided.
- There was a lack of clarity around governance arrangements from consultants who worked within CICU, such as information collected on the performance of the unit.
- Risks inherent in the delivery of safe care were identified on the trust's risk register: for example, the risk of insufficient critical care capacity to meet fluctuations in demand. Supporting actions were identified and discussed at governance and board meetings.
- A root cause analysis was undertaken following each serious incident. Investigations undertaken detailed identified actions to reduce the risk of further similar incidents in the future.

Leadership of service

- Critical care and CICU were within different divisions and had different leadership and management arrangements. Both critical care and CICU had a consultant intensivist who was the medical clinical lead. The strong leadership between consultants on intensive care contrasted with the leadership in the CICU.
- Both critical care and CICU had a matron (band 8) who had a specialist qualification in critical care or cardiology in addition to a management qualification.
- There was a supernumerary band 7 nurse who was in charge of each shift.
- Matrons said that they were supported by the divisional management and executive team and felt that the head and deputy head nurses were approachable and supportive.

- The leadership ensured that there was shared learning and support for critical care and CICU staff.
- There was a band 8 nurse who managed the critical care unit who was experienced and qualified in critical care nursing. This met good practice guidelines.
- Most staff reported that their matron was visible and approachable. Staff generally reported that the leadership of both units was good, although, particularly in critical care, they felt that it was stretched by bed management as this frequently took the nurse in charge away from the day-to-day management and supervision of staff and patients within the unit.
- Each shift was led by a band 7 nurse with supervisory responsibility for the staff working with them.
- The critical care unit had a band 7 clinical nurse educator. A proposal to increase the nurse educator role to 1.8 whole time equivalents had been agreed. This would meet good practice guidance.

Culture within the service

- Staff working on both the critical care unit and CICU spoke positively about the service they provided for patients.
- Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty were the expectation for both units and encouraged at all levels. Staff were encouraged to complete incident forms or raise concerns.
- When an incident was reported, as part of the learning from the incident staff were asked to complete a reflective practice report. This report included the member of staff's views of the incident, both negative and positive, and what they had learned as a result of the incident.
- Staff worked well together and there was obvious respect for colleagues. Staff reported that relationships with other departments in the hospital, such as theatres, worked well.

Public and staff engagement

- There was ongoing consultation with staff about changes and developments for both units.
- Staff and patients had been consulted about their views and needs for the new critical care unit.
- Patients and visitors were asked to feed back their experiences of care. We saw 'You said, we did' information displayed in the visitor rooms and also in prominent areas on the units. Improvements made had included the improved arrangements for visitors within

Critical care

ward 600 and arrangements to make the wards darker were in place. Some patients and visitors identified that ward 99 appeared dark; others commented that critical care was noisy and patients were unable to sleep.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Staff were able to give examples of practice that had changed as a result. For example, the computerised patient records system, referred to by staff as the 'plasma screen', had been developed by consultants and nurses from the unit and provided ongoing monitoring of optimal care for patients. Doctors and nurses said that this system had ensured that ventilated patients received appropriate ventilation, as it highlighted if flow rates were higher than required. The outcome of this was that patients were able to come off ventilators sooner, which shortened patients' length of stay.
- Improvements were identified to prevent pressure ulcers for prone patients. These included changing the way patients were moved and positioned.
- Staff told us that innovation was encouraged in the department and within the hospital. Recently, critical care nursing staff had spoken to national conferences on how they had reduced pressure ulcers for prone patients.
- The matron for critical care identified that there had been no system within critical care to identify and manage staff who had made a drug error. This had been addressed and a new procedure was in place to ensure that consistent actions were taken to reduce the risk of further errors.
- Both units had cost improvement programmes. Initiatives that were in place to identify such improvements included a review of the use of the most frequently prescribed medications and a reduction in drug wastage. Staff sickness had been improved by meeting monthly with staff who were off sick to check whether anything could be changed to assist the staff member back to work.

Maternity and family planning

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

Information about the service

Maternity services were located at St Michael's Hospital, which was part of the University Hospitals Bristol Main Site. The trust provided services to the local community of Bristol and also provided tertiary services as a regional referral centre for women who had medical conditions themselves or if there were concerns about the health of the baby.

Services included antenatal, induction of labour and postnatal care provided in 44 beds on wards 71 and 74. Transitional care (where babies can be cared for alongside their mothers) was provided on ward 76, which had 16 beds. A midwifery-led unit, opened in June 2013, had four en-suite rooms, two with a birthing pool.

There was an obstetric-led unit, with 16 rooms, one with a birthing pool. The rooms were undergoing phased refurbishment at the time of our inspection, with one room being closed at a time to ensure that the service could still be provided effectively.

There were designated obstetric theatres in St Michael's Hospital that were manned 24 hours a day.

Obstetric and specialist clinics were run by obstetricians and specially trained midwives along with other specialist consultants as required (for example, a cardiologist). Where appropriate and where needed, some specialist clinics were held in the community: for example, teenage pregnancy clinics were held in areas with high rates of teenage pregnancy and social deprivation, as well as at St Michael's Hospital.

There was a consultant-led fetal medicine unit for women who might need specialist tests such as chorionic villus sampling and amniocentesis. Specialist screening midwives worked closely with the women who attended these clinics.

There was a multi-professional (consultant, specialist midwife, sonographer and laboratory) early pregnancy assessment unit, managed by the gynaecology service.

Antenatal clinics were held five days a week, Monday to Friday, at St Michael's Hospital and in community settings such as health centres and community clinics.

Ultrasound scans were carried out adjacent to the antenatal clinic. The service was provided by trained sonographers. Additionally, there were also some midwives trained to carry out ultrasound scans, for example in the day assessment unit for dating purposes and/or fetal wellbeing.

The day assessment unit (triage) had five beds and seating facilities with access to an examination room. The unit was open from 8.30am to 6pm on Monday to Friday with occasional Saturday morning opening.

Community midwives were based at surgeries and health centres around the local Bristol community.

There were specialist physiotherapists trained to work with women during pregnancy and following birth.

Between 1 April 2013 and 31 March 2014, there were 5,412 births across the whole of the service.

Maternity and family planning

Summary of findings

The maternity and family planning services were found to be good in the safe, effective, caring and responsive domains and outstanding in the well-led domain. The maternity services provided care and support in accordance with recommended guidance. Audit systems in place meant that practices were monitored continuously and action was taken when improvements were required. Staff were confident in reporting incidents, telling us that they had confidence that any lessons learned would lead to the necessary change in practice.

There were times when records were left unattended on the postnatal ward, meaning that confidentiality of information was not always assured.

The services had enough resources, including equipment and staff, to meet the needs of women, although the midwife-to-women in labour ratio was lower than the recommended level. On occasion, sanitary bins on the postnatal ward were overflowing and domestic staff on the labour ward had not always cleaned a room within the set timescales. Staff told us that discussions were ongoing with the trust's hotel services team who were involved in the provision of domestic staff.

Staff at all levels undertook the required training and assessments of their competencies were ongoing. Midwives had regular supervision of their practice. Staff reported that they had opportunities to develop their skills.

Women's individual needs and level of risk were taken into account when planning their care. As a regional referral centre, the maternity services worked with a range of other services to ensure that women's plans for their pregnancy were carried out where possible.

Feedback from women and their families was positive about the services they received, the level of support and information they received and the way in which their dignity and privacy were maintained.

Leadership in the maternity and family planning services was outstanding. There was a high level of satisfaction amongst staff. There was evidence of strong

collaboration and support across the service. Staff spoke of an open, supportive and friendly culture, with "great teamwork". Leadership was encouraged at all levels within maternity services. Staff were able to input ideas and were empowered to find and implement solutions. The team worked cohesively with open communication and all members of the staff team felt they were able to speak up and were listened to. This led to a highly functional team.

The service had a proactive and well-defined governance structure. Meetings existed that oversaw activity, performance, quality, safety, audit and risk. Issues were escalated within the trust, as required.

There was strong engagement with patients and a focus on gaining greater involvement in the MSLC from patients groups who represented the local population using the service.

Continuous improvement was embedded within the service with multidisciplinary working parties empowered to develop, discuss and test new ideas and guidance. Innovative approaches were adopted to resolving challenges.

Maternity and family planning

Are maternity and family planning services safe?

Good



Midwifery levels were sufficient to provide one-to-one care and support to women in labour, enabling a safe service. There was 24-hour medical cover, seven days a week. The labour ward (central delivery suite) had over 80 hours per week of designated consultant cover, which is more than the Royal College of Obstetricians and Gynaecologists (RCOG) recommended standard for a service delivering more than 2,500 and fewer than 6,000 women per year.

All areas within the maternity service were tidy, with equipment stored in locked rooms or appropriate corridor space. Staff told us that they reported incidents via their electronic reporting system. Staff told us that they always got an email that provided feedback about incidents they had reported with outcomes of any investigations that had taken place.

We found the way in which the medical and midwifery teams were organised ensured that mandatory training was attended consistently, due to good advance planning and sufficient staffing numbers to ensure that all shifts were covered when staff were attending training. All midwives must have access to a supervisor of midwives (SoM) at all times, according to the Nursing and Midwifery Council's Midwives Rules and Standards (rule 12 of 2004). Midwives told us that they had access to an SoM at all times and had regular support and supervision sessions with them.

Incidents

- All staff we spoke with stated that they were encouraged to report incidents and were aware of the process to do so.
- Incidents were reported on the trust's electronic incident-reporting system. Staff told us that they always got an email that provided feedback about incidents they had reported with outcomes of any investigations that had taken place. Staff were able to describe learning from incidents and changes in practice that had been implemented as a result. For example, the results of unsatisfactory nuchal translucency scans (a scan used to assess for possible Down's syndrome) for four women were not communicated to the women

until after 20 weeks of pregnancy, by which time it was too late to offer an alternative method of non-invasive prenatal screening, and so the women did not have the reassurance of a normal screening test result. All of the babies were subsequently born without Down's syndrome. As a result, a new system was introduced whereby a daily list of scan results was faxed to the community midwives office and followed up by a telephone call to ensure that the fax had been received. The midwife then telephoned the women with the results. This process was recorded at every level for audit purposes.

- Incidents were discussed by the corporate risk team and patient safety team. The local incident team then investigated appropriately.
- Perinatal mortality and morbidity meetings took place monthly. We saw the minutes for February 2014. Case reviews were discussed, with learning points detailed for each one.

Safety Thermometer

- We saw that incidences of new venous thromboembolisms (VTEs), urinary catheters and urinary tract infections (UTIs) were reported via the Safety Thermometer system. The trust rates for VTEs and UTIs were consistently below the England average.

Cleanliness, infection control and hygiene

- Incidences of infection were reported as required.
- Cases of methicillin-resistant *Staphylococcus aureus* (MRSA) were within the accepted range and *Clostridium difficile* rates were within an acceptable range. Maternity services were not identified as outliers for these infections.
- We saw staff observing good hand-hygiene practices and using gloves and aprons where necessary. These were readily available in all of the departments we visited. There were hand-washing sinks available throughout the departments with liquid soap, paper towels and pedal bins at each one.
- Liquid hand-sanitising gel and notices encouraging its use were displayed at the entrances to all of the maternity departments.
- The results of the internal monthly hand-hygiene audits were displayed on large boards at the entrance to the units. Compliance was good.
- We saw all staff adhering to the trust's 'bare below the elbows' policy.

Maternity and family planning

- The ward and departments we visited and equipment were clean. Women and visitors we spoke with all said they thought the units were clean. We saw evidence that equipment had been cleaned and documents to indicate when it had been cleaned and who had undertaken the task. However, there was no system in place for showing when a resuscitaire, for example, had been cleaned following each use apart from the routine daily check.
- Some of the bins used for sanitary products on the ante- and postnatal ward were too small and therefore overflowing. The two we saw that were adjacent to bays in constant use were not only unsightly but one had started to cause an odour. The two bins were changed while we were on the ward. The matron said that there had been complaints from women in the past and the issue had been raised at various meetings. As a result, more bins (although not bigger bins) were supplied. Staff had to double-bag the full bins and store them until the contractors collected them during their routine collections. There was a notice by each bin to say that, if the bin were full, people should see a member of staff who would ensure it was changed.

Environment and equipment

- Entry to the labour suite and wards was via a swipe card for staff and via a locked door, controlled by a buzzer, for visitors.
- All areas within the maternity service were tidy, with equipment stored in locked rooms or appropriate corridor space.
- There were two obstetric theatres and a dedicated recovery space. Midwives reported that there was sufficient equipment to meet patients' needs and for use in emergencies.
- Emergency equipment was checked and documented daily.
- Emergency resuscitation equipment was available for both mothers and babies and was checked regularly.
- There was a hoist available in the midwifery-led unit and in the labour suite. This enabled the swift evacuation of a woman from a birthing pool in the case of emergency and ensured that the safety of staff was maintained.
- We saw outside contractors on the labour suite who were involved in the refurbishment programme. There had been a risk assessment carried out, for example of the equipment they used and the dust caused.

- Midwives told us that there had been some comments about the clinical look of the antenatal waiting room, which was also used by women waiting for ultrasound scans and for the fetal medicine and other specialist clinics. We were told that women were being asked to make suggestions about how the environment could be improved.

Medicines

- Medicines were stored in locked cupboards and trolleys throughout all of the units.
- Medicines that required storage at a low temperature were stored within a specific medicines fridge. All of the fridge and freezer temperatures were checked or recorded daily.
- Nitrous oxide for pain relief was piped into the delivery rooms. Stronger analgesia was available for women in labour.
- Midwives told us that they received support from the on-site pharmacist, when required.
- We saw that there were packs of medicines ready to take home on the postnatal ward so that women did not have to wait for their medicines and could go home once they were discharged.

Records

- Women had hand-held records from their initial booking through to completion of their postnatal care by the midwives. The hand-held records meant that staff had direct access to notes carried by the patient; without these, sometimes a practitioner might not be able to access relevant notes on a computer due to connection difficulties or no access to a computer.
- Previous medical records were obtained in the antenatal period to allow staff to look at the woman's history and review the details of previous deliveries. The notes were held securely in the hospital until the postnatal period.
- The eight patient notes we looked at were well organised and contained the relevant information, including risk assessments and detailed plans of care.
- The antenatal and newborn screening coordinator described the challenges faced in trying to collect data for local and national requirements from in-house records and community midwives' records. They added that a new system was being developed to make collection easier and, in turn, to ensure its accuracy.

Maternity and family planning

- We saw modified early obstetric warning score (MEOWS) documents, baby observation charts and baby check records prior to discharge being completed appropriately.
- We saw some records left unattended when a paediatrician was carrying out baby checks prior to their discharge. The problem arose because there were two nurseries in use for this process, and what used to be two wards were now being operated as one, with the paediatrician using the one nearest to the mother's bed. This meant that some notes were left in one nursery while the paediatrician was in the other.
- The early pregnancy assessment unit was attended by junior medical staff at weekends. Midwives felt that they had to check the documentation on Monday mornings to ensure that it had been completed correctly in line with best practice. They told us that this sometimes impacted on their planned workload for the morning. These concerns had been escalated and detailed on the risk register.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked to sign appropriate consent forms. At the time of the inspection, there were no women without capacity to consent to their procedure.
- Midwifery staff we spoke with showed a good understanding of the Mental Capacity Act 2005 and its relation to decision making in the antenatal, labour and postnatal period.
- The termination of pregnancy consent form states that the "baby will be sensitively disposed of unless you say otherwise". We saw that these had been signed by the woman and a doctor.
- There is no consent form that needs to be signed for the disposal of fetal remains. However, guidance says that women should be offered a choice of how to manage the remains and the conversation should be recorded in the woman's notes. While we heard that the conversations always took place, they were not always recorded in the notes. We were told that, once the expected new guidance had been issued by the Human Tissue Authority (HTA), the maternity services would amend their policy to ensure that the conversations were recorded.

Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding process and aspects of the associated Mental Capacity Act 2005.
- There were systems in place to identify people in vulnerable circumstances from the local community and the wider community served by the maternity services. Midwives told us that working relationships with organisations in the wider community were established and allowed for relevant information sharing.
- There were clear pathways for the escalation of concerns to senior staff and the chief nurse if required.
- Staff were aware of their responsibilities with regards to safeguarding and had undergone training to level three.
- Noticeboards throughout the hospital displayed information about safeguarding and how to raise safeguarding concerns.
- We were told that the outside contractors working on the delivery suite had been checked by the Disclosure and Barring Service (DBS).

Mandatory training

- We found the way in which the duty rotas were organised ensured that mandatory training was always attended, due to good advance planning and the staffing numbers being sufficient to ensure that all shifts were covered when staff were attending training. Staff reported that very occasionally a teaching session had to be cancelled due to unexpected staff sickness, but the session was always rearranged.
- Staff told us that compliance with mandatory training was good. Training records showed that some areas fell below the required targets. Staff told us that there had been issues with a new system of recording training and the figures were lower than actual attendance. There were dedicated practice development midwives who monitored attendance and organised training sessions. Staff said access to training was good and midwives attended the trust's mandatory training as well as obstetric emergency skills training, and neonatal and adult resuscitation training.
- Additional skills training could be accessed if recognised through appraisals and supervision sessions.

Assessing and responding to patient risk

- All staff we spoke with had attended annual obstetric emergency skills training.

Maternity and family planning

- Maternity services used the MEOWS system to record observations. They also used a detailed newborn observation system. Staff we spoke with were able to describe at what point care needs would be escalated to a senior midwife or a doctor.
- Staff used the Situation, Background, Assessment, Recommendation (SBAR) communication tool when handing over or discussing concerns, for example in situations where high-risk women on the postnatal ward had had a caesarean section during the second stage of labour. The tool ensured that these women were offered a postnatal appointment to check they had recovered appropriately.
- The labour suite was consultant-led. There was access to a neonatal intensive care unit (NICU) with 12 intensive care cots. As the unit often dealt with high-risk women, part of the risk assessment carried out sometimes included planned admission of the baby to the NICU or transitional care ward as they may have needed extra care and support immediately following birth.
- Some women with medical conditions needed to be admitted to a specialist ward at the Bristol Royal Infirmary, such as the cardiology ward, either ante- or postnatally. These women would be seen daily by a member of the obstetric team as well as by a midwife. We saw detailed care plans in place for women with cardiology conditions. They were held by the patient, in the emergency department (A&E) at the Bristol Royal Infirmary and on the delivery suite.
- We saw that the World Health Organization (WHO) surgical safety checklist was completed as required. The checklist identified three phases of an operation: before the induction of anaesthesia ('sign in'); before the incision of the skin ('time out'); and before the patient left the operating room ('sign out'). In each phase, a checklist coordinator had to confirm that the surgery team had completed the listed tasks before it proceeded with the operation.
- One consultant explained to us that, although the unit needed more midwives (acknowledging that 10 were about to start in October 2014), the maternity services were safe because of the "flexibility, loyalty and hard work of the staff". Another told us there were "detailed systems in place in terms of escalation processes that staff were very aware of and used appropriately".

Midwifery staffing

- The trust does not meet the national benchmark for midwifery but achieves one-to-one care for women during their labour consistently by a variety of innovative measures.
- RCOG guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) recommends that there should be an average midwife to birth ratio of 1:28. These figures were derived from Birthrate Plus (workforce planning for midwifery services) and do not take into account the effectiveness of a combination of other staff, such as registered general nurses (RGNs) and support workers, who are able to take on some non-midwifery roles. The King's Fund document Staffing in Maternity Units: Getting the Right People in the Right Place at the Right Time (2011) explores staffing levels including the use of trained nurses and maternity support workers and their effective deployment to assist midwives.
- The ratio of midwives to births was 1:34 at the time of the inspection. To mitigate this and ensure that women always received one-to-one care during their labour the trust had employed three RGNs to release midwives to carry out midwifery-specific roles. The RGNs recovered women after caesarean sections, carried out medicine rounds on the ante- and postnatal ward and helped with the care of 'high-dependency women' in the labour suite. To further release midwives to carry out their role, the labour suite had 24-hour ward clerk cover. This meant that midwives did not have to, for example, answer the door, answer the phone, request notes or always deal with hotel services issues. We were told that 10 newly qualified midwives, who had all trained at the trust, were starting work in October 2014. They were to work as band 4 maternity assistants until they got their registration number and had completed their full programme of induction. This would further improve the midwife to birth ratio. We were told that at the time of inspection the trust funded the maternity unit for a maximum ratio of 1:32 midwives to births.
- We were told that the staffing ratios were arranged as 80% midwives to 20% other staff, as opposed to the more usual 90% midwives to 10% other staff. We were told that this arrangement worked well for the maternity services the trust provided.
- We were told and saw that some maternity assistants were trained to assist in clinics, conduct mother and

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baby observations, take blood (venepuncture) and carry out routine electrocardiographs (ECGs) on the ward. They were experienced and midwives told us they reported any concerns about women's or their babies' welfare appropriately and quickly. In the community, similar staff were known as maternity support workers and helped women with concerns about feeding their babies and with clinics, among other things. Staff told us that there was a number of volunteers who helped with breastfeeding (following training) and with the antenatal tours of the units.

- There were five midwives on call out of hours, including a community midwife, a supervisor of midwives and an experienced on-call midwife. We were told that the units did not use agency midwives who would not necessarily be familiar with the units, but that the trust employed bank midwives who worked on the units regularly.
- The transitional care ward had neonatal nurses as part of its establishment, which also enhanced midwifery care.
- Midwives, obstetricians and women we spoke with told us that there were sufficient staff on the unit to always provide one-to-one midwifery care to women during their labour. Women we spoke with confirmed that they had received one-to-one care during their labour.
- All midwives must have access to a SoM at all times (according to the Nursing and Midwifery Council's Midwives Rules and Standards (rule 12 of 2004)). The ratio of SoMs to midwives was 1:16. This was above the recommended ratio of 1:15. SoMs are required to carry out annual reviews with all midwives. All midwives we spoke with had received a supervisory review and were aware of how to contact a supervisor if required. SoM contact details were on noticeboards throughout the units. SoMs we spoke with told us that they enjoyed their role and were able to support midwives as required.

Medical staffing

- There were 12 consultant obstetricians with a variety of lead roles, including fetal medicine, training, obstetric ultrasound, normal birth, maternal medicine and clinical governance. There were nine gynaecologists, some of whom were also obstetricians or had an interest in early pregnancy; they too had a variety of lead roles. The consultants were supported by a team of medical staff. There was very little use of locum doctors and no current medical vacancies.

- All grades of medical staff we spoke with told us that the whole team worked together well and was described as a "very functional unit". One doctor told us that "this is a brilliant place to work" and everybody was "supportive".
- The labour ward had 80 hours per week of designated consultant cover. This was more than the RCOG recommended standard for a service delivering more than 2,500 women and fewer than 6,000 per year. We saw and were told that there was "good consultant cover" and presence on the labour suite, including at weekends.
- The labour suite had medical cover 24 hours a day, seven days a week. At weekends, consultants had fixed sessions on the labour ward in the mornings; consultants also carried out telephone ward rounds with the medical staff on duty twice a day at weekends and would come into the unit if required. Midwifery and medical staff confirmed that they felt supported by the consultant group.
- There was anaesthetic cover for the birth suite seven days a week, 24 hours a day. Staff reported no delays in accessing anaesthetic support when needed, for example to provide an epidural to a labouring woman.

Major incident awareness and training

- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually.
- The trust had a major incident plan that was available on all units.

Are maternity and family planning services effective?

Good



The maternity and family planning services provided effective services. Staff followed nationally recognised guidance, policies and procedures.

Women had choices regarding pain relief in labour. There was an anaesthetist available 24 hours a day for women who chose to have an epidural.

Communication between obstetric, medical, anaesthetic and neonatal staff, midwives and allied health professionals (AHPs) such as sonographers and physiotherapists was described as excellent. Obstetricians

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and gynaecologists spoke about the respect they had for the midwives and AHPs with whom they worked. They told us that the whole team was flexible and worked to meet the individual needs of the women and their babies.

As a regional referral centre, the unit had many external arrangements with South West and South Wales providers. These ranged from transfers between sites for mothers and babies, screening tests that could not be carried out at local units and arrangements for the care of women with complex medical conditions who needed specific care and support.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with both National Institute for Health and Care Excellence (NICE) and RCOG guidelines Safer Childbirth (2007) and Termination of Pregnancy for Fetal Abnormality (2010). The policies and procedures were available on the trust's intranet. We saw examples of policies available, including on when to carry out an induction of labour, how to assess a woman's suitability to use the midwifery-led unit and how to manage water births.
- There was evidence available to demonstrate that women using the maternity services were receiving care in line with NICE quality standards 22 (which related to routine antenatal care), 32 (caesarean section) and guidance 37 (for postnatal care).
- Care was seen to be provided in line with RCOG's guidelines Safer Childbirth (2007). This included the organisation and delivery of care in labour, the arrangements around staffing levels, roles, facilities and equipment provision. The arrangements for continuous professional development supported the principles underpinning the guidance. Staff we spoke with were able to talk in detail about how guidance had been reviewed and incorporated into practice.
- Working parties were set up to develop new guidelines. We saw that these were well attended by the appropriate professionals. Staff spoke enthusiastically about the groups and how they had helped to develop new systems and practices when guidance had changed or following incident investigations when improvements needed to be made.
- We reviewed information relating to various audits and working parties, for example around perinatal mental health assessments of women. The maternity services did not have a dedicated perinatal mental health team and wanted to ensure that women were being assessed

and referred appropriately. It was clear that there were good working relationships between the maternity services and relevant mental health services across the city and the region. However, as a result of the audit and working party, a psychologist was soon to be employed to enhance the service offered.

- The trust acknowledged that NICE guidance on ectopic pregnancy and miscarriage (CG154, December 2012), which said that women with previous similar issues should be able to self-refer to an early pregnancy assessment clinic (EPAC), was not being met. On the risk register it stated that the current commissioners of care did not support self-referral and that women were currently asked to contact their GP. The risk register stated that this "potentially adds a delay to their [the women's] treatment pathway and could result in less invasive treatments e.g. medical management of ectopic pregnancy being unsuitable". The issue had been added to the risk register in May 2013 and was still rated as high risk. Staff we spoke with were aware of the concerns and knew that work was ongoing to try to improve the service offered.

Pain relief

- There was anaesthetic cover 24 hours a day, seven days a week, providing women with the option of an epidural if they chose. Midwives reported that women did not have to wait more than 20 minutes to see an anaesthetist. The delivery rooms had piped nitrous oxide (Entonox®), which meant that it was available to women at all times during labour. It was also available in the midwifery-led unit and carried by community midwives. In addition, opioid analgesia was available to labouring women, if required.
- Women we spoke with told us they were offered pain relief for perineal tears and post-operatively following caesarean section. They said that they did not have to wait long for their medication if they asked for it in between medicine rounds.

Nutrition and hydration

- Women were encouraged to breastfeed. Breastfeeding initiation rates for deliveries that took place in the hospital for April 2013 to March 2014 were reported as 82%, well above the average national rate.
- There was a milk storage fridge for expressed breast milk and made-up feeds. Breast pumps were available to women who were expressing milk.

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- There was an infant feeding coordinator, who trained midwives, maternity assistants (in the hospital) and maternity support workers (in the community) in aspects of breastfeeding and bottle-feeding. They also advised and supported parents of babies who had special feeding needs.
- The trust had level 3 UNICEF Baby Friendly Initiative status.
- We saw that snacks, cold drinks and facilities to make hot drinks were available on the ante- and postnatal ward, so women had access to nourishment if they needed it outside the set meal times.

Patient outcomes

- The maternity service had a maternity dashboard, which was reviewed regularly at the maternity services patient safety meetings. This used a red/amber/green flagging system to highlight areas of concern. This was provided to us prior to the inspection.
- Our 'intelligent monitoring' system showed that the maternity services (including home births, St Michael's Hospital and Ashcombe in Weston-super-Mare) achieved a normal vaginal delivery rate of 61%. The national average for normal vaginal deliveries was 60.4%.
- According to the 'intelligent monitoring' system, no risk was identified in maternal readmission, elective caesarean section (CS) rates (12% trust rate compared with 10.8% England average) or emergency CS rates (11.6% trust rate compared with 14.8% England average). The overall caesarean section rate was 23.6% compared with the England rate of 25.6%. The higher-than-average rates for elective CS could be because the trust provides services to high-risk women from the wider South West regions and parts of South Wales, meaning that there may be assessed medical reasons for planning to have a CS.
- The number of instrumental deliveries (forceps or ventouse) was within the trust's own range of 10% to 15% for all of the previous 12 months.
- The induction of labour rate was recorded as being 30.8% against the trust's own target of 27.5%.
- Vaginal birth after caesarean section (VBAC) clinics were not held as staff reported that they routinely offered this option to women: it had become embedded in practice and was part of their normal processes. This was

considered to be good practice and resulted in a higher rate of VBACs (75.5% for the year to April 2014) than the median average of 40% (Promoting Normal Birth, 2010, Department of Health).

- There was a standard operating procedure for women where there was the possibility that they may require interventional radiology. The women were admitted to the main hospital so that they could be operated on in the main theatres. For emergency cases, such as bleeding post-delivery, they had to be transferred by ambulance to the main hospital where facilities were available.
- There was one reported unplanned admission to the intensive care unit from the obstetric unit in the last 12 months.
- Staff we spoke with at all levels told us that they thought there was a robust audit cycle. There were ongoing audits for rates of third-degree tears, post-partum haemorrhage, infection control, transfers from the midwifery-led unit to consultant care, breastfeeding initiation and many more areas.

Competent staff

- Every midwife had a named SoM. An SoM is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (rule 8, Nursing and Midwifery Council – NMC – 2012). They are someone to whom midwives go for advice, guidance and support, and they monitor care by meeting with each midwife annually (rule 9, NMC, 2012), auditing the midwives' record keeping and investigating any reports of problems or concerns in practice. All midwives we spoke with had received an annual supervisory review.
- All midwifery staff we spoke with were aware how to contact an SoM at all times. We saw notices throughout the units indicating who the SoMs were, who was on call and how to contact them.
- Teams of midwives were led by an experienced band 7 midwife from whom they could seek support and guidance as necessary.
- Staff reported that they regularly had appraisals and personal development review (PDR) meetings. We saw that appointments had been made in one of the ward sister's diaries. The head of midwifery and the unit

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matrons spoke of the importance of regular appraisals and PDRs. Medical staff spoke of their job plans and how they were encouraged in their continued professional development.

- The unit used an evidence-based multi-professional training package for obstetric emergencies. Staff attended this training once a year. Records showed that, in May 2014, 83% of staff had attended the training; this was above the trust's own target of 75%. Staff we spoke with told us that they had received advanced life support training. Records showed that, in May 2014, 74% of staff had attended the training; this was below the trust's own target of 75%. One midwife told us that they had received a reminder to attend this training and was surprised. When they looked at their certificate their training was still in date. They thought that there had been some difficulties with the new computer-based system used to record training and the due training dates may not be accurate.
- Staff reported that they attended regular 'drills and skills' training. We were told that staff tried to recreate 'realistic and credible scenarios' for training.
- There were clear named consultant leads for all areas of obstetric and gynaecology care.

Multidisciplinary working

- Communication between obstetric, medical, anaesthetic and neonatal staff, midwives and AHPs such as sonographers and physiotherapists was described as excellent. Obstetricians and gynaecologists spoke about the respect they had for the midwives and AHPs with whom they worked. They told us that the whole team was flexible and worked to meet the individual needs of the women and their babies.
- Staff working at St Michael's told us that they had excellent working relationships with community midwives as they communicated frequently about women and babies who were due to be admitted or discharged. They said that, as a result, they knew the community midwives well and they worked together as a team. Community midwives reported good team working and said that there was good support among the midwives and maternity support workers.
- The midwifery-led unit and community midwives reported good working relationships with local GP surgeries and health centres.
- We were given examples of multidisciplinary working with external groups that included a midwife attending

female genital mutilation (FGM) advice sessions, pre- and post-pregnancy clinics, and working with community mental health teams and substance and alcohol abuse teams.

- As a regional referral centre, the unit had many external arrangements with South West and South Wales providers. These ranged from transfers between sites for mothers and babies, screening tests that could not be carried out at local units and arrangements for the care of women with complex medical conditions who needed specific care and support. Staff told us that they had contacts with the staff at these sites, specific documentation that was shared between the providers, and standard procedures in place for each situation.
- Sonographers told us that they worked closely with midwives. This had especially been the case since the introduction of nuchal translucency scanning for Down's syndrome.
- Perinatal mortality meetings took place regularly and included midwifery, obstetric and paediatric staff.
- Following the antenatal and neonatal screening governance meetings, the screening midwife sent out a screening newsletter to all wards, departments and community midwife bases to ensure that they were all kept informed.
- There was a consultant meeting every Friday between 8am and 9am when all matters relating to the consultants were discussed openly and issues such as infection control, policy changes, new guidance, training and equipment were raised. Minutes were not taken but letters were sent out if the consultants wanted to convey the consensus view on any issues.
- There was a perinatal liaison meeting every Monday that was attended by neonatologists, fetal medicine consultants and relevant obstetricians.

Seven-day services

- There was an obstetric theatre that was staffed and available at all times. There was a second team on call at all times. When the second team was needed, an anaesthetist had to get from Bristol Royal Infirmary to St Michael's Hospital, a walk or run of approximately five minutes up a steep hill, with the rest of the team coming from home. It was reported that, on the few occasions when the second team had been called, the team always got to the theatre within the specified time parameter of 20 minutes.

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- There was medical presence on the labour suite 24 hours a day.
- There was access to an anaesthetist at all times for epidural pain relief and emergency caesarean sections.
- There was 24-hour pharmacy support seven days a week.
- Physiotherapy was available from Monday to Friday and women with third- or fourth-degree tears were reviewed by a physiotherapist who also offered advice about self-care. Out of hours, physiotherapists could be contacted by a bleep.
- Imaging services were available at all times, as some midwives had specialist training in sonography. Complex imaging was carried out during routine obstetric-run specialist clinics.

Are maternity and family planning services caring?

Good



Staff provided compassionate care and emotional support to women and their partners. The results of the NHS Friends and Family Test (that were available) showed that most respondents were likely to recommend the service to friends and family.

Chaplaincy support was available at all times. Staff told us that they also benefited from the chaplaincy service when dealing with emotional and distressing situations.

We witnessed and were told that women and their families were treated with dignity and respect. Women we spoke with said they had felt involved in their care, they understood choices open to them and were given options of where to have their baby.

Compassionate care

- In the CQC maternity service survey for 2013, women were asked about their care at the hospital. The trust scored about the same as other trusts for 14 questions and better than other trusts in three of the 17 questions asked about maternity care, including antenatal care, care during labour and birth and in the first few weeks after birth.
- The available results of the NHS Friends and Family Test showed that most respondents were likely to recommend the service to friends and family. Results

were on display throughout the departments. The antenatal response rate for the trust was high (36% compared with the England average of 14%) but the birth score (14% compared with the England average of 21%) and postnatal score (13% compared with the England average of 23%) were lower than average. The matrons and ward sisters were actively encouraging staff to ask women to complete the forms.

- Throughout our inspection, we witnessed women and their partners or family being treated with compassion, dignity and respect.
- Women and their families with whom we spoke told us that they were happy with the care and support provided. Comments included: "My dignity was maintained throughout my labour and on the ward afterwards when I needed some help with feeding my baby." Other comments included "they explained everything". Partners we spoke with all said they were happy with the way their partners and themselves had been treated and that they felt fully informed.
- We spoke with the chaplain who described how fetal remains were managed sensitively. They showed us the non-denominational words they said at the disposal of fetal remains at the crematorium.
- We were told that the babies of women who were in the recovery areas following caesarean section did not go with them to recovery as there may be women who had undergone a termination or a surgical procedure following a miscarriage in the same recovery area.

Patient understanding and involvement

- Women were involved in their choice of birth at booking and throughout the antenatal period. Even though the unit was a regional referral unit and looked after women with complex needs, we were told that choices were offered to them within trust guidelines and specific NICE guidance. Women we spoke with said that they had felt involved in their care; they understood choices open to them and were given options of where to have their baby.
- Women carried their own records throughout their pregnancy and postnatal period of care.
- A cross-Bristol maternity services liaison committee (MSLC), known locally as Maternity Voices, held regular meetings. We saw minutes from two meetings that showed the breadth of discussion that took place. The MSLC also had a website supported by the three local trusts and clinical commissioning groups. The website

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was easily accessible, had a lot of useful information and gave women the opportunity to ask for advice and to provide feedback about their experiences at their respective trust. The Department of Health says that each trust providing maternity services should have an MSLC that includes the provider, the commissioning body and local people who have used the services.

Emotional support

- Chaplaincy care was available and details of how to contact the service were available throughout the maternity unit. Midwives and the chaplain we spoke with told us of the excellent working relationships they had with each other. Midwives told us that staff also benefited from support offered by the chaplain.
- Staff spoke highly of the chaplaincy service offered to parents in times of bereavement. We spoke to one of the chaplains who spoke with great understanding, kindness and compassion about how they could support parents at this difficult time.
- Staff on all of the units told us that they had good working relationships with the community midwives and local GPs, so they felt they were able to hand over any concerns they may have about a woman's wellbeing on discharge.
- The antenatal and newborn screening coordinator described how they supported women and their families when they had received bad news.
- The gynaecology day surgery unit undertook terminations of pregnancy. The staff were trained to care for these women and chaplaincy support was also available. Terminations carried out for fetal abnormalities took place on the delivery suite, where appropriately trained and experienced staff were available to provide support.

Are maternity and family planning services responsive?

Good



The services provided were responsive to the needs of local people. The service offered a range of facilities within St Michael's and in the local community. For example, clinics had been held in the mother and baby school to ensure that women did not miss out on education but could still attend their appointments.

There were two birthing pools available in the midwifery-led unit and one in the 'low-risk' room on the delivery suite.

We were told that succession planning was under way to ensure there were enough midwives trained to band 6 and 7 to cover the posts made available by several midwives who were due to retire over the next few years.

Information was available regarding the trust and maternity services on the trust's website. Translation and interpretation services were available at all times. Staff told us that the range of languages available met the needs of the local population.

All midwives had specialist training in bereavement and were able to offer appropriate care to women at all times. There was also a very responsive chaplaincy service available at all times to offer support.

Service planning and delivery to meet the needs of local people

- The service was planned and delivered to meet patients' needs: for example, women from the local population could elect for delivery at home, at St Michael's Hospital or at the Ashcombe birth unit in Weston-super-Mare. Women with complex health needs during pregnancy, who may have been referred from around the region, would have their delivery in the obstetric-led unit at St Michael's Hospital.
- Most of the routine antenatal care was carried out by community midwives based in health centres or community clinics. Antenatal clinics were held at St Michael's Hospital from Monday to Friday.
- Obstetricians and specialist midwives, along with cardiologists, physiotherapists and other healthcare professionals, ran specialist clinics for teenage pregnancies, substance and alcohol misuse in pregnancy, women with medical conditions such as diabetes or cardiac conditions and fetal medicine clinics. We were told that clinics had been held in the local mother and baby school to ensure that women did not miss out on education but could still attend their appointments.
- The cardiology clinics ran once a fortnight and included a three-hour appointment so the woman could see an obstetrician, a cardiologist and an anaesthetist and also have a scan if necessary, blood tests, electroencephalograms (EEGs) and ECG. This was

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described as a 'one-stop shop' and meant that the women who often travelled a great distance to the hospital did not have to make the trip more often than necessary.

- There were two birthing pools in the midwifery-led unit and one on the delivery suite. We were told that this met current demand and it was unusual for a woman not to have her choice of delivery method because all of the pools were in use at the same time.
- The midwifery-led unit opened in June 2013 and had delivered 1,116 babies to uncomplicated, low-risk women. Water births accounted for 45% of the births. The unit offered four birthing rooms, two with birthing pools, and others with birthing couches. All had en-suite facilities.
- There was a 44-bedded combined ante- and postnatal ward, which also assessed people for induction of labour and started the process. Two wards (wards 71 and 74) had recently merged to streamline the care and support offered to women. It was reported that this had enhanced team working.
- There was a 16-bedded transitional ward (ward 76) where babies could be cared for alongside their mothers. These could be babies who were born prematurely, who weighed less than 2.5kg at birth or babies of mothers on particular medications that may affect the baby.
- One of the three matrons and two midwives told us that there was no dedicated perinatal mental health team. They said an assessment (designed using NICE guidance) was carried out on women, and, if necessary, they were referred to appropriate mental health services in and around the Bristol area. Staff reported that they had no problems accessing the right support for people and had good working relationships with local organisations. We were told a psychologist was soon to start in post as a need had been identified during a project around trust provision of perinatal mental health services.
- We were told that succession planning was under way to ensure that there were enough midwives trained and employed to cover the posts made available by several midwives who were due to retire over the next few years.
- Women were booked for their pregnancy and ongoing care by their community midwife at their local health centre or community clinic. They attended St Michael's Hospital only for their dating scan and appointment with an obstetrician (at the same visit) and then once again for a growth scan later in their pregnancy.
- Staff reported that the day assessment unit and triage system reduced the need for women to be admitted to the midwifery-led unit or labour suite unnecessarily.
- The labour suite was closed 17 times between January 2013 and June 2014. Staff told us that this was sometimes only for a couple of hours while they discharged women from the delivery suite. There were no reported incidents of women in established labour being looked after in an inappropriate setting. Women were given information about alternative units they could attend during closures.
- On occasion, flow had recently been compromised in the labour suite, when hotel services staff had not arrived to clean a delivery room. There had been occasions when a woman had to wait for a short time while a room was cleaned, which took about half an hour. The matron told us that, when this happened recently, she spoke with the cleaning supervisor and the issue was resolved in a very short time. The hotel services were provided by the trust and, we were told, they had suffered some high sickness levels that had meant using agency staff, who had not always provided the service expected.
- The EPAC was run by two specially trained midwives supported by one consultant. It was open five days a week from 8.30am to 5pm. Out of hours and at weekends ultrasound scans were carried out and interpreted by junior doctors who had access to a senior registrar for advice. Midwives always checked the patients' notes on Monday morning to confirm that the clinical management was appropriate. We were told that the service would be even more effective if the specialist midwives were able to offer a service at the weekends as well. The issue of providing an effective EPAC was detailed on the risk register.
- Routine ultrasound scanning clinics for dating and growth, manned by sonographers, were held Monday to Friday at St Michael's Hospital. Sonographers and some specially trained midwives carried out specialist scans for the fetal medicine unit. We heard that dating

Access and flow

- Bed occupancy for the maternity services (excluding the delivery suite) in the first quarter of 2014 was 57.5%. This was lower than the England national average of 58.6%.

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scanning sometimes took place at teenage pregnancy clinics held in the city. This increased the attendance rate for antenatal appointments where a problem had been identified.

- Physiotherapists ran third- and fourth-degree tear clinics postnatally to help women recover the use of their pelvic floor. There was also access to a colorectal surgeon if required.
- Following a concern raised about help for women with babies who had a tongue tie, a clinic had been set up to help and support women breastfeeding babies with a tongue tie. It was hoped that the clinic would also reduce admissions of babies with weight loss due to feeding problems.
- There was a consultant-led fetal medicine unit for women who might need specialist tests such as chorionic villus sampling (CVS) and amniocentesis as well as treatment for the baby in the womb. Specialist screening midwives worked closely with the women who used these clinics.
- There was a day assessment unit, open from 8.30am to 6.30pm, Monday to Friday, and occasionally on a Saturday morning, for women who had reduced fetal movements and attended for cardiotocography (CTG) monitoring. The unit also offered ultrasound scans (carried out by specially trained midwives), glucose screening and iron infusions. There was also a triage facility used to identify if women were in labour but could be sent home, or if they needed to stay in the unit. The unit had a combination of women with appointments made in advance and women asked to come in from the antenatal clinic or from home following a telephone consultation.
- There were two obstetric and gynaecology operating theatres. There were two dedicated recovery beds staffed by a midwife and a trained nurse. One theatre was manned 24 hours a day with a second team on call if required for emergencies. The on-call team had to come from the main Bristol Royal Infirmary site, which meant leaving the hospital and negotiating a steep hill to St Michael's Hospital. Staff reported that this caused exertion but the "adrenalin kicks in so it is not a problem". The on-call team could be called upon 24 hours a day so could need to negotiate the hill at night. We were told that a security person could accompany

staff to St Michael's Hospital if they felt vulnerable. Staff told us it would take too much time to consider this as they needed to respond to the emergency call immediately.

- The obstetric theatre team carried out elective (planned) caesarean section lists and emergency caesarean sections as required.
- The obstetric-run labour suite had 16 rooms, one with a birthing pool. This was described as a 'low-risk' room for women who wanted a vaginal delivery but had a history that suggested they might need some assistance. This was seen as a compromise as the women would not have been assessed as suitable to use the midwifery-led unit. The rooms were currently undergoing a phased refurbishment, meaning that one room was closed at a time to ensure that the service could still be provided effectively.
- NICE guidelines say that two sonographers have to confirm 'fetal demise'. There were not always two sonographers available so sometimes when women were referred for a scan from the early pregnancy assessment unit they could have to come back for confirmation of fetal demise once a second sonographer had been able to view the scan. The appointment was made to return within one week, where possible, when a different sonographer was on duty. Staff knew that this was not ideal and that it was upsetting for women and their families. This issue was detailed on the risk register, with a high rating, but no plan to make improvements had yet been decided upon.

Meeting people's individual needs

- Information was available regarding the trust and maternity services on the trust's website.
- Translation and interpretation services were available. Midwives told us that this was provided via a 'bank' of people who could provide translation in 15 different languages. The team was employed by the trust and often pre-booked as clinic staff would know in advance who would be attending. They could also be called on at short notice if a woman was admitted to the labour suite or midwifery-led unit. An out-of-hours service was available via Bristol Council. There was also a telephone service available if a person with the required language was not available in the trust. We were given examples of when and how the service had been used.

Maternity and family planning

- We saw some information at St Michael's Hospital that was in a number of languages. Staff told us that any leaflets or information could be printed in other languages or formats if they requested it via the trust's communications team.
- We were told that all midwives had specialist training in bereavement and were able to offer appropriate care to women at all times. There was a counselling room available for use by bereaved parents or parents who had received bad news. The Lavender Suite provided a room where bereaved parents could stay together. It had a sitting room, kitchen area and bathroom. A cold cot could be used in this room if required so that parents could spend time with their baby.
- We spoke with the infant feeding coordinator, who worked throughout the units from Monday to Friday. They described their role in supporting mothers, their families and staff with any feeding issues. Staff told us that the coordinator was "very visible" and "always helpful".
- Women from the region, including South Wales, who had to stay in the hospital ante- and postnatally were able to do so. There were some side rooms available where partners could stay overnight if necessary, for example if a woman had been induced into labour and would soon be transferred to the labour suite. There was accommodation for families whose baby and mother were in the transitional ward in the local Ronald McDonald House and the charity ran a 12-bedded 'Cots for Tots' house opposite St Michael's Hospital.
- Women were given information leaflets at booking and there was access to a wide range of leaflets and links to useful websites on the trust's own website.
- We saw that there were plans in place to meet the special needs of women with conditions such as autism. There was a folder that gave advice on how to meet specific needs during the woman's stay on the units and detailed discharge plans.
- All formal complaints were dealt with using the trust policy. The complaint would be seen by the corporate complaints team and then handed back to the head of midwifery to investigate (unless the complaint concerned that person).
- Staff told us that learning had taken place following formal complaints investigations and practice had changed accordingly. They said any new practice introduced was subject to internal audit programmes. Women referred from the early pregnancy assessment unit to the ultrasound department for a scan had raised concerns that they had to wait in the same room as antenatal clinic patients. As a result, a quiet room had been made available for these women to wait in, monitored by the administrative staff to ensure that they were not forgotten.
- Staff told us that they sometimes had face-to-face discussions with the person who had made a complaint. They found this to be beneficial to the practitioner and provided reassurance to the person raising concerns.

Are maternity and family planning services well-led?

Outstanding



Leadership in the maternity and family planning services was outstanding. There was a high level of satisfaction amongst staff who described the maternity service as "very functional" with "trust and respect between all grades of staff, meaning we work together well, work hard and are very flexible".

There was evidence of strong collaboration and support across the service. Staff spoke of an open, supportive and friendly culture, with "great teamwork". Leadership was encouraged at all levels within maternity services. Staff were able to input ideas and were empowered to find and implement solutions. The team worked cohesively with open communication and all members of the staff team felt they were able to speak up and were listened to. This led to a highly functional team.

The service had a proactive and well-defined governance structure. Meetings existed that oversaw activity, performance, quality, safety, audit and risk. Issues were escalated within the trust, as required.

Learning from complaints and concerns

- Staff told us that informal complaints were directed to the person in charge at the time. If they were not able to deal with the issue, we were told that patients were advised about the Patient Advice and Liaison Service (PALS). We saw information about how to contact PALS on the units we visited and clearly displayed in St Michael's Hospital main reception.

Maternity and family planning

There was strong engagement with patients and a focus on gaining greater involvement in the MSLC from patients groups who represented the local population using the service.

Continuous improvement was embedded within the service with multidisciplinary working parties empowered to develop, discuss and test new ideas and guidance. Innovative approaches were adopted to resolving challenges, such as the low midwife-to-birth ratio, and the whole team worked to develop and embed a new and sustainable model of care whilst maintaining a continued focus on recruitment of midwives.

Vision and strategy for this service

- Staff were aware of the organisational strategy at trust level and within maternity services. The service level strategy was well defined. Challenges such as the midwifery to birth ratio were addressed, research was integral and continuous improvement was embedded. There were strong community links.
- The head of midwifery told us that the chief executive and/or the director of nursing were seen in St Michael's Hospital on a regular basis. She said that she felt able to contact the chief executive or their team if the need arose and would be confident she would be heard.

Governance, risk management and quality measurement

- The service had a well-defined governance structure. Meetings were held that oversaw activity, performance, quality, safety, audit and risk. We were told that minutes of governance meetings were added to the trust's audit website. We saw minutes of the quality assurance committee from July 2014, divisional management board meetings from May 2014, and maternal morbidity meeting from September 2014.
- The governance lead for the maternity services told us that they worked with the trust's audit department facilitator on a regular basis and attended five half-day audit meetings annually. They spoke about how new guidance/best practice was introduced and subject to ongoing governance processes that included reviewing and adapting the process as necessary to achieve best practice.
- Performance and outcome data was reported and monitored via the service performance dashboard.
- There was a risk register that had 19 risks identified. None were classified as very high: eight were classified

as high, nine as moderate and two as low. All had ongoing actions and review dates. A number were near to completion, for example ordering automatic swipe doors to secure access from the labour ward to theatre to ensure compliance with the safe storage of medicines and fluids within the theatre areas. These doors were waiting to be fitted by the estates department; the target date was 29 September 2014. There was a potential risk of a rise in the number of complaints due to "potential noise, dust and disruption" during the ongoing refurbishment of the labour suite. This had been classified as a moderate risk.

- There were regular governance meetings, including: SoM, MSLC, perinatal mortality and morbidity, maternity audit, antenatal and neonatal screening (every four months) and patient safety (monthly – these included a practice development midwife and a band 7 midwife). We were told about a number of newsletters (Close Encounters, Top Tips and Matrons Mutterings) designed to make staff aware of incidents that had been investigated and the subsequent risks. They included advice about how to reduce the risk in future.
- Midwives and clinicians told us about numerous working parties developed. This included when learning from an incident required a change in practice to be introduced, for example mental health screening of women in the antenatal period, introduction of new screening procedures, and criteria for admission to the midwifery-led unit. Members included consultants, neonatologists, medical staff, midwifery staff (matrons and band 7 and band 6 staff) and lay representation (where appropriate). This meant that an appropriate and interested multidisciplinary team concentrated on that area and then disseminated the outcomes, rather than a larger group spending time on all areas. These groups were well attended and influential.
- Staff at all levels were aware of the low midwife-to-birth ratio and were confident in describing the strategies they had in place to increase the number of midwives. They also described how the whole team worked to ensure the ongoing safety of women by employing three RGNs to carry out roles that did not require a midwife (see the 'Safe' section). They ensured that many of their maternity assistants (in the hospital) and maternity support workers (in the community) had extended competencies to provide extra support to midwives. The transitional care ward had neonatal nurses as part of its establishment, which also enhanced midwifery care.

Maternity and family planning

- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms were completed by only two people who followed guidance and submitted the forms to the Department of Health as required.
- We saw a safe system in place for recording information about fetal remains and how they were disposed of. The information was logged in a book and electronically on a secure server.
- The trust was actively trying to reduce the low midwife-to-birth ratio by advertising on the NHS jobs website and in relevant journals (we saw an advert for band 6 midwives in the Royal College of Midwives journal during the week we were carrying out the inspection) and attending a jobs fair in Scotland.
- Staff spoke of an open, supportive and friendly culture, with “great teamwork”. Community midwives we spoke with agreed. We heard a lot of staff talk fondly of the Christmas show that had been put on every year since 2004. It included all grades of staff, from consultants to ancillary staff, and involved staff enjoying good-natured teasing and impersonations of other staff, for example. It was felt that staff would not engage in that sort of activity unless they had really good working relationships and felt comfortable with and trusting of each other. One of the consultants said it was “better than an expensive away day”.
- Staff spoke passionately about the service and it was clear from all we spoke with that they enjoyed working within the maternity services and for the trust. Staff we spoke with said that, although the maternity services were based at St Michael’s Hospital (five minutes’ walk from the Bristol Royal Infirmary and education centre), they felt included in mainstream trust activity and were included in mandatory training programmes, on which they often met staff from other directorates.

Leadership of service

- Staff told us that the three matrons and head of midwifery were very approachable and good to work with. They told us that they could contact the head of midwifery when required.
- The head of midwifery and matrons were seen in clinical areas and had a good awareness of activity within the service during the inspection. Staff were clear about who their manager was.
- Staff told us about the monthly maternity newsletter that kept them informed about developments within the division.
- We spoke with the clinical director, lead doctor for obstetrics, the head of midwifery and a number of senior midwives who spoke passionately about the services they offered and the creative ways they worked to ensure they met the needs of the women that used their services. They explained how their systems and processes were always developing in line with latest research findings.
- Leadership was encouraged at all levels within maternity services. Staff were able to input ideas and were empowered to find and implement solutions. The team worked cohesively with open communication and all members of the staff team felt they were able to speak up and were listened to. This led to a highly functional team.
- All of the staff we spoke with described the maternity services as “very functional” with “trust and respect between all grades of staff, meaning we work together well, work hard and are very flexible”
- Staff we spoke to at all levels told us they liked working for the maternity services and many had worked in the units “happily” for many years. Senior midwives told us retention of staff was very good and contributed to the “smooth running” of the services as people often knew each other well.
- We were told that there were systems in place for all staff to use if they felt stressed or bullied at work. For example, one of the consultants was available to meet with medical staff to discuss their concerns and, if appropriate, there was a retired consultant available to give pastoral advice and support. We were told that this system was explained to medical staff at their induction and a new member of staff we spoke with confirmed that this was the case.

Public and staff engagement

- A cross-Bristol MSLC was highly functional, well established and met every three months. We saw evidence that the group was looking to ensure that it continued to be representative of the population and was looking to further increase representation of parents with learning disabilities, Somali women’s

Culture within the service

- Staff were aware of the whistle-blowing policy and were encouraged to raise any concerns they might have. They told us they had confidence in raising concerns.

Maternity and family planning

groups and Young Healthwatch. The group had developed a website supported by the three local trusts and clinical commissioning groups. The website was easily accessible, had a lot of useful information and gave women the opportunity to ask for advice and to provide feedback about their experiences at their respective trust. The Department of Health says that each trust providing maternity services should have an MSLC that includes the provider, the commissioning body and local people who have used the services. The purpose of an MSLC is to contribute to the improvement of maternity care and facilities for parents and babies.

- The Family and Friends Test responses were not very high following birth and postnatally. Staff were being asked to encourage women to complete the forms. The MSLC had also been asked to consider ways in which women could be encouraged to complete the forms.
- The matron of the midwifery-led unit was engaged with the local Somali population and spoke at meetings on the subject of FGM to help women understand their rights.
- Staff told us they had strong and collaborative working relationships with all staff groups in the maternity services and with hospitals and community groups external to the organisation.

Innovation, improvement and sustainability

- Staff were pleased about the ongoing upgrading of rooms on the delivery suite. We were told that this would take some time to complete as only one room could be spared at a time.
- Three consultants had been elected to leading roles in national professional organisations and were released from their substantive posts to attend meetings.

- The introduction of a midwifery-led unit in June 2013 was described by staff as “excellent”, “a brilliant success” and “great for women”. Consultants told us how much they valued the service since it had opened.
- Staff told us that innovation and improvements were encouraged and welcomed. Most of the consultants also had research interests and a number had published research, including clinical research, which had helped to move obstetric practice forward over the years.
- Senior midwives and medical staff told us about their drive for continuous improvement. Areas for improvement were highlighted by both the leadership and staff within the service, for example, where national guidance had changed or risks arose. Multidisciplinary working parties of the most appropriate staff, were set up to develop, discuss and test the resulting new ideas and guidance. This multidisciplinary approach was to ensure that there was involvement from all within the service, changes were implemented in a controlled way and audited appropriately. Each working party took ownership for the piece of work and were accountable for managing and supporting the changes.
- Some members of the consultant team attended the South West Obstetric Network (SWON) on a quarterly basis, where practice developments, new guidelines and ongoing research in the region were discussed.
- One of the sonographers told us that a member of their department was involved in the peer review process of the NHS Fetal Anomaly Screening Programme (FASP), and that this had brought “huge benefits” to their department.

Services for children and young people

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

Information about the service

The Bristol Royal Hospital for Children provided 127 inpatient beds, 17 intensive care beds and 27 day case beds and was part of the wider University Hospitals Bristol Main Site. The hospital provided services for the children and young people of Bristol as well as specialist children's services and was a children's trauma centre for the South West of England and South Wales. The hospital provided care to approximately 20,000 children per year plus an additional 35,000 via the accident and emergency department. The hospital sees a further 40,000 children each year in consultant-led outpatient clinics. The services provided within the children's hospital included: oncology, haematology, bone marrow transplant, adolescent services, physiotherapy, outpatients, surgery (including general surgery, urology, trauma and orthopaedics, ear, nose and throat (ENT) and plastics), cardiology and cardiac surgery, medicine, burns and plastics, neurosurgery and neurology, neonatal and paediatric intensive care units, accident and emergency, renal and nephrology, and support services such as radiology, play, education and a clinical investigation unit.

We spoke with 80 staff, including nurses, consultants and support staff, 32 parents and 15 children and young people during our inspection. We visited most of the wards and departments within the hospital and observed care and looked at care records and other documents in each of the wards visited.

Summary of findings

Services for children and young people were found to be good. Children received good care from dedicated, caring and well-trained staff who were skilled in working and communicating with children, young people and their families.

Patient outcomes were routinely better than expected which was demonstrated through independent benchmarking. There was evidence of staff being involved in the development and review of policy, procedures and implementing a change practice, where improvements in outcomes were required. There was a strong commitment to the skills knowledge and competence of all staff. The trust had developed a Paediatric Faculty of Education at the hospital to develop the skills, competence and knowledge of staff. Transitional care was outstanding, young people had been involved in the development of the service and planning occurred from an early stage.

Children and their families were actively involved in their care and treatment and their feedback regularly sought and listened to.

The arrangements for safeguarding were excellent and staff told us about the open culture that encouraged them to report issues as they arose. Following a successful recruitment campaign, wards were staffed with well-trained and competent staff.

Services for children and young people

The majority of comments from parents, children and young people were very positive. They thought the staff were brilliant and the facilities excellent.

Are services for children and young people safe?

Good



Children's services were good. The children's hospital had previously had problems with staffing levels, particularly for nursing staff. However, following a successful recruitment programme, 110 nurses had been recruited. Records were very comprehensive and child-centred. Excellent procedures were in place to safeguard children. The staff used the paediatric early warning scores (PEWS) very well to identify whether a child's condition was deteriorating. The children's hospital was the only children's hospital in the UK to have a fully established 24-hour clinical outreach team to support staff and to review children discharged from the paediatric intensive care unit and the high-dependency units.

Incidents

- The children's hospital had not reported any never events and had systems in place to make sure that these did not occur. Never events are serious and largely preventable incidents. We saw evidence that where never events had taken place elsewhere in the trust, learning had been cascaded throughout the trust. For example, the World Health Organization (WHO) checklist for surgical procedures had been reinforced with all staff and we saw evidence in the children's hospital that staff were following this checklist and confirming details with the parents and child (where appropriate) and also with the ward staff.
- The hospital had systems in place to make sure that incidents were reported and investigated appropriately. Staff were able to tell us about how they reported incidents and said that they would have no hesitation in doing so. We saw examples showing that, where incidents had been reported, a full investigation had been carried out, including looking at the root cause of why the incident happened in the first place. We also saw evidence that systems were put in place across the hospital to prevent the incident happening again. We were shown a root cause analysis investigation and found it to be comprehensive; it included areas of notable practice and an action plan for the required improvements.

Services for children and young people

- Within the children's hospital, four serious incidents had been reported between April 2013 and March 2014 via the Strategic Executive Information System (STEIS). Staff were aware of these incidents and the resulting learning through dissemination from department meetings and safety briefings.
- Ward managers and matrons received details of all incidents within their areas and these were shared across the children's hospital. Incidents were reported on each ward dashboard.

Cleanliness, infection control and hygiene

- In all the wards and departments we visited we observed staff at all levels washing their hands and using hand sanitizer according to the trust policy. We observed the appropriate use of personal protective equipment (PPE) such as aprons and gloves. There were sufficient hand-washing sinks and hand gel dispensers in each area. All the ward and department areas we visited looked clean and tidy and individual cleaning schedules were being maintained.
- Each ward we visited displayed Safety Thermometer information on cleanliness, hand hygiene and hospital associated infections. All the wards scored above 93% for cleanliness and above 96% for hand hygiene in the three months preceding our visit. Ward 32 (cardiology) consistently scored over 99% for the nine months before our inspection. The Safety Thermometer also showed that no hospital associated infections had been reported by the majority of wards within the children's hospital from October 2013 to August 2014. In the isolated occasions where methicillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile* (C. difficile) had been identified, a root cause investigation had been completed to ascertain where the infection had been acquired from. The Safety Thermometer also showed us that the children's hospital had low rates of catheter acquired urinary tract infections (usually none, but occasionally 1 per 100 children) from May 2013 to May 2014.
- There were infection control link workers on each ward. They acted as a resource for staff within their clinical area, conducted audits and assisted with teaching other staff on infection control principles.
- Where children or young people were suffering from an infectious condition or had a poor immune system, single side rooms were used to reduce the risk of

cross-infection. Where this took place, we observed signs informing other staff and visitors of what individual precautions they needed to take to maintain good hygiene practices.

- Theatre staff were aware of concerns seen at a previous inspection in November 2013 and of the measures that had been taken to rectify the concerns. The theatres within the children's hospital were clean and daily cleaning checklists were in place and reviewed each week for compliance. Equipment was no longer stored in corridors, but in dedicated storage areas. Staff wore theatre scrubs and we saw appropriate use of PPE such as gloves, aprons and masks. We saw evidence that a member of the divisional management team inspected theatres twice a week to ensure that compliance was being maintained.
- We saw evidence that showed the neonatal intensive care unit had particularly low rates of infection for babies who needed central lines. We observed that a sterile area was also available to make up the feeds for babies within the unit; this reduced the risk of babies acquiring infections.
- On ward 34 (children's oncology), children and young people often had poor immune systems. We observed that new bed linen was pre-sealed with polythene which made sure that it remained clean. Also, the play specialist team member selected toys that would be suitably cleaned. These measures reduced the risk of cross-infection.
- The comments we received from parents and young people we spoke with during our visit were very positive regarding the cleanliness across the children's hospital. One parent told us "the cleanliness was amazing"; this reflected the comments from other parents.

Environment and equipment

- All the wards and departments we visited had a mixture of two- to four-bedded bays and single rooms. Each bed space had the facility for a parent to stay with their children if necessary. Separate toilet facilities were available for children, parents and staff.
- Each ward had secure access to maintain the safety of the children and young people. Staff were able to control access to their department via video entry systems.

Services for children and young people

- Each department had resuscitation equipment appropriate for children and young people. We observed that this equipment was checked daily and that this checking was carried out consistently.
- Systems were in place to remove broken or faulty equipment. Staff told us that equipment would be removed from service immediately a problem was identified and the equipment reviewed by the medical engineers. We saw evidence that maintenance issues were documented and any updates were recorded. Equipment was serviced according to the manufacturer's instructions.
- We visited the high-dependency units and intensive care units for children and neonates and found that each bed space had the necessary equipment. Machines with batteries were plugged into the mains to make sure that the batteries were charged.
- A paediatric medicines safety bulletin was circulated to staff and included advice, reminders and new procedures, including details of storage of medicines, drug calculations and the differences in doses between intravenous and oral administration.
- Each bed space within the theatres had its own set of paediatric formulary, guidelines and calculation aids to support staff. These measures reduced the risks of incorrect prescribing and of delays while staff found the appropriate guidelines.
- Staff within paediatric theatres knew how to isolate medical gases as necessary in the event of an emergency.
- Where medication administration errors had taken place, we saw evidence to show that they had been reported and investigated in line with the trust's incident-reporting procedures. Where necessary, appropriate action had been taken to prevent their recurrence.

Medicines

- On all the wards we visited, we found that medicines were stored correctly. Medicines were kept within a locked room to which only staff had access. Controlled medicines were stored in separate locked cupboards and were double-checked by qualified nurses. Where medicines needed to be kept in fridges, the temperature of the fridges was checked consistently every day. Emergency 'grab bags' were stored in the paediatric intensive care unit for use in emergencies across the children's hospital.
- Qualified staff within the dental theatres did not double-check the medicines they gave to children. The risk of single checking had been assessed and approved by the medicines committee before being implemented. Single checking meant fewer delays for children receiving medication as part of their dental surgery. Staff were accountable for the medicines they gave in line with the Nursing and Midwifery Council standards for medicines management.
- Some departments, such as the paediatric intensive care unit, had their own pharmacist who monitored prescriptions and was available for help and support. Other departments had dedicated ward pharmacists who visited the ward daily. The children's hospital had good pharmacy input and had a separate children's medication group. This group developed guidance on the administration of medicines for children, for example paediatric fluid prescription. Our pharmacist found the guidance to be comprehensive.

Records

- Medical and nursing records were stored securely at the nurses' station. Nursing monitoring charts such as fluid charts and observation charts were kept at the end of each child's bed or outside their side rooms.
- We looked at the medical records and nursing records in all the wards we visited. In every case we saw clear, detailed notes that reflected each child's care and treatment. Entries were signed and dated in accordance with the trust's record-keeping policy.
- In the records we looked at, we saw that core screening had been completed for each child; this included risk assessments for the patient's safety, infection control, pressure areas and moving and handling. We saw that care plans were in place; while these were generic paediatric core care plans, they were individualised for each child depending on their needs.
- Observation (temperature, pulse, etc.) charts were available for different ages of children and young people. These forms were comprehensive and included pain scores and PEWS. In the notes we looked at, we found that these observation charts had been completed consistently.
- The paediatric intensive care unit used handover sheets between clinical staff; these had improved the communication between different shifts of staff. To maintain confidentiality, these handover sheets were not allowed to be removed from the unit.

Services for children and young people

- The children's hospital used standardised admission, assessment and observation charts across all the wards and departments. Integrated care pathways were used within surgery and day case surgery and incorporated preoperative checklists and anaesthetic care through to post-operative care. This ensured consistency across the children's hospital and that staff were familiar with the paperwork, no matter which ward they worked on.
- Discharge information was communicated to the child's GP as well as to their health visitor or school nurse.
- In December 2013, the accident and emergency department implemented a system of scanning all the treatment cards used in the department onto the electronic patient administration system. This ensured that all wards and departments within the children's hospital were able to access that information instantly when necessary or appropriate to that child's individual care.

Consent

- We were told that consent was obtained for all children who were admitted for surgery or for a procedure at the pre-admission clinic or prior to surgery itself. We checked the notes for children on ward 31 (surgery) and ward 36 (surgical day case) and found fully completed consent forms in place. The consent forms included details of the specific procedure and the potential risks and complications of surgery.
- Consent was obtained from parents or carers for each child or young person. Staff were aware of the appropriate procedures in obtaining consent. We observed how staff talked and explained procedures to children in a way they could understand without getting frightened. Staff were aware of Gillick competence in relation to consent for young people under 16 years of age and followed these when necessary.
- We followed five children from the ward through to the anaesthetic room and observed theatre staff checking the details on the consent form with both the accompanying nurse, the parents and the child (where appropriate). This provided a triple-check system that the correct child had been called for the correct procedure.
- We saw examples of how staff on each ward involved children and young people in their care and treatment and would seek the child's consent prior to doing anything, for example taking their temperature.

- On ward 32 (cardiology) the staff explained how they were looking at ways to improve the consent process within cardiology to make sure that the risks, complications and benefits were explained more comprehensively to parents.
- One parent told us that "the staff always provided me and my child with very good information before asking me to sign my consent". This view reflected the opinion of the other parents we spoke with regarding consent.

Safeguarding

- The children's hospital had a dedicated safeguarding team, which included clinical nursing staff and administrative support. The team was able to support staff across the children's hospital, keep them informed on safeguarding issues, provide training across the hospital and link directly to other areas of the trust where children are seen, such as the eye and dental hospitals.
- There was a proactive approach to children's safeguarding across the trust. The safeguarding team told us that the trust had a "family approach" to safeguarding. This meant that if adults were admitted and staff were concerned that their admission or condition might have a negative impact on children, then a discussion and possible referral was held with the children's safeguarding team.
- The safeguarding team trained individual ward nurses to be safeguarding link nurses within their own clinical areas. These link nurses acted as an additional resource for their colleagues and were able to assist with training.
- The safeguarding team linked directly with the Bristol children's safeguarding board, and the nurses from the safeguarding team regularly rotated to sit on subgroups of the safeguarding board.
- Procedures were in place to obtain the advice and support of a community paediatrician 24 hours a day; this was in line with best practice. When necessary, child protection medicals were held in dedicated clinics and by staff who were specially trained to perform them.
- Medical and nursing staff were trained to level three in children's safeguarding. An up-to-date training register was held by the safeguarding team. We saw evidence to show that the majority of staff had completed this training and that it was up to date. Those staff who had yet to complete it or who required a training update had dates scheduled for their training.

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- A safeguarding policy was in place across the trust. The staff we spoke with all knew how to access the policy and were able to explain the different types of abuse and how they would refer a child should they have any safeguarding concerns. Staff showed us the referral forms and the emergency contact numbers, should they need them. We were also shown chronology communication sheets that were used when safeguarding concerns had been identified.
- Staff recognised that being involved in a safeguarding referral could be distressing to both the child and their parents. An information leaflet was available for parents involved in any safeguarding concerns. The leaflet described what happens when a referral is made and from whom the parents can seek further help and advice.
- A safeguarding checklist was completed for each child on admission. The notes that we looked at had completed checklists in place. For young people, additional adolescent checklists were in place and had been completed appropriately.
- The electronic patient administration system had the facility for alerts to be displayed for any child where safeguarding concerns were already known. This made staff aware of additional things that might need to be put in place or considered for that individual child, for instance family visiting arrangements.
- Where children or young people failed to attend two clinic appointments, a referral would be made to the safeguarding team and contact would be made with the child's GP and health visitor or school nurse to ascertain whether there were any concerns.

Mandatory training

- The trust held central mandatory training records for all wards and departments, including the children's hospital. Senior nursing staff told us that they had found problems with the accuracy of this database and had therefore kept their own departmental training records. We looked at the training records for the wards we visited and they showed that all staff were either up to date with their training or had training days scheduled.
- The staff we spoke with all confirmed that they were up to date with their mandatory training. They also told us that they were fully supported by their manager and department to attend any relevant training. Several new staff told us that the trust induction they attended had

incorporated some of the mandatory training. Where staff were not up to date with their mandatory training, arrangements were in place to resolve this in a timely way.

Assessing and responding to patient risk

- Each child had core screening assessments completed on admission. These included risk assessments in relation to falls, nutrition and pressure ulcer risk. These were completed in all the records we reviewed during the inspection.
- All the wards and departments used PEWS. These were present on the observation charts and also used colour coding of green, amber and red. This assisted staff to recognise when a child's condition was deteriorating and when to seek further help and support from medical staff or the 24-hour outreach team. The staff we spoke with were all very familiar with PEWS and the scores had been used appropriately in the records we looked at.
- A patient safety checklist was completed twice a day for every child and young person. This checklist included whether the patient's bed space was accessible and whether the equipment around the bed space was in full working order through to intravenous cannula checks. We saw that these were completed on the wards that we visited.
- Anaesthetists visited all children on the ward prior to surgery to check consent and pre-admission details and to explain the anaesthetic procedure to the parent and the child (where appropriate). Time was allowed for the parents and child to ask questions and we observed that explanations were given in a way the children could understand.
- WHO surgical safety checklists were in place in theatres. The staff we spoke with were all aware of the checks that needed to be done to make sure that each child had been consented for the correct procedure. We observed staff completing these checks appropriately in the anaesthetic room. We also saw that audits of completion showed a 99% compliance rate. Staff told us that they used the checklists to improve and maintain good communication between staff and parents to maintain the child's safety.
- When children were moved into the recovery area after their operation, the staff followed discharge criteria to

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make sure that children were safe to return to the wards. Parents were allowed to be with their children once they were awake and a qualified nurse escorted the child back to the ward.

- In May 2014, paediatric services were transferred from North Bristol NHS Trust to the children's hospital. In preparation for this move, the staff and children's departments at North Bristol NHS Trust started using the children's hospital's documentation several months prior to the move. This made sure that any risks associated with using new paperwork were reduced and staff were familiar with the children's hospital paperwork.
- There were occasions when children were admitted to wards outside the specialty the children required. For instance, a child needing oncology care might be admitted to the medical ward, or a younger child might be admitted to the adolescent unit. The hospital had plans in place to reduce the risk of this. These included an oncology link nurse who worked with staff on other wards to make sure that appropriate guidelines were followed.
- The children's hospital was designated a children's trauma centre. The paediatric intensive care unit and the accident and emergency department had dedicated 24-hour access to the new helipad on top of the hospital. This ensured quick access to the departments for emergencies.
- We saw evidence that risk assessments were completed by other teams within the children's hospital where necessary. For example, the play specialist team completed assessments for cooking and pets as therapy.
- We saw evidence of the use of Situation, Background, Assessment, Recommendation (SBAR) on the wards within the children's hospital. SBAR is a recognised communication tool to ensure that appropriate information is handed over verbally and an adequate response is received.

Nursing staffing

- The children's hospital, like other hospitals and units, had suffered from staffing shortages in the past. At the time of our inspection, this had largely been resolved with the recruitment of 110 nurses. An open advert was in place for skilled paediatric nurses and the trust was exploring new and innovative ways to attract and keep staff. One of these innovations was the launch of the

Paediatric Faculty of Education. The staff told us that staffing had improved greatly over the previous months. Staff on all the wards we visited told us that they were staffed up to their establishment.

- The children's hospital's staffing complied with the standards set by the Royal College of Nursing and had a nurse-to-child ratio of 1:4 or 1:3 within the general wards. This ratio was increased to 1:2 for the high-dependency areas and increased again to 1:1 in intensive care areas. In the paediatric intensive care unit and the renal unit, this ratio would sometimes be increased further to two nurses for every patient. An acuity tool was used across the children's hospital; this tool used clear descriptions of a child's care needs and the corresponding level of staffing required to care for those needs. The acuity score was also linked to PEWS.
- Where there were shortfalls in staffing due to sickness or annual leave, staff within the particular clinical area would be flexible and cover shifts. Where this was not possible, bank staff were used and, as a last resort, agency staff would be used. Procedures were in place to request additional staff. The staff we spoke with confirmed that this was done via the 24-hour site team.
- The staff in paediatric theatres told us that they still found staffing challenging because not all the expected staff had transferred from North Bristol. However, they told us about their recruitment plans for additional staff. Despite the staffing challenges, the theatre team was able to maintain two on-call teams available for overnight emergencies.
- Each ward and department had access to senior paediatric nursing advice 24 hours a day via the ward managers, matrons, head nurse and clinical site team.
- Each department was led by a ward manager and a designated nurse in charge led each shift. Qualified nurses were complemented by non-qualified nurses with additional skills and training. This additional training enabled the non-qualified nurses to care for children, carry out observations (temperature, pulse, etc.) and, where necessary, taken children to theatre. Some areas had clinical nurse specialists linked to their wards and 12 advanced neonatal nurse practitioners were available within the neonatal intensive care unit.
- Each ward displayed its staffing levels, together with the staff who were currently on duty on any given shift.
- In some ward areas, the sickness rate had been consistently high, particularly on ward 31 (surgery), ward 30 (medicine) and ward 35 (adolescents). We spoke with

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the senior staff in these areas and were informed that they had a couple of staff on long-term sick leave, which had increased their sickness rates. They told us how appropriate referrals were made to occupational health and regular contact was kept with the staff concerned. Phased return-to-work plans were available as necessary. Vacancy rates had also been reported as high in a number of ward areas. However, this had been resolved with the recent recruitment campaign.

Medical staffing

- Each specialty within the children's hospital had its own team of specialist consultants, registrars and junior doctors. The children's hospital had a higher proportion of registrar doctors (70%) compared with the UK average of 51% but slightly fewer consultants at 24% compared with the UK average of 34%. We did not see any evidence that suggested that the reduced number of consultants had any negative impact on the care and treatment children and young people received.
- Every specialty developed its own medical rotas to maintain cover for their specialty. The consultants were supported by registrars and junior doctors. Consultants were available overnight via on-call arrangements. Junior medical staff were given rota descriptions so that they were aware of their additional duties, such as clinics, or when to see children in the accident and emergency department.
- We observed ward rounds in a number of ward areas including the paediatric intensive care unit.
- Feedback from the General Medical Council training survey for 2013 showed concerns in overall satisfaction, clinical supervision, induction, workload, access to educational resources, educational supervision, local and regional paediatric teaching. Measures had been put in place to improve the experience for medical staff and a review in 2014 showed that improvements had been made. These changes included new rotas, new induction, more formalised training each week and the inclusion of trainees in the consultants' ward rounds. The medical staff we spoke with confirmed that these changes had been made and were being sustained. A trainee forum had been set up within paediatric cardiology following this survey. The aim of the forum was to review the survey results and facilitate improvements. The children's hospital met the Royal College of Paediatrics and Child Health's standards for acute paediatric services.

- The General Medical Council training survey for 2014 showed that the neonatal intensive care unit scored above the national average for trainee experience, handover and induction.

Major incident awareness and training

- Since the transfer of children's services from North Bristol NHS Trust to the children's hospital in May 2014, the children's hospital had become the children's trauma centre for the South West of England and South Wales. These changes had placed additional responsibilities on particular departments, such as the paediatric intensive care unit and the neurology and burns unit, to respond to emergency situations. Staff in these areas were aware of the major incident policy and how it related to their specialty.
- All the staff we spoke with were aware of the major incident policy and understood their roles and responsibilities within a major incident.

Are services for children and young people effective?

Outstanding



The effectiveness of children's services were rated as outstanding. Patient outcomes were routinely better than expected which was demonstrated through independent benchmarking. There was evidence of staff being involved in the development and review of policy, procedures and implementing a change practice, where improvements in outcomes were required. This included improvements in neonatal mortality data and also a specific cardiac procedure.

Transitional care for young people to adult services was outstanding. Planning was started at an early stage for children with complex conditions for whom treatment would continue into adult life. In cardiac services planning started from the age of 12 years continued throughout the patient's teenage years. Young people were actively involved in transitional care arrangements, individually, in order to meet their needs and in reviewing transitional arrangements as a group.

There was a strong commitment to the skills knowledge and competence of all staff. There was a fully established paediatric outreach team 24/7. The development of the

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Paediatric Faculty of Education at the hospital to develop the skills, competence and knowledge of staff alongside ensuring that staff were appropriately prepared and upskilled to provide care for the children's services prior to being moved over from NBT was outstanding. There were strong shared care protocols in place across the South West and South Wales.

Play therapy services were creative and innovative in their approach, providing distraction therapy and in working with children as part of the planning process for future procedures, in order to allay anxiety and fear surrounding hospital admissions.

Evidence-based care and treatment

- Policies, procedures and guidelines were developed in line with national best practice where available, for example the starvation guidelines for children before an anaesthetic.
- Policies, procedures and guidelines were available to all staff via the trust intranet. Staff we spoke with knew how to access them when necessary, although some staff reported that it was sometimes cumbersome to find what they were looking for.

Pain relief

- The children's hospital had a dedicated paediatric pain team that was able to review children who needed additional support with their pain management. The team was also able to provide staff with training, complete pain audits and develop policies. The pain team trained link nurses on each ward area to act as an additional resource on pain management within their own clinical area.
- The pain team carried out audits to inform, develop and change practice within the hospital. For example, one audit led to a change in pain relief medication after a specific operation. Another audit confirmed that the pain relief regime in place for another procedure was effective and therefore nothing needed to be changed.
- Staff were expected to complete training in pain management for children. This was provided by the pain team, covered general pain assessment and management, and was suitable for all levels of staff. Additional training was provided for more experienced staff, such as epidural care.
- A pain assessment and management policy was in place across the trust. This policy reflected best practice such

as the good practice in postoperative and procedure pain from the Association of Paediatric Anaesthetists. The staff we spoke with knew how to access this policy and how to access the specialist pain team.

- Pain scores were an integral part of the observation charts. Different pain assessment tools were used depending on the age of the children. For example, FLACC (Face, Legs, Activity, Cry and Consolability) assessments were used for babies and toddlers; Wong and Baker (the use of happy and sad faces) were used for younger children; and a visual analogue scale (scale of 1 to 10) was used for older children and young people. The records we looked at during the inspection confirmed that staff completed the pain assessment section of the observation charts when appropriate.
- Paediatric pain management information was included on all observation charts. This information included the contact numbers for the clinical nurse specialist for pain management. The charts also reminded staff what combinations of medicines to prescribe and administer depending on the levels of pain.
- The play specialist team was available in each ward and department and provided valuable distraction therapy for children undergoing different procedures.
- The children and young people told us that they received pain relief medication when they needed it. Parents also confirmed that the staff worked hard to make sure their children were not in pain.

Nutrition and hydration

- All the wards within the children's hospital operated a protected meal times policy for both lunchtime and evening meals. This meant that children and young people could eat without being disturbed by staff on ward rounds or visitors (except parents and siblings). We saw that this was observed by staff on the wards we visited.
- Children and young people were able to choose what they wanted to eat from a menu. If they did not like what was on offer, parents were allowed to bring in food for them. Where their condition allowed, children were also allowed off the ward with their parents to visit the coffee shop or the main hospital shops. Snack trolleys were available on the wards and children could help themselves to drinks and snacks throughout the day.

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- On the adolescent unit, the young people were allowed (following risk assessment) to use their own kitchen to make themselves drinks, breakfast and other snacks. They were also able to have their meals outside the normal meal times if they so wished.
- The children's hospital had a team of paediatric dieticians who were available for specialist advice and support with special diets and feeds. The dieticians had their own website on the hospital intranet from which staff could access policies and guidelines as well as any relevant training. The staff were aware of this information and how and when to access the dietician service. The staff were also aware of how to order specialist menu choices such as Halal food or gluten-free meals.
- We saw staff ensure that any mothers who were breastfeeding their babies were provided with meals at the relevant times.
- The records we reviewed during our inspection showed that any fluid or dietary intake was monitored and recorded where necessary.
- The children and young people we spoke with thought the food was very good overall. However, they also said that it was not as good as they had at home. The parents we spoke with all confirmed that they thought the meals were good.

Patient outcomes

- The children's hospital is exceptional in having a fully established outreach team available 24 hours a day. The team was able to attend emergencies across the children's hospital site; review children in high-dependency areas; and follow up children discharged back to the wards from the paediatric intensive care unit or high-dependency units. Staff could also contact the outreach team if they were worried about a child's deteriorating condition. The outreach team was able to start specific treatments as necessary, which improved the child's chances of recovery. The staff we spoke with all knew about the outreach team and how and when to contact them. Staff also told us how supportive and responsive the outreach team was.
- The hospital play specialist team was trained to use play therapy with children and young people. Staff across the children's hospital told us how important this was because often children were scared about particular procedures. The play team was able to work with the children and family to overcome those fears through play. We were shown a letter to the play team from the parents of a child who had been a patient in August 2014. The letter was full of compliments for the staff. Part of it read: "as a result of the play specialist, our brave little boy who was once too frightened to sit in a hospital bed and of any interventions was able to participate in almost seven hours of tests. We are forever grateful and it's changed his life." This comment reflected those of other parents who we spoke with during our inspection. The play specialist team was highly regarded by children, parents and staff alike.
- The neonatal intensive care unit had improved its mortality rates since 2010 by making sure that staff followed the available policies and procedures to provide care to the babies within the unit. As a result, a 24% reduction had been seen in the number of neonatal deaths. The data presented to us before our inspection also showed that the unit had low rates of infection for central lines, and low hypothermia rates.
- The number of multiple emergency admissions (April 2013 to April 2014) for children with asthma, diabetes and epilepsy was lower than the national average. There was evidence to show that readmission rates were lower than the national average for general paediatrics, paediatric surgery, oncology, and trauma and orthopaedics. Emergency readmissions were comparable with the national average for ENT and clinical haematology.
- The centralisation of children's services in Bristol at the children's hospital had already improved the outcomes for emergency admissions. The staff were able to give us information about children who had been admitted as emergencies from across the South West of England and who required multiple specialists, including neurology and respiratory medicine. Because the specialties were on site at a single location, they were able to see and treat the child without delay, working as a multidisciplinary team to give the child the best possible outcome from severe trauma.
- A clinical nurse specialist was available for anticoagulant therapy and was the lead for making sure that children received the appropriate medication according to their blood results.
- The cardiology department within the children's hospital participated in the National Institute for Cardiovascular Outcomes Research (NICOR) audits. An analysis of the data submitted from 1 April 2010 to 31 March 2013 showed that overall survival at 30 days

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following a heart operation in all specialist children's heart units was above the specified limit. It also found that survival at 30 days after each of the 57 surgical and transcatheter cardiovascular interventions most frequently undertaken to treat congenital heart disease in children and young people continued to be above the specified limit. However, for the arterial shunt procedure at the BRHC the outcomes were below the warning limit, which indicated a higher than expected level of mortality for this procedure. This could be for a number of reasons, including the complexity of the cases and small numbers of the procedure being undertaken. The trust had reviewed this data and their practice against other paediatric cardiac centres. As result of this practice and guidance had been reviewed and implemented new practice guidance for this procedure.

Competent staff

- Student nurses told us that they were mentored by experienced, qualified staff and supervised in their practice. They said that they had received orientation to the ward before they started their placement and had all received very good supervision.
- We spoke with several newly qualified nursing staff who had been employed as part of the latest recruitment drive. They told us that they had received an overall trust induction, which they felt gave them the appropriate information for the trust as a whole. It also included some of the mandatory training that they were expected to complete. They told us that they had a very good ward induction and then were able to work on a supernumerary basis (not included in the ward staffing numbers) for two weeks to allow them time to settle into the ward and the specialty. We saw excellent examples of comprehensive competency-based preceptorship and orientation programmes for new staff within the neonatal and paediatric intensive care units.
- The children's hospital also made sure that other staff were appropriately skilled and we spoke with several non-qualified nurses who had been given additional training to allow them to look after their own caseload of children, complete observations (temperature, pulse, etc.), write their own entries in the multidisciplinary team (MDT) notes and, where necessary, take children to theatre. These skills complemented the skills of the qualified nursing staff. We were shown evidence that their work was supervised by experienced, qualified nurses.
- Nursing staff at all levels told us about the supervision arrangements in their own ward areas. All the staff we spoke with told us how well supported they felt by their ward teams, their managers and the senior nursing and managerial staff within the children's hospital. Senior staff were always on hand to supervise, guide and support junior staff. All the wards and departments we visited had completed appraisals for the majority of their staff. For example, theatres had completed appraisals for 97% (according to records held within the theatre department, trust data stated 80%) of their staff, while the neonatal intensive care unit had achieved 100%.
- A new development at the children's hospital was the new Paediatric Faculty of Education, which was linked to Plymouth University. The faculty provided specialist courses up to master's level and was accessible to staff within the children's hospital. The training provided ranged from an advanced critical care practitioners programme through to training staff on the use of medical devices. The staff we spoke with were all very positive about this faculty and the benefits it would bring to all staff, as well as saying that it was a positive initiative for the retention of staff. Staff expressed concerns to us that it would not continue after the initial period of funding expired. We raised these concerns with senior staff and we were told that they were looking to be self-funding within two years by advertising their courses to other hospital staff across the country and charging accordingly.
- We looked at the training records on each ward we visited. These showed that the majority of staff were up to date with their mandatory training as well as being trained to use specific medical devices and had had their competency checked. We saw evidence that, where appropriate, staff had also received additional training in neurology, burns and plastics in readiness for children's services moving into the children's hospital from North Bristol NHS Trust in May 2014. This was particularly relevant to staff within the paediatric intensive care unit, accident and emergency department and theatres.
- The medical staff we spoke with all confirmed that they had received an appropriate induction both to the trust and to the children's hospital when they started work.

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The medical staff told us that they received good training opportunities and we saw evidence of this on ward 32 (paediatric cardiology), which had dedicated teaching slots and weekly specialist registrar training.

Multidisciplinary working

- We saw examples of multidisciplinary team working across the children's hospital. This had been enhanced by the centralisation of children's services at the children's hospital. We observed excellent multidisciplinary working in the ward round within the cardiology high-dependency units. The ward round was attended by the medical staff from cardiology and the paediatric intensive care unit. This combined the skills of the specialty consultants and the intensivists. The ward round also included nursing staff, play specialists and other staff as necessary. On ward 34 (oncology and haematology), we observed integrated care meetings that involved specialist cancer nurses, doctors, physiotherapists, play specialists and psychologists. We were told of other examples where specialties had come together immediately to care for children admitted with multiple traumas; this had not been possible before children's services had all come together at the children's hospital.
- Shared care protocols were in place with other children's units across the South West of England and South Wales. Good communication existed between them and treatment was arranged close to the child's home where possible, with admission to the children's hospital for more specialist treatments that could not be provided at their local hospital.
- The wards were visited by physiotherapists, occupational therapists, pharmacists, dieticians, play specialists, teachers and specialist nurses.
- The ward rounds were attended by a multidisciplinary team and reviewed each child. Discussions were documented in the medical notes.

Transition

- Planning for transitional care for young people who had complex conditions and would require ongoing treatment into adult life was started at an early stage. For example, within cardiology this was started when the child reached 12 years of age and slowly progressed in order to ensure the young person was prepared to transfer to adult services at the age of 18 years. Within oncology, a transition ward was available for young people aged 16 to 24 years. The ward was jointly

managed by the paediatric and adult oncology team but staffed with adult-trained nurses. Staff also told us that a named transition support worker continued to work with a young person for up to a year after the transfer of care.

- There was a creative and innovative approach to the development of transitional care arrangements. Young people were involved individually in transitional care in order that their needs were met, but also involved as a group in the continued development and improvement of transitional care. The trust had established a trust-wide transition group led by the chief nurse. The purpose of this group was to draw on the excellent examples that already existed and make sure that they were reflected consistently in all clinical areas. The group had produced a policy and guidelines (not ratified at the time of our visit). We were shown the policy, which included the process that had to be followed at each year from 12 through to 18 years of age. We were shown the actions being taken across the children's hospital and the wider trust in order to further improve services for young people transferring to adult services. The work that had already been completed and was ongoing was clearly identified.
- The young person's council was actively involved in the transition project and had been developing a dedicated transition website specifically for young people within the children's hospital. We saw a preview of the website. Audits were completed directly with young people to get their feedback on the transition process. Overall, this was positive and the areas for improvement from the young person's point of view had already been identified by the transition group, with measures put in place to rectify the issues.

Seven-day services

- There were seven-day services within the children's hospital, with the exception of day surgery, outpatient clinics and the play and school departments. All the wards operated a service 24 hours a day. We saw examples where services, such as physiotherapy, were available both out of hours and at weekends.
- Theatres were available out of hours for emergencies via the use of two on-call nursing teams. There was access to imaging services out of hours and at weekends.
- Consultants reviewed their patients daily on the ward rounds and were available out of hours via on-call arrangements.

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Play Therapy

- The play specialist team and the hospital education team were part of the multidisciplinary team across the children's hospital and supported children and young people emotionally during particularly difficult times. The play specialist team supported children through play therapy. The teaching staff were able to support children with their educational needs to make sure that they did not fall too far behind in their school work.
- A play team was able to provide qualified play specialists and play assistants to all wards and departments across the children's hospital in addition to a central play room. The play team was informed of all planned admissions and involved in multidisciplinary ward rounds as necessary. The play team had received specialist training on having difficult conversations with children. For those children who spent a long time in hospital, or those who were anxious or had fear of being in hospital, the play team worked with the child and family to reassure them about future procedures. This work was turned into a pictorial journey or progress book which detailed enabled the child to look back on their journey and to support them in the future.
- The play team received a lot of support from charities to purchase toys, etc. However, the staff told us that the department did not hold its own budget (except for pay). There was no cover between play specialists for annual leave or sickness.

Are services for children and young people caring?

Good



Children and young people were treated with compassion and respect and staff were found to be caring. The needs of the child or young person and family were always at the forefront of what staff did. The caring attitude of all the staff shone through in every department we visited. The staff had expertise in caring and communicating with children and young people. We observed excellent child-centred care being given. The atmosphere was geared towards children and the staff always had time to explain and involve children in their care in ways they could understand. All the parents, children and young people we spoke with told us how brilliant the staff were.

Compassionate care

- Friends and Family Test was not carried out within the hospital at the time of our inspection but was to be rolled out on children's wards in line with the national programme. Patient and parent survey results were displayed in each ward and showed high levels of satisfaction with the care provided to children and young people. For example, on ward 34 (oncology, haematology and bone marrow transplant (BMT)), 90% of parents said that the care provided to their children was either excellent or very good, and 100% of parents said that they and their children were treated with dignity and respect. On ward 37 (renal and nephrology), 100% of parents said that the care their children received was excellent or very good and that they and their children were treated with dignity and respect.
- During our visit, we observed excellent interactions between staff, children and young people and their parents. This interaction was kind, compassionate and very caring. Staff were skilled in communicating with children and young people; we observed this on every ward and department we visited. Children and young people told us that staff were very caring; one said staff were "brilliant". We also saw thank you cards on each ward from parents and children expressing their thanks for the care provided. One parent told us that the care on the neonatal intensive care unit was brilliant and that they were very impressed with the standards of the care the babies received. On ward 38 (neurosciences), the ward manager was very proud to show us a framed piece of writing from a parent. A key sentence said: "they [the staff] care for the children like their own".
- We observed discussions between staff and parents on the paediatric intensive care unit. Staff were caring and compassionate in their manner and acted on the wishes of parents while ensuring that the impact of those wishes was communicated clearly.
- We saw evidence that parents were encouraged to be involved in the care of their child as much as they wanted to be. Parents were asked by staff how they wanted to be involved when their child was admitted to the ward. On the adolescent ward, the young people were encouraged to be independent and just to be teenagers. For example, one young person told us that they did not want their parents staying with them,

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whereas another young person did. A young person also told us how they did not want the staff doing everything for them, but were grateful that they were there when needed.

Patient understanding and involvement

- We observed how staff explained things to both parents and children and young people. For example, we observed an anaesthetist explaining what would happen in the anaesthetic room to a child in a way they could understand and in a way that was not frightening for them. We saw how this reassured both the child and their parents. Parents told us that the staff listened to what they had to say and involved them in the care and treatment of their child. Two parents said that they were always kept well informed by staff and that staff repeated things when necessary to make sure they understood what was being said. They also added that this was done in a very compassionate way. This represented the views of the majority of parents with whom we spoke.
- Children and young people told us how staff involved them in their own care. One young person told us that they were able to do most things for themselves but that the staff were there whenever they needed additional help or support.
- A range of information on specific procedures and conditions was available for parents on all the wards and departments. This was used to support verbal explanations given by staff. Some leaflets were given to parents when their child was discharged. We saw that the leaflets included important information, for example on when pain relief should next be given and who the parents should contact if they were worried about their child. We observed staff explaining things using the leaflets for support. They allowed time for questions from parents or the children themselves and checked understanding. We saw that information had also been written especially for children and young people in a way that they could understand.
- Nursing assessments encouraged the family and nursing teams to have clear lines of communication in relation to the child's care. They promoted understanding and involvement from both parents and their children. Staff on the paediatric intensive care unit told us that

parental involvement was paramount. We saw evidence of this on the unit and also in all the wards and departments we visited. The parents we spoke with confirmed that this was the case.

- On each ward and department it was clear which nurse was looking after each particular child or young person. The children and young people we spoke with all knew who was looking after them.

Emotional support

- The chaplain service was available throughout the children's hospital to support parents, children and young people with their emotional and spiritual needs. The chaplain we spoke with told us about the duty rounds they completed each day and how they paid particular attention to the accident and emergency department, paediatric and neonatal intensive care units, the oncology department and the prayer room. A prayer room was available for people of all faiths to support their spiritual needs. Spiritual workers from all faiths were available to support people.
- We observed staff emotionally supporting parents, children and young people. For example, a nurse accompanying a child and their parent to the anaesthetic room was able to reassure and comfort the parent when their child was asleep and they were asked to leave the anaesthetic room. Staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this in every ward and department we visited.
- Additional support was available throughout the children's hospital: for example, a parent support group within cardiology, specialist cancer nurses within the oncology department, and psychologists within the paediatric intensive care unit. The South West Children's Heart Circle had started preparing boxes with useful items such as shampoo and vouchers for the local shops to make the stay in hospital a little easier for parents. Specialist fetal counsellors were available within the neonatal intensive care unit to screen and counsel parents who may have been at risk of genetic problems. Staff also told us about the FAB Club; this was a charity whose aim was to provide ongoing support to burn-injured children and their families. Music therapists were available throughout the children's hospital and provided a valuable support for children.
- Children and young people who needed surgery were allowed to have their parents accompany them to the

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anaesthetic room and stay with them until they were asleep. This ensured that parents were able to continue to provide emotional support for their children. Parents were called to the recovery room after the surgery as soon as their child was awake to provide reassurance and support for their child.

- A palliative care liaison nurse was available to support the delivery of palliative care by consultants and clinical teams; a dedicated palliative care team was due to be created in 2015. They provided clinical reviews and support with symptom management, training for staff on palliative care issues, and support for staff and parents following the death of a child.
- Information booklets were available for parents thinking about resuscitation for their child, and the children's hospital used a 'child and family wishes' document to detail preferences regarding the care parents would like if the child's condition deteriorated or if they became very ill. The palliative care team was able to support the child and family in completing this document where necessary. The team was also available to support staff with difficult conversations with families. Clinical guidelines were available for staff for end of life care planning.

Are services for children and young people responsive?

Good



Services for children and young people were responsive to their needs. The children's hospital provided local care and treatment to the children of Bristol and the surrounding area. It also provided centralised children's services and a trauma centre for the children of the South West of England and South Wales. Staff were experienced in caring for and communicating with children, young people and their families. We saw good evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- The children's hospital provided general children's services for the children and young people of the Bristol area. They also provided specialist children's services for the South West of England and South Wales. For the local population, the hospital provided outpatient

clinics both at the main children's hospital and also in local communities around Bristol. The hospital also provided medical and surgical wards covering conditions that children might experience, ranging from asthma through to ENT surgery. For children who lived long distances from the children's hospital, shared care arrangements were in place where possible at the child's local hospital. This meant that they needed to travel to Bristol only for specialist care that could not be delivered locally near their home.

- Each ward and department had escalation plans in place to meet capacity and demand for their services. The 24-hour on-site clinical team had an overall view of capacity and emergencies within the hospital.

Access and flow

- For planned surgery, pre-admission clinics were held between two to four weeks before the surgery. During this appointment, all the relevant information was taken from the parents and the child or young person. The procedure was explained to the parents and the child and consent was taken from the parents (and the young person, where appropriate). Parents of children or young people who had planned admissions were asked to phone the ward on the day of admission to check for bed availability. Planned admissions were sometimes cancelled if emergency admissions had filled the available beds. However, this was always a last resort.
- When a child or young person was admitted to the ward, they were oriented and the facilities explained. Where possible, children were admitted onto the most suitable ward depending on their needs. For example, a young person would be admitted to the adolescent unit, and a child with a heart condition would be admitted to cardiology. Plans were in place when it was not possible for children to be admitted onto their designated ward. For example, during the winter prior to our inspection, the surgical ward needed to take children with medical problems. Staff from the medical ward supported the surgical ward staff in caring for these children. During our inspection, we did not observe any outliers; however, staff told us that this did happen during the winter months.
- Children were discharged directly from the wards. If there was any delay in discharge, there were play specialists on hand to involve the child in activities while they were waiting. Some wards, for example ward 36 (day case surgery), operated a nurse-led discharge

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system for the majority of children. This meant that the surgeon specified in the operation notes what criteria the child must have met before discharge. Once the nursing staff were satisfied that those criteria had been met, they were able to discharge the child without waiting for an additional medical review. This followed good practice and reduced delays for children waiting to go home.

- The records we looked at during our visit showed that the admission and discharge paperwork and checklists had been completed appropriately.

Meeting people's individual needs

- A family support service was based within the LIAISE (listening, information, advice, involvement, support and experience) office to help parents with any issues that might be worrying them, for example arranging time off work or dealing with financial issues.
- A learning disability nurse specialist was available within the children's hospital to provide advice and support to children with a learning disability. They also provided advice and support to staff so that they could meet these patients' needs.
- A disability nursing assessment was completed when appropriate and contained more detailed information on how to care for the individual child should the parents not be present. The children's hospital also operated a 'patient passport' for children with disabilities. This was completed by parents and complemented the nursing assessment. It detailed what the child was able to do for themselves and where they needed additional support from the staff. Where additional help was needed, the passport explained how staff were to provide that care. Portable sensory equipment was available from the play team; this included a water bed, bubble tubes and music therapy.
- The adolescent unit catered for the needs of young people. Several different 'chill out' and games rooms were available. There were two two-bedded bays but accommodation was mostly in single rooms. This offered the young person more privacy if they needed it.
- On admission, children from two to 12 years were told if they would be in a bay with other children of different ages and sex. Young people between 12 and 18 years old were asked if they would like single-sex accommodation; their requests were accommodated where possible.

- Each ward and department catered to the needs of children. This included ensuring that there was enough space by each bed for a parent to stay and providing play and school rooms. Outside play space was available in the main play room and on ward 38 (neurosciences).
- The hospital schools service provided education to all children within the children's hospital and where necessary their siblings. Where the child was able to, they could attend the school room to make sure they did not fall too far behind in their learning. The school liaised with the child's normal school and could support young people in taking exams.

Learning from complaints and concerns

- The LIAISE team was available from Monday to Friday to listen to any concerns children, young people or their parents might have. Staff were available to see a parent and/or child in their office or on the ward to provide advice and support. The LIAISE team told us that they always did what they could for families and always gave them information so that the family could make a choice as to whether they wanted to make a formal complaint.
- Information leaflets and posters were displayed in all wards and departments to explain how parents, children and young people could raise their concerns or complaints.
- Where parents decided to raise a complaint, they could do this by using complaint forms or contacting the trust's complaints team directly, or the LIAISE team would take the details and pass them to the complaints team on the family's behalf. The parents knew how to access the complaints procedure if they wanted to. Some parents told us that, if they had any concerns, they would raise them directly with their child's nurse or the ward manager. They also told us that they had confidence that their concerns would be resolved.
- Staff we spoke with were all aware of the LIAISE team and the complaints process. Staff told us that they would always try to resolve any issues there and then. If they were unable to do this, they would refer the family to the LIAISE team, which would try to resolve the problem by working in partnership with the family and the ward staff. If issues could not be resolved, the family

Services for children and young people

was directed to the complaints process. Staff were aware of any complaints that had been made about their own ward and any learning that had resulted from them.

- All complaints that came into the children's hospital were seen by the divisional director and the head nurse. Complaints were then disseminated through the specialty to the ward or department for investigation. Staff (the ward manager in conjunction with the staff involved) would investigate the complaint and draft a response that was then approved by the head nurse and the divisional director. Once it had been approved, it was forwarded to the complaints department and the attention of the chief executive.
- Trends and themes from complaints and concerns were discussed at ward level, specialty level and divisional level. This made sure that themes and trends were identified and actions taken where necessary. A patient story for children's services was presented routinely at the main trust board to highlight complaints within the children's hospital. The story included what had happened and identified any good practice, learning and actions taken.
- We saw examples of lessons being learned from complaints. For example, a parent had complained about the location of a parents' room in which they received bad news. The parent had subsequently been involved in the planning, relocation and redesign of the parents' room.
- Following the death of a child, a rapid response meeting was held and a child death review investigation commenced within 24 hours. Parents were involved in this process to enable them to ask questions of the review. The review looked at the cause of death, the care provided, and whether there was anything that could have been done differently. This was routine for all child deaths, whether they were expected or unexpected. Parents were kept informed of the progress of the review and any follow-up was agreed with them.
- Learning from complaints was included within staff training and meetings to make sure that staff were aware of and learned from complaints.

Are services for children and young people well-led?

Good



Services for children and young people were well led. All senior staff from ward managers through to the divisional management team were visible throughout the hospital and well respected by staff. Staff told us how well supported they felt. They also told us they thought that the children's hospital was well led both at ward and specialty level but also through the divisional management team. All the staff worked hard to make the children's hospital a centre of excellence. Children's services had good governance systems in place with risks escalated through from ward, specialty and division to the trust patient safety team and trust board.

Vision and strategy for this service

- The staff we spoke with were aware of the overall trust mission and values. They were also aware of the vision for their own ward or department and the children's hospital overall.
- We saw evidence of redesign taking place, particularly within the accident and emergency department.
- The recent centralisation of general paediatrics and specialist neurosurgery and burns from North Bristol NHS Trust to the children's hospital has supported the overall aim to centralise children's services and to create a specialist children's trauma centre for the South West of England and South Wales.

Governance, risk management and quality measurement

- The divisional management team acknowledged that in the past, while they took governance very seriously, they had not always been able to learn lessons across the children's hospital. However, they had changed their approach to governance and learning from instances when things had not gone as planned. Wards held their own ward meetings to discuss complaints, concerns, incidents, etc. These meetings linked directly to specialty meetings and then into the divisional governance meeting. This enabled issues to be risk-assessed and escalated in a timely way and to be added to the divisional or trust risk register. It also meant that action plans could be put in place. The trust's patient safety team was automatically notified of any risk issues.

Services for children and young people

- Wards produced monthly dashboards showing their current and historical statistics for a variety of indicators, including staffing and cleanliness. In addition, ward managers fed back all the comments made by parents and children through their regular meetings with staff. Staff also received feedback via newsletters and emails.

Leadership of service

- The staff we spoke with were all aware of their immediate managers. Staff described them as being supportive, approachable and visible. Staff also told us that the matrons, head nurse and divisional managers were all visible and visited the wards regularly. Staff complimented their managers, matrons and senior staff within the children's hospital for the way in which they managed the services.
- The trust and divisional management team had implemented measures to change practice and to support staff within the hospital. This support included counselling provision and weekly meetings and briefings with the staff. Staff appreciated this level of support from both the divisional management team and the trust's chief executive.
- Senior divisional managers had 'back to the floor' days when staff could openly discuss any problems or concerns. The staff we spoke with told us that they had confidence that their managers would listen to any concerns raised and take appropriate action when necessary. The staff also told us that the children's hospital was well run and the leadership was good.

Culture within the service

- The culture in the children's hospital was described by staff as one that put the child and family first. This was evidenced through our observations during our visit.
- All the staff we spoke with were very proud of the care they provided and of their ward or department, their specialty and the children's hospital in general. The staff worked well together and felt part of the children's hospital team. All the staff we spoke with felt part of the children's hospital first and then part of the wider University Hospitals Bristol.
- The staff described an open culture in which they were encouraged to report incidents, concerns and complaints to their manager. Staff felt able to raise any concerns.

Public and staff engagement

- A young person's council was in place and was proactive in ensuring that young people had a voice within the children's hospital and wider trust. We saw, for example, that young people were particularly involved in the transitional care project. The children's hospital employed a young person's involvement worker to facilitate the council and other involvement work across the hospital. We were also told that two young people had been appointed to the role of 'young governors' in March 2014.
- Satisfaction questionnaires were sent directly to children aged 12 and over and to parents of children aged 0 to 11 years. In the 12 months to the end of June 2014, 1,109 parents and 300 young people had responded to the survey with very positive results.
- Comment cards were available in all wards and departments. These were managed by the ward manager and the results displayed each month on a 'You said, we did' board. Themes of these comment cards were also discussed at the ward meetings, fed through the divisional management structure and reviewed by the trust-wide patient experience group.
- We saw examples where the children's hospital had engaged with local parent and carer networks who were involved in supporting children and young people with disabilities. The hospital's 'patient passport' was developed out of this collaborative work. The trust also engaged with young carer groups to recognise their role when the adults they cared for were being looked after in the trust. We were also told of where, especially in cardiology, parents had been invited back to feedback sessions. The staff and parents found this a positive experience and it played a vital part in improving services for children and young people.
- Staff told us that they felt included in changes and developments within the children's hospital. Staff were able to participate in the staff satisfaction survey and 52% had participated across the trust (compared with the England average of 49%).

Innovation, improvement and sustainability

- The children's hospital provides care to children and young people across the South West of England and South Wales. Shared care arrangements were in place with children's units in district general hospitals.

Services for children and young people

- To improve retention of staff, the new Faculty of Paediatric Education provided specialist courses up to master's level.
- It is unusual for babies to require dialysis, but occasionally it does happen. The renal unit had developed specialised simulation babies to train staff and had presented this at a national conference to share innovative and good practice.

End of life care

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

Information about the service

End of life care was delivered where required by ward staff throughout the hospital. There was a specialist palliative care team that provided support and advice for those patients who had complex care needs and/or complex symptom management. Support was also provided to relatives of end of life patients. The specialist palliative care team consisted of 2.3 whole time equivalent (WTE) consultants and 4.8 WTE nurses who were based in the haematology and oncology centre. The team was accessible 24 hours a day and facilitated weekly multidisciplinary meetings with other professionals to support end of life care. These included an occupational therapist, physiotherapist, oncology psychologist, chaplain and a member of the hospital discharge team. Staff throughout the trust understood how to make a referral to the specialist team and consistently reported that the team responded promptly.

We visited 13 wards and seven specialist departments. We met 11 patients, spoke with four relatives and reviewed 14 care records. We talked to 47 staff about end of life care. These included the specialist palliative care team, ward nurses and doctors, allied health professionals, porters, psychologists, the chaplaincy team and bereavement and mortuary staff. We observed care being provided to patients and relatives. Before and during our inspection we reviewed the trust's performance information.

Summary of findings

The specialist palliative care team had developed a range of tools and processes in order to deliver, monitor and evaluate care in line with current best practice. They regularly reviewed patients within multidisciplinary forums to promote coordinated, safe and effective care. Care records demonstrated that potential problems for patients were identified and planned for in advance with action plans. This information was recorded clearly in care plans.

We found that end of life care was effective and responsive to individual patient needs, particularly in the last days and hours of life. Improvements were needed to identify patients who were potentially in their last year of life in order to better plan care. End of life patients were not always able to be in their preferred place of care as the discharge-planning process was not fully effective. Intermediate improvements were required to the mortuary facilities while the planned redevelopment of this facility were completed.

All the patients and relatives we spoke with told us that they had been involved in decisions, care was good and staff were respectful and kind. Staff throughout the trust valued the expertise and responsiveness of the specialist palliative care team.

End of life care

Are end of life care services safe?

Good



The specialist palliative care team provided consistent, safe care and advice for patients, relatives and staff throughout the trust. Equipment and other resources were available to manage patients' pain and other symptoms safely. The team demonstrated how it learned from incidents and shared learning with others. Although the trust had plans to update the mortuary facilities, at the time of our visit there was a lack of regard for cleanliness for staff and visitors who had to use the current facilities.

Incidents

- There had been no never events in the specialist palliative care service. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
- Staff understood their responsibilities with regard to reporting incidents.
- The specialist palliative care team reviewed incidents relating to end of life care as a standing agenda item at its monthly business meeting. Staff said that this ensured that feedback and learning were shared and understood by the whole team.
- Incidents were also reviewed as a standing agenda item during the quarterly end of life steering group for adults and children. This enabled incidents relating to end of life care to be reviewed for trust-wide learning to be shared where appropriate.
- The last incident, which occurred in April 2014, was a medicine error. Staff demonstrated their understanding and learning, which resulted in improvements to the way in which information was checked when patients were referred to the specialist team.

Safety Thermometer

- There was no Safety Thermometer directly related to palliative care. (The Safety Thermometer is a tool designed to be used by frontline healthcare professionals. Once a month, it measures specific patient risks such as falls, infection control and pressure ulcers.)
- The specialist palliative care team did not directly participate in the Safety Thermometer on wards.

Cleanliness, infection control and hygiene

- The ward areas we inspected were clean. There were sufficient hand-washing sinks and hand gels in bays and near side rooms.
- We saw that staff were observing the trust's 'bare below the elbow' policy and adequate supplies of personal protective equipment were available in all clinical areas.
- In the mortuary there was a lack of regard for cleanliness for staff and visitors who had to use the current facilities. The toilet facilities which were available were designated for staff use, were not well maintained or clean. Outside the mortuary by the entrance to the lifts we observed that three large clinical waste bins and a full black plastic waste bag had been left by the entrance to the lifts near the mortuary. Two of these clinical waste bins were not locked and were full of waste materials. This presented an infection control risk. This did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections or related guidance.

Medicines

- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to manage promptly any changes in patients' pain or symptoms.
- Clear guidance on medicines was provided for doctors and nurses to assess, manage and review a range of end of life symptoms. This was part of the end of life tools used on wards.
- Records showed that those patients who were referred to the specialist palliative care team had their medicines reviewed regularly. This was done in consultation with other medical staff involved with the patient's care.

Equipment

- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. The specialist palliative care team had been responsible for training staff throughout the trust to use the alternative McKinley syringe driver. Documents recorded that all identified staff had attended a two-hour training session and competency assessment. This training had been completed prior to the syringe driver changeover date of 1 April 2014.

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Records

- Patients' end of life care records were kept in both paper and electronic formats. We reviewed 14 sets of patient records. We saw that detailed discussions between clinical staff and patients and relatives were recorded sensitively. Records were legible and illustrated clear plans detailing current and planned care, which was reviewed regularly.
- We saw that clinical staff used the trust's end of life care tools. These detailed actions for staff to follow once no active interventions were considered appropriate for a patient. These included stopping unnecessary observations and non-essential medicines and documenting the patient's preferred place of care.
- We observed that weekend management plans had been completed. These recorded potential or anticipated problems and actions staff were required to take to ensure that care remained effective and consistent.
- We looked at 10 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. All had been completed in line with the national guidance published by the General Medical Council.
- We saw that many clinicians used a signature stamp which identified their name and title. On records where this was used, the clinician wrote their signature with the stamp. In other records, we saw printed lists of names and titles with the associated signatures for ease of identification.
- We spoke with a sister who showed us the 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Guidance', which had been updated recently. We saw an email circulation from September 2014 to notify nurses of the change. However, junior doctors were unaware of the updated guidance and were unable to locate it on the intranet when we asked.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The specialist palliative care team and other ward staff were knowledgeable regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt.
- Care records showed that patients' next of kin or advocates had been involved in decisions when patients were no longer able to make decisions independently.

Safeguarding

- Staff were knowledgeable about their role and responsibilities to safeguard vulnerable adults and children from abuse and they understood what processes to follow.
- The specialist palliative care team told us that all members of the team were in date with the trust's mandatory safeguarding training.

Mandatory training

- The specialist palliative care team told us that all members of the team were in date with all of the trust's mandatory training. This included health and safety, infection control and safeguarding training.

Assessing and responding to patient risk

- The specialist palliative care team was in the process of training clinical staff on all wards to use a 'treatment escalation personalised plan' (TEPP). These plans were used to document discussions with patients regarding ceilings of care (which treatments would or would not be appropriate when their condition deteriorated).
- We looked at 14 patient records and saw that two included a completed TEPP form. The specialist palliative care team had audited and evaluated the use of TEPP (in July and August 2014) and had developed action plans to increase its use.
- Advice and support from the specialist palliative care team regarding deteriorating patients were available on all wards.

Nursing and medical staffing

- The specialist palliative care team provided support, advice, training and care to patients and staff trust-wide. The team consisted of 2.3 WTE consultants and 4.8 WTE nurses. The team said that this was adequate staffing and that it would review the skill mix as vacancies arose.
- The team responded to all referrals from clinicians throughout the trust for adult patients who had complex support and/or complex symptom management needs during end of life care. This included support to the families of referred patients.
- The specialist palliative care team met every morning to update on changes in patients' status and care and to review new referrals and allocate work.
- The team facilitated a weekly multidisciplinary meeting for an hour and a half to discuss patients and end of life

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care. This meeting was also attended by an occupational therapist, physiotherapist, oncology psychologist, chaplain and a member of the hospital discharge team.

Major incident awareness and training

- Mortuary staff had additional facilities available in the event that the mortuary became full.
- The chaplaincy services were on call for any major incidents in the local area.
- The specialist palliative care team had not been included or involved in any major incident planning or training.

Are end of life care services effective?

Good



Patients identified as having end of life care needs had their needs assessed and reviewed and had pain and other symptoms managed effectively. Staff recognised that end of life care related to a range of conditions and had training and resources to respond appropriately to patients' individual needs.

End of life care in the last hours or days of life was provided in line with national guidance. However, patients with long-term conditions who may have been in the last year of life were not recognised consistently by staff throughout the trust.

The specialist palliative care team was highly regarded by colleagues throughout the trust. The team was reported as being accessible, responsive and effective in supporting patients with complex end of life care needs and staff training needs.

Evidence-based care and treatment

- The specialist palliative care team followed national guidance from the National Institute for Health and Care Excellence's (NICE's) Quality Standard for End of Life Care for Adults (2011, updated 2013). This was demonstrated in a number of ways. For example, there was a prompt service provided by the patient affairs office, which provided practical and compassionate support to the bereaved, and there was a 24-hour chaplaincy service. Staff in this service told us that the majority of out-of-hours calls (from 5pm to 9am) were in response to requests for end of life rites.

- The hospital had not contributed to the National Care of the Dying Audit as, until recently, this had been linked to use of the Liverpool Care Pathway (LCP). The LCP had never been used by the trust. The specialist palliative care team had designed, audited and evaluated alternative end of life care and assessment tools.
- The specialist palliative care team was using the Gold Standards Prognostic Indicator Guidance from the Royal College of General Practitioners (2011) to develop screening tools. These tools aimed to prompt conversations about future care and treatment with patients with long-term conditions and poor prognosis in specialty wards, including cardiology, respiratory, liver disease, care of the elderly and oncology.
- The specialist palliative care team had developed a 'poor prognosis letter'. This informed GPs of the possibility that their patient could be in the last year of life. The letter prompted GPs to link the patient to the surgery's Gold Standards Framework register (which would enable the patient to access extra support).
- As part of its ongoing work plan, the specialist palliative care team had identified actions for improvements within the trust's end of life pathway. These actions followed recommendations in the Department of Health End of Life Care Strategy (2008) and in One Chance to Get it Right from the Leadership Alliance for the Care of Dying People (2014).

Local audit

- The specialist palliative care team provided written audit evidence relating to end of life tools developed by the team. These tools included action plans relating to the end of life tool, TEPP, advanced care planning and the 'poor prognosis letter'.

Pain relief

- One patient told us that the doctors and nurses regularly checked that the medicines prescribed had been effective for pain relief. This patient said that they had not experienced delays in receiving medicines.
- We spoke with four relatives of patients receiving end of life care, who told us that staff regularly checked that medicines were being administered effectively. Relatives said that staff reviewed the equipment used to relieve pain and checked the comfort of patients. They also told us that staff explained the use of medicines and equipment to relieve pain.
- Patients and relatives were offered support with emotional and psychological pain through the specialist

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palliative care team, the chaplaincy service, ward staff, the specialist cancer psychology service and patient affairs (bereavement offices). We saw that this was documented in care records.

- Palliative medicines (which can alleviate the pain and symptoms associated with end of life) were available at all times. The trust had an adequate supply of syringe drivers and trained staff to set up this equipment.
- Clear guidance on medicines was provided for clinical staff and care records showed that pain was regularly assessed and reviewed. Staff used an assessment tool called the Abbey Pain Scale when patients were not able to articulate their needs.
- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to manage promptly any changes in patients' pain or symptoms.
- Pain management guidance tools for doctors and pain medicine information leaflets for patients and relatives were provided where required. These had been developed by the specialist palliative care team.

Nutrition and hydration

- We saw that patients had been assessed using a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that, following MUST, appropriate nutrition and hydration actions and monitoring tools had been used by staff.
- Specialist dietician support was available on all wards as required.
- We observed that patients had drinks and snacks within reach and relatives said that they were offered food and drinks when visiting, including throughout the night.
- Patients' records showed that those identified as being in the last hours or days of life had had their nutrition and hydration needs evaluated and appropriate actions followed. These records documented subsequent discussions with relatives.

Patient outcomes

- The specialist palliative care team had designed an end of life assessment and care tool. With identified patients, staff used the assessment tool, which scored symptoms and prompted actions based on the scores. The specialist team had audited its tool against the National Care of the Dying Audit. This showed that, in most areas

of care, the trust was comparable with other hospital trusts that participated in the national audit. In areas identified as requiring improvements, action plans had been developed.

- The specialist palliative care team undertook a patient satisfaction survey every two years. The last survey was completed during January 2013. The 20 patients who took part in the last survey all reported that the care they had received was 'very good' or 'good'.
- Patients in the last hours or days of life were identified and staff used the end of life care tools, which promoted effective care.
- Patients with long-term conditions who may have been in the last year of life were not recognised consistently by staff throughout the trust. These patients may have benefited from early discussions and care planning.
- Staff throughout the trust demonstrated an understanding that the end of life pathway was for use with patients diagnosed with any life-threatening condition. This was reflected in the specialist palliative care team's referral audit information. For example, between April 2014 and June 2014, the team received 264 referrals; 65 of these were for patients with conditions other than cancer.

Competent staff

- We saw evidence that the specialist palliative care team provided regular and ongoing training to staff teams and professional groups. These included medical and nursing staff, allied health professionals, ward clerks, pharmacy students and nursing assistants.
- There was evidence in records that between September 2013 and September 2014, only 81 staff had attended the 'Breaking bad news and having difficult conversations' study day. During the same period, only 54 people were recorded as having attended a pain study day. Both teaching sessions were facilitated by the specialist palliative care team.
- The specialist palliative care team contributed to the trust's formal induction training sessions for new nursing assistants and doctors.
- The specialist palliative care team was in the process of setting up link nurses specifically to champion end of life care, processes and policy in all ward areas. Documentation showed that 33 staff had been

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identified, covering 21 different wards. The specialist palliative care team had planned two introductory half-day training sessions for the link nurses with a view to facilitating two further study days per year.

- Staff throughout the hospital said that the specialist palliative care team was exceedingly helpful, supportive and responsive. For example, the dieticians identified specific learning needs relating to patients receiving end of life care. Staff said that they asked the specialist palliative care team for advice and the team provided a two-hour training session. Staff said that this training had enabled them to improve end of life care to patients.

Multidisciplinary working

- The team facilitated a weekly end of life multidisciplinary meeting for an hour and a half to discuss patients' care. This meeting was also attended by an occupational therapist, physiotherapist, oncology psychologist, chaplain and a member of the hospital discharge team.
- The consultants attended seven different condition-specific multidisciplinary meetings every week. Attendance at these meetings was audited and showed that the consultants regularly attended 80% of the meetings. The specialist palliative care consultants told us that they attended other multidisciplinary meetings on an ad hoc basis when requested by other teams.
- The specialist palliative care team and staff throughout the hospital worked effectively with the hospital discharge team. Patients receiving end of life care who wished to be cared for at home or in an alternative community setting and patients identified for fast-track discharge had their assessments and funding arrangements completed promptly.
- One consultant from the specialist palliative care team chaired the trust's clinical ethics committee. This multidisciplinary meeting included ethics academics. The team provided advice trust-wide on a range of diverse and complex patient issues.

Seven-day services

- The specialist palliative care team worked from Monday to Friday, 9am to 5pm. The consultants worked out of hours on a rota basis, which ensured that prompt expert advice was readily available.

- All ward staff we spoke with said that the palliative care team responded promptly to referrals, with many patients being seen the same day or within 24 hours.
- Care records documented that end of life patients had care anticipated to meet their needs during the night and at weekends. This included medicines and equipment.
- The chaplaincy service provided pastoral and spiritual support 24 hours a day.

Are end of life care services caring?

Good



Compassionate and sensitive end of life care was provided to patients on wards by staff. A range of services to support the emotional needs of patients and relatives was available throughout the trust. Patients and relatives told us that they felt involved in care and were treated with dignity and respect.

Compassionate care

- Patients and relatives we spoke with said that they felt involved in care and that staff had taken time to talk through any concerns. Relatives used words such as "exceptional", "good" and "brilliant" when describing how nurses and doctors had delivered care. We observed staff speaking with patients and their visitors with compassion, dignity and respect.
- The patients and relatives we spoke with were all accommodated in side rooms on wards. Relatives said they appreciated the privacy this provided. Relatives told us that all ward visiting restrictions had been lifted and food and drink were offered frequently.
- Patients' feedback regarding end of life care was positive. All the patients who took part in the last satisfaction survey during January 2013 reported that the care they had received was 'very good' or 'good'.

Patient understanding and involvement

- Patients and relatives told us that information was presented in a way they understood. We spoke with one patient and four relatives who all told us that they felt involved in and informed about decisions and care.

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- We reviewed 14 care records and saw detailed recordings of discussions with patients and relatives. Records included discussions relating to medical treatments, prognosis and actions staff should take in response to patients' and relatives' wishes.

Emotional support

- Training by the specialist palliative care team was available to ward staff on 'Breaking bad news and having difficult conversations'. Between September 2013 and September 2014, only 81 staff had attended this.
- Emotional support for patients and relatives was available through the specialist palliative care team, ward-based clinical nurse specialists, the oncology psychology team, the cancer information and support centre, the chaplaincy team and patient affairs offices (bereavement services).
- Theatre staff explained how they provided emotional support at the time of a death in theatre. We saw staff accompany one set of bereaved relatives to theatre and stay with them in order to provide emotional support following the death of a relative.

Are end of life care services responsive?

Good



Patients' individual needs were effectively responded to by ward staff. The specialist palliative care team was responsive to requests to support patients with complex end of life symptoms and care needs. However, the discharge process was not responsive to patients' needs as staff throughout the trust reported frequent delays, including for those patients identified for fast-track discharge. The specialist palliative care team demonstrated how it made changes to practice in response to patient feedback.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team had established links with the local hospice and clinical commissioning group (CCG). One consultant working at the local hospice was subcontracted to work with the specialist palliative care team one day per week. Staff said that this promoted shared learning and expertise and meant that complex patients who switched between services could have consistent care.

- One consultant from the specialist palliative care team was part of the end of life strategy group for the local CCG. A key function of this group was to develop service planning and delivery to meet the needs of local people.

Access and flow

- End of life care was delivered where required by ward staff throughout the hospital. The specialist palliative care team was accessible 24 hours a day for support and advice regarding patients who had complex care and/or complex symptom management needs.
- Staff throughout the trust understood how to make a referral to the specialist team and consistently reported that the team responded promptly, usually within the same day. The specialist palliative care team met every day to allocate work and new referrals.
- We spoke with one relative of a patient with end of life care needs who had attended an outpatient appointment. During this appointment it was agreed that the patient needed to be admitted urgently. The relative told us that the patient's consultant came from the ward and arranged for the admission within a few hours.
- The fast track process for patient discharge was not responsive. Patients receiving end of life care who wished to transfer their care home or to an alternative service and patients identified for fast-track discharge had their assessments and funding arrangements completed promptly. However, staff throughout the trust consistently reported frequent delays of days or weeks for patients' discharges. Staff said that this was due to the time taken by the local authority to arrange care packages. Records from the hospital discharge team showed that, from 8 August 2014 to 11 September 2014, 18 patients receiving end of life care had been identified for fast-track discharge. The appropriate assessments and funding applications had been completed and approved by the hospital discharge team but only four of the patients had been given discharge dates.

Meeting people's individual needs

- The specialist palliative care team was accessible 24 hours a day for support and advice for patients who had complex care and/or complex symptom management needs.
- The specialist palliative care team told us how it had met the end of life needs of a recent patient who had learning disabilities. The team worked with the patient,

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their carers and the trust's learning disability nurse using resources to maximise communication and understanding. Staff said that this had enabled the patient to be as fully involved with decisions about their care as they wanted.

- Translation services were available for end of life patients and relatives. We spoke with a relative of a patient who told us that the translation service had been integral to completing a mental capacity assessment. The relative said this had enabled the patient's care wishes to be followed. We saw that this was fully documented in the patient's care records.
- The specialist palliative care team had audited and evaluated its performance in relation to patients' preferred place of care by reviewing 18 sets of patient notes. The audit reviewed discussions and actions taken to comply with patients' wishes. For 10 patients, their preferred place of care was achieved. For the majority of patients where this was not achieved, waiting for a bed in an alternative service or waiting for equipment or home care was recorded as the reason why discharge was not possible.
- The relatives we spoke with told us that preferred places of care had been discussed and appropriate actions were being taken. We saw that these discussions had been recorded in care records.
- Although the trust had plans to update the mortuary facilities those in place at the time of the inspection did not provide a pleasant environment for relatives to view their loved ones. The mortuary viewing area did not have a toilet or washing facilities for visitors. Staff offered the use of their facilities, which were not well maintained or clean. Staff told us that most visitors used the internal lift to gain access. Outside of these lifts, there were clinical waste bins and waste bags which visitors had to pass to access the mortuary.

Learning from complaints and concerns

- The specialist palliative care team undertook a patient satisfaction survey every two years. The last survey was completed during January 2013. The team told us how it was planning to make improvements to its service as a result of patient feedback. For example, patients reported that they could not easily identify the specialist palliative care team as staff members did not wear a uniform. Action plans were in place to address this.
- An audit and qualitative analysis of end of life complaints had been completed during July 2013 by a

fourth-year medical student. During a one-year period, 2% (15) of complaints to the trust related to end of life care. This audit concluded that the majority of complaints were made when end of life care was not what patients or relatives expected it to be.

Recommendations from the audit were transferred to a clinical audit summary form and action plan. This documented proposals for change, where the results should be disseminated, actions to be followed and plans to repeat the audit to check for improvements (by the end of 2015).

Are end of life care services well-led?

Good



Leadership of end of life services by the specialist palliative care team was clear to staff throughout the trust. All staff we spoke with on wards valued the expertise and responsiveness of the specialist team. The specialist palliative care team was passionate about the quality of end of life care provision and promoted a culture of sharing knowledge and developing the skills of others. There were governance processes in place to monitor the quality of end of life care throughout the trust. The specialist palliative care team demonstrated learning and changes in practice as a result of audits, incidents and complaints.

Vision and strategy for this service

- The specialist palliative care team had a clear strategy and work plan priorities for the present and future. Palliative care priorities were discussed by the specialist team during monthly business meetings. This included taking into account national guidance and policy and local priorities from the CCG's end of life group.
- Identified priorities from the business meetings were presented at the trust's end of life steering group for adults and children. These meetings were used to inform and update the annual end of life work plans. The deputy chief nurse chaired the steering group and told us that other relevant end of life issues and activities from other directorates were fed into this meeting. This resulted in a clear vision and strategy for end of life care, and this was documented in meeting minutes.

End of life care

Governance, risk management and quality measurement

- The specialist palliative care team reviewed risk and quality indicators such as incidents, audits and quality improvement programmes as standing agenda items during the monthly business meeting. The team explained how it had adjusted its practice as a consequence of incidents and complaints. This included the way in which the team shared its learning with others. This information was documented in meeting minutes and audits.
- End of life patient care was monitored by senior staff on wards. If learning needs were identified, the specialist palliative care team provided bespoke training.
- All issues or outcomes from governance, audits and quality improvement programmes from the monthly specialist palliative care team meetings were reviewed as standing agenda items during the end of life steering group meetings. Staff said that this enabled current work plans to be appropriately risk-assessed and prioritised.
- The specialist palliative care team maintained a record of audits and action plans relating to end of life care projects and initiatives developed by the team. This included trust-wide audits such as an audit of advanced care planning.

Leadership of service

- The consultant lead for the specialist palliative care team was described by staff as a good and supportive manager. The specialist palliative care team had regular informal and formal supervision.
- Staff throughout the trust said that the specialist palliative care team was visible, approachable and accessible. All staff we spoke with on wards valued the expertise and responsiveness of the specialist team.

Culture within the service

- The specialist palliative care team was passionate about the quality of end of life care provision in the hospital. The team said it felt supported and listened to by the trust board.

- The specialist palliative care team was dynamic and promoted a culture of sharing knowledge and developing the skills of others. The team regularly published its research and shared training events with the local hospice.





Public and staff engagement

- The specialist palliative care team said that it facilitated a weekly end of life journal club; any clinician based in the local area could attend this. Staff said that most of the registrars from the trust attended, as well as staff from the local hospice. Once a month the meeting was held at the local hospice to enable more clinicians to attend. A summary of all feedback was shared with the group. Staff said that this enabled networking and shared learning.
- The specialist palliative care team told us that the local CCG's end of life group facilitated carers' meetings. In response to carers' requests, one of the consultants had a date arranged to speak at one of the carers' group meetings to advise carers on how they could best discuss end of life care issues with their GPs.

Innovation, improvement and sustainability

- The specialist palliative care team worked collaboratively with other services to improve end of life care for patients. For example, the team was working with the CCG to develop a care coordination centre to provide support and information to patients and their relatives during the patient's last year of life.
- One of the consultants in the specialist palliative care team had developed an interactive (IT) end of life teaching tool. This was designed to improve and enhance clinicians' skills in managing end of life symptoms. Plans were in place to launch this tool for doctors and nurses.
- Two nurse specialist posts within the specialist palliative care team had recently become vacant. The team said that it was currently reviewing its skill mix.

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Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

The University Hospitals Bristol NHS Foundation Trust had provided an outpatient service of approximately 600,000 first and follow-up appointments over the 12 months prior to our inspection.

The outpatient clinics were located throughout the main hospital building and on other sites. The dental and eye hospitals were each located in their own buildings. Each clinic had its own reception desk and waiting area. The administrative staff were located throughout the individual clinics. Each outpatient service was located within one of the five allocated medical divisions and was managed through that department.

During our inspection, we visited the outpatient service in Bristol Eye Hospital and The University of Bristol Dental Hospital. We also visited clinics for rheumatology, orthopaedics, audiology, ear, nose and throat (ENT), physiotherapy, cardiology, respiratory, radiology, dermatology, paediatrics, geriatric medicine and phlebotomy. We spoke with 25 patients and 32 staff, including receptionists, booking staff, nursing staff, healthcare assistants, consultants and therapists. We looked at the patient environment and observed waiting areas and clinics in operation.

Summary of findings

The environment in the outpatient clinics we visited was generally clean, reasonably comfortable and well maintained. We found that there were inconsistencies in the maintenance of a safe environment. This related to maintenance of equipment and the risk management of building work in one of the clinics.

There were consistent issues with missing patient notes and also with the protection of confidentiality with the storage of some patient records.

Patients were very positive about the quality of clinical treatment and the professionalism of all the staff.

Staff were professional and promoted a caring ethos. Compassionate care was provided and staff interacted with patients in a friendly manner while treating patients with dignity and respect.

Some clinics had made progress in meeting the demands of increased capacity following the reorganisation of some services. Some of this followed the amalgamation of certain services from another provider. Several clinic services were able to respond quickly and directly to patients who required treatment.

Government targets for referral-to-treatment times were not being met in a number of the services. Patients were dissatisfied with communication with the hospital over the booking and arranging of appointments. The

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introduction of a more centralised booking system had produced limited improved outcomes for patients. However, this was still being rolled out throughout the service.

There were also long waiting times in some clinics and patients were not kept informed of the delays, or the reasons for them.

Staff were positive about the leadership within their medical divisions but some staff felt unsupported by the leadership above this. There were inconsistencies in the monitoring and managing of the quality of service in the outpatient clinics across the different medical divisions.

There was low morale among some administrative staff for reasons including increased workloads and the perceived slowness of the recruitment process to fill vacancies.

We found that all staff took pride in the quality of care and treatment provided by the outpatient department and were aware of the key trust values.

Are outpatient services safe?

Requires improvement



We found shortfalls in the monitoring and auditing of maintaining a safe environment. In some areas the required checks on safety equipment had not been completed and were not recorded. Building work in one clinic was being carried out without sufficient consideration or planning for patient or staff safety. We identified maintenance issues in another clinic. We found that in one area boxes of medical records were being stored where they blocked a fire exit and access to fire safety equipment.

All staff had been trained in incident reporting and were up to date with their mandatory training. Safe staffing levels were identified and maintained. Patients told us that they thought the outpatient department was a safe place to visit for treatment. We saw that regular infection audits were carried out and there were nominated staff to lead on infection control in the various clinics. We saw that not all clinical staff observed the trust policy of being 'bare below the elbow'.

We found that there were issues in some clinics with the frequency of patient notes going missing and also that clinical notes were not always stored securely to protect patient confidentiality.

Staff had completed safeguarding training and were aware of the procedure to follow if they needed to raise a concern.

Overall, we have required that improvements are made.

Incidents

- There had been one reported serious incident in outpatients over the 12 months prior to our inspection. This related to an incident in the dental hospital and had been investigated by the trust. There had been no reported never events (serious, largely preventable patient safety incidents that should not occur if the available, preventative measures have been implemented by healthcare providers).
- Staff we spoke with were clear about the process for reporting incidents. Staff confirmed that they received feedback from incidents regarding any learning that was required.

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Cleanliness, infection control and hygiene

- We saw the waiting areas for all of the clinics we visited and also a selection of consulting rooms and treatment areas. With the exception of the orthopaedic fracture clinic, which was undergoing building work, all were clean and hygienic. Patients we spoke with told us that they thought the hospital was always clean and expressed no concerns about the risk of infection.
- Individual clinics had nominated infection leads who carried out regular audits of their respective areas. For example, in the dental hospital there was a nominated person for each floor of the building. We saw samples of these audits in the ENT and respiratory clinics. We saw that hand gel dispensers were readily available and there were signs advising about hand washing. Regular hand hygiene audits were also carried out.
- All staff we spoke with had completed infection control training. We observed that reception staff and nursing staff observed the 'bare below the elbow' dress policy but we also saw clinical staff contravening this by wearing wristwatches.
- Where toilet facilities were located in clinics, they were clearly signposted. We looked at a sample of the facilities and saw that they were cleaned regularly and that this was recorded. Two reception staff we spoke with said that if a concern was identified about the cleanliness of the facilities, this was responded to promptly. Some areas, such as the dental hospital and the eye hospital, had their own cleaning staff.

Environment and equipment

- We looked at the patient environment in the clinics we visited and found two particular concerns. One was in the fracture clinic in the main building, where building work was being undertaken; the other was in the dermatology clinic, where there had been issues with air flow in clinical areas, heating and at times no hot water.
- At the time of inspection the fracture clinic was undergoing refurbishment. In order to maintain a level of outpatient service the department was being run from the part of the department that had been completed but did not have full facilities. The temporary arrangements we saw were not adequate to protect patients and staff from risk of harm.
- We visited the clinic and found that it was extremely busy and providing treatment to both children and adults. There were inadequate waiting areas, with rooms being out of sight of the staff and limited space

for those patients using a wheelchair or who were not very mobile. Staff told us that on occasion patients would faint after having a plaster applied and that there was a lack of visibility in the temporary arrangements. Parents and children were seen to be queuing in the corridors with some children at times playing on the floors and in the corridors between the reception desk and the treatment rooms.

- There was a lack of control of the environment, we observed builders carrying equipment through the clinic and accessing areas which staff told us were out of bounds to the builders while clinics were in operation. There were trip hazards on the floor in one of the three treatment booths. This posed a risk to patients and staff. We were told that a risk assessment had been completed for the building work but staff were unable to locate this.
- The doors between the areas where the builders worked and the clinic were not secured and posed a risk that records were not secure and that doors to the treatment rooms could be opened from the areas controlled by the builders.
- Provision of the temporary plaster room led to children and adults being treated in adjacent booths. The plaster room was limited space for the storing of equipment with flexes for the machines at times posing a trip hazard.
- During the refurbishment of the fracture clinic there were no toilet facilities available for patients. The nearest toilets were located on a lower floor. This could create a staffing problem if a patient needed escorting. One elderly patient told us that she had been waiting for two hours and was anxious about using the toilet as she was concerned that she might miss her appointment.
- Staff in audiology, ENT and radiology explained how the equipment was serviced and maintained and how this was audited. We saw examples of labelling on equipment to show that testing had been completed. Staff described the servicing and maintenance of equipment as being efficient, with concerns or faults being dealt with promptly by the appropriate department in the trust.
- We looked at a sample of resuscitation equipment in eight of the clinics we visited. Not all the required checks had been completed and signed off in some areas, for example in the dermatology area, the

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phlebotomy clinic and the eye hospital. We also spoke with a nurse in the eye hospital who was unable to locate the checklist for the resuscitation trolley equipment.

- In the dermatology clinic we found some maintenance concerns. At times there was no hot water available and there was a leak in the roof. There was limited air flow in the theatre areas and staff told us that at times the waiting area could become very hot, making it uncomfortable for patients. There was a floor mat at one entrance to the clinic that presented a trip hazard to patients. The alternative entrance to the clinic was via a very steep hill with an uneven surface. We were also concerned about the procedures in place for the storage of liquid nitrogen and we saw that intravenous medicines were being prepared in an area where chronic wounds were being treated. This all presented potential infection control and safety issues.

Medicines

- The majority of the clinics we visited did not store medicines. Where medicines were kept in the clinic, they were stored securely. We looked at the storage in two clinics. We saw that the correct protocols and procedures were in place for the storing of controlled drugs where this was required.
- Patients we spoke with told us that they received appropriate information about the medication they were prescribed and that changes in medication were explained to them.

Records

- In several of the clinics we were told that there were regular problems with missing patient notes. In the fracture clinic, for example, we were told by senior staff that as many as 30% of patients would have temporary notes. Other clinics explained how they regularly made up temporary notes when the full set could not be located in time. We were told that sometimes these notes did not contain all the relevant and appropriate information, which could result in patients having to make further appointments. The trust was relying on false assurance with regards to the data supplied to us.
- In the diabetes clinic, nursing staff we spoke with told us that access to medical records was poor at times. We were told of an administrative or clerical group that had recently been set up to discuss the issue of medical notes in outpatient clinics.

- There was an electronic tracking system in place for patient notes but several administrative staff expressed frustration that the system was not used consistently by clinical staff.
- In the fracture clinic, we saw that patient notes were not stored securely. A trolley full of files located near the entrance to the clinic was unattended and could easily be accessed by other patients or by the workmen who were carrying out renovations to the clinic area. For a brief period, we saw that a trolley of files was left unattended in the corridor outside the clinic in an area where patients were waiting. The temporary arrangements had led to inadequate storage facilities for patient records as these were stored on open shelves near the booking in desk. We observed at one time the desk was unattended and provided opportunity for unauthorised people to access records.
- The eye hospital had a shortage of storage space for records and we found a large quantity of boxes being stored in a corridor and blocking a fire exit. This area was not accessible to the public but presented a potential hazard to staff.
- In the phlebotomy clinic, we were told that there were also occasional problems with missing referral letters and that a group in administration or governance had been set up to look at this issue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked to give their consent appropriately and correctly. Patients we spoke with told us that the clinical staff asked for consent before commencing any examination or procedure. We observed staff asking for consent.

Safeguarding

- All the staff we spoke with told us that they had completed safeguarding training, which was part of the required mandatory training for the trust. Managers in departments explained how staff completed different levels of training depending on their role. Nursing staff and reception staff we spoke with were aware of the process to follow if they wished to report a concern.

Mandatory training

- Staff said that they were up to date with their mandatory training. The clinic coordinators explained how they monitored mandatory training and provided reminders to staff. We were told that the trust system for

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monitoring compliance with mandatory training was not always accurate. Several staff commented about receiving reminders to complete training that had already been completed.

Assessing and responding to patient risk

- Staff were present in all the waiting areas for clinics and able to notice patients who appeared unwell or needed assistance. If required, the staff member would arrange for a doctor to see the patient.

Staffing

- Each clinic's staffing was organised from within the division by which it was managed. Each service was supported by reception staff, doctors, nursing staff and healthcare support workers. Student nurses could also attend the outpatient departments on placements as part of their training.
- Staffing levels varied according to the clinics running and bank staff could be used to ensure that the designated numbers were in place. Due to the structure of outpatients, there was limited flexibility in moving staff between clinics in different divisions.
- Some clinics were run by clinical nurse specialists.
- In some departments, such as the dental hospital, a lack of staff had been identified and increased staffing levels agreed.
- Managers of the administrative staff we spoke with felt that staffing reductions had increased the workload for many of the staff they managed. They also told us that the recruitment procedure for new staff could be drawn out, which meant that they were often working below their full complement, putting staff under pressure for considerable periods of time.

Are outpatient services effective?

Not sufficient evidence to rate

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

We observed that patients were receiving effective care and treatment. Patients were provided with sufficient information about their treatments and the opportunity to discuss their concerns, care and treatment with clinical staff.

Information about national guidelines, trust policies and procedures were effectively cascaded through the department.

We saw that some clinics did not run on time and that patients were not always kept informed of any delays.

Patients received care from suitably qualified staff who were trained appropriately. There was an inconsistency in completing annual appraisals across the different clinic services. There was evidence of multidisciplinary working, which promoted effective patient treatment.

Evidence-based care and treatment

- We were told that guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines, were followed where appropriate. There were clinical governance meetings within each specialty and information was cascaded through the clinic teams. Nursing staff told us that any new guidance or procedures were highlighted during staff meetings.
- We saw that there was a pressure ulcer prevention protocol in place across the outpatient services. This provided guidance for staff to follow when an at-risk patient was identified.
- Staff were aware of how to access trust policies and procedures online. Reception staff told us how new practice guidance could be cascaded through the clinic coordinators or directly from other managers in the specialist area in which they were working.

Patient outcomes

- We observed that none of the clinics publicly displayed any information about the performance of the department apart from the DNA (did not attend) rates.
- We saw a range of patient comments from the outpatient survey conducted by the trust and from surveys carried out by some of the individual clinics. Positive comments were made about the efficiency of some of the clinics and the service received.

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Competent staff

- Some clinics were run by a clinical nurse specialist. These included cardiology, phlebotomy and ENT. For these clinics there were quality-assured protocols and competencies in place for nurses.
- There was a system in place for staff to receive annual appraisals but we found that there were inconsistencies between clinics in how many were being completed..

Multidisciplinary working

- We were told of various positive examples of multidisciplinary working that supported good patient outcomes. For example, the staff in the respiratory clinic worked closely with district nursing teams to support early discharge from the outpatient clinic. They were also able to support patients at home by coordinating with the community chronic obstructive pulmonary disease (COPD) teams. These teams consisted of nurses, physiotherapists and healthcare assistants.
- Podiatry clinics were held twice a week for referrals from the community and there was an additional multidisciplinary foot clinic that was held monthly, with referrals coming from podiatrists within the hospital.
- The radiology team described how it worked closely with the nursing staff on interventional treatment. Reception and administrative staff in this clinic commented that everyone worked together. One staff member told us that it was “a great team to be part of – everyone is supportive and committed to the patients”.
- In the cardiology outpatient clinic, we spoke with staff including a consultant, a student nurse and a clinical nurse specialist. We were told that the multidisciplinary working was effective and professional. Staff told us that they worked well as a team, with everyone aware of their roles and responsibilities. The clinic staff had been presented with an award by the trust to recognise the quality of service they provided. Patients we spoke with were very positive about the running of the clinic and communication from the staff.

Are outpatient services caring?

Good



We found that staff in the outpatient department were caring and compassionate towards patients attending clinics.

We observed that staff throughout the department treated patients, their relatives and visitors in a respectful manner. All the patients we spoke with told us that staff were caring and polite.

Compassionate care

- During our visit we spoke with 25 patients, all of whom said that they found the staff caring and respectful. Throughout our visit we observed staff interacting in a caring and considerate manner with patients. We saw that patients were treated politely and respectfully when approaching reception desks and when being called for their consultation.
- Patients were positive about the individual outpatient clinics they were visiting. They told us that they were satisfied with their care and treatment and the professional approach of the staff. Patients made positive comments about nursing staff, therapists, healthcare assistants, receptionists and consultants.
- We observed patients approaching the welcome desk at the main entrance to the hospital and asking for directions to the various clinics. Staff were helpful and polite and ensured that patients understood where they needed to go.
- Patients' confidentiality was respected. In two of the clinics, the nursing staff explained how they used a private room if they needed to speak with patients about sensitive issues. Patients we spoke with told us that conversations with clinical staff were conducted in private.
- The trust's outpatient survey in 2014 identified that 96% of patients attending clinics felt that they were treated with dignity and respect by hospital staff.

Patient understanding and involvement

- The majority of patients we spoke with told us that they felt involved in their care and were fully consulted about their treatment options. Clinics such as respiratory, audiology and ENT had a wide range of leaflets displayed for patients to take. These provided information about conditions and treatments.
- At several clinics, we observed nursing staff answering concerns or providing explanations to patients about their care or treatment. Patients we spoke with told us that the nursing staff answered questions with a caring and professional approach. One patient visiting the cardiology clinic told us: “You can always ask questions and they always will take the time to ensure you understand.” A parent visiting with their daughter, who

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was a patient, told us that the consultant they had seen in the ENT clinic had “explained everything brilliantly for me and my daughter and made sure we were clear about the next stage of the treatment and the progress we could expect”.

- Patients told us how they were able to ask questions during their consultations and also by speaking with nursing staff running the clinics. We were told that staff took time to explain things clearly and to provide the appropriate reassurance. One patient attending the cardiology clinic told us that they thought the nurse and consultant were “exceptional at relaying information and answering questions”.
- Patients told us how they could involve their relatives in discussions about their treatment. We saw that patients could attend appointments with their partners if they chose to do so. One patient told us how the nurse, who was leading the clinic, always ensured that their partner understood their medication and also when they needed to make another visit to the clinic.
- We spoke with two patients who told us that English was not their first language. We were told that they felt confident about asking questions as the consultant and nurse took time to explain things clearly. They told us that they were aware of the interpreting and translation services that were available but felt they did not require these as the staff were “always helpful and caring”.

Emotional support

- Information was displayed in the various waiting areas about any support services that might be appropriate. This included helpline numbers and support networks that were run in the local community.
- We spoke with patients who were attending a clinic run by the oncology service. We were told that the staff were sensitive and caring. One patient we spoke with explained how they and their partner had recently been given some difficult news about their condition. They said that they were spoken to in a supportive and informative manner. We were told: “We cannot fault the way they have dealt with everything.”
- Staff in several of the clinics explained how they would ensure that the patient was in a suitably private area or room before discussing any distressing news.

Are outpatient services responsive?

Requires improvement



We found that the trust had taken action and implemented changes to respond to demands for increased capacity in some clinic services. Some of these changes were the result of organisational changes and the moving of services from another provider.

Some clinics offered direct access for patients and also extended opening.

An improvement plan had been implemented to address the efficiency of the booking system and there were plans in place to further develop the centralised booking system across the various departments. There was, however, despite these improvements still some patient dissatisfaction regarding communication from the hospital over the booking and arranging of appointments.

Some services were struggling to meet demand and were not meeting the 18-week referral-to-treatment target. There were also lengthy waiting times for people to be seen in some clinics and an inconsistency in how well patients were kept informed of waiting times.

Overall, we judged that improvement was required.

Service planning and delivery to meet the needs of local people

- The trust had opened a new call centre for the booking of outpatient appointments. When we visited, approximately half of the clinic services had transferred to this service. We were told that, since its inception, the new service had resulted in the halving of complaints about bookings. However, the trust’s 2014 survey of outpatients showed that there had been no improvement in patient satisfaction with contacting the hospital. In response to the question “When you contacted the hospital, was it easy to get through to a member of staff who could help you?” only 58% of respondents said yes; this was a decrease of 1% from the previous year. The lowest score, 43%, was recorded in relation to the dental hospital and the eye hospital. We found that the experience was different for different services. For example, the musculoskeletal outpatients had conducted its own survey; this had found that 96% of patients had found the appointment easy to arrange. Similarly, a survey carried out by the dietetics outpatient

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clinic had found that 95% of patients had found the appointment easy to arrange. Patients we spoke with in the audiology and ENT clinics also told us that they were happy with communication relating to booking appointments and accessing information from the clinics.

- Several clinics had arrangements to respond directly to patient needs. For example, the respiratory clinic ran a 'hot clinic' where health professionals or GPs could contact the clinic directly and arrange an appointment that day. This was part of an admission avoidance policy. The clinic also, where possible, provided patients with a one-stop system. For example, a person would see a nurse specialist, have a breathing test and blood tests and also see the consultant, all on one visit. We spoke with two patients who had visited the clinic that day and both were very positive about the treatment and advice they had received. One patient told us: "I cannot fault them. My doctor made the appointment yesterday and I am here now getting the help I need."
- Some of the clinics we visited had delays in getting clinic letters out to patients. In the orthopaedic clinic, we were told that it could take up to six weeks for some letters, although the target time was five days.
- Until July 2014, there had been a pharmacy located within the eye hospital. This had been closed and outpatients with a prescription had to walk 100 metres, cross the main road and use the pharmacy in the main building. Some patients we spoke with were critical of this decision and thought that the new arrangement was inconvenient. We were told that elderly patients could find the journey to the main building stressful. Patients also said that they were concerned about crossing a busy road after having had treatment on their eyes. Some staff we spoke with were also critical of the new arrangement and told us that they felt there had been insufficient consultation over the closure. However, the hospital had consulted with patients' groups before making the change and we saw that this was documented. The new arrangement provided the opportunity for patients to collect their prescriptions from a local pharmacy, although this had to be one on the prescriptive list. There was also a contractual arrangement with the pharmacy in the main hospital that prescriptions should be ready within 30 minutes. The hospital had also put in place arrangements for the dispensing of medicines at the eye hospital site if they

were required urgently and if the patient was unable to access the main site. An impact assessment by the hospital pharmacy service estimated that this should happen between 10 and 20 times a week.

- The dental hospital outpatient service had experienced an increase in demand following the transfer of some services from an adjoining trust. The matron in the dental hospital explained how the service had responded to this. The hospital had organised some evening and weekend clinics to meet increases in demand for treatment. They had also submitted a business plan for more consultants. We were told of work that was being done on the access criteria for the dental clinics to ensure that appropriate referrals were made. The front sheet of the referral form was being rewritten to provide clearer information. The website for the service was also being updated as the managers thought it could be made more user-friendly and could provide clearer information for the public.
- Staff in the physiotherapy service explained that they were meeting a target of seeing urgent referrals within 10 days but were not always meeting the target of seeing non-urgent referrals within their internal target of 11 weeks. Initiatives to improve this were being put in place. These included a 'physio direct' service, which involved initial assessments being completed by telephone and the development of more group-based therapy sessions. There were also plans to develop six-day working for some therapies.
- The manager of the ENT outpatient service explained how the service had doubled in size following the transfer of some services from an adjoining trust. They had responded to the increase in demand by running an additional 15 clinics a week and recruiting two new consultants. The clinic had been exceeding the 18-week patient pathway, but in the previous two months the average wait had been reduced to 11 weeks. We were told that they planned to reduce the waiting time to six weeks when the backlog arising from the changes was cleared.

Access and flow

- The trust was not meeting the national target time for the 18-week patient pathway of referral-to-treatment time (RTT) for outpatient services. The data showed that the trust had operated at between 95% and 92% compliance over the 12 months prior to our inspection.

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- Individual departments managed and monitored their performance in relation to these targets. We found varying levels of awareness of these outcomes among the staff running the clinics. Some clinic coordinators and nursing staff were able to provide up-to-date information about the RTTs and some were not. It appeared that targets were monitored on a divisional level and it was unclear how this information was utilised to inform improvements or changes. Information about RTTs was not displayed in the clinics we visited.
- The department was meeting the two-week target for urgent cancer referrals (i.e. that people should be seen by a specialist within two weeks of a GP referral). However, the target for people waiting less than 31 days from diagnosis to first definitive treatment was not always being met.
- Clinics we visited that were meeting the RTT targets included the radiology and audiology clinics. In radiology, they aimed to see GP referrals within four weeks, but we were told that in practice most patients were seen within two days. The clinic had four clinic suites situated over two floors. During busy times, patients could be moved between suites to ensure that they were seen within a reasonable time. We saw that patients in these clinics were kept informed of waiting times for their treatments. The clinic was open seven days a week from 7.30am to 7.30pm. There were plans to improve the service by providing separate inpatient and outpatient waiting areas. The intention was that this would provide improved respect and dignity for patients visiting the clinic.
- During the 12 months prior to the inspection, the audiology clinic had responded to an increase in demand after the transfer of certain services from an adjoining trust. Following an initial increase in waiting times, the service had reduced these to be within the target referral times. The clinic also offered a direct access repair service for hearing aids that ensured people would be seen within 48 hours, although in practice patients were usually seen the same day they reported a fault with their hearing aid. We spoke with two patients visiting the audiology clinic and both were very positive about the service and treatment they received. We were told: "The appointment was arranged around my work and I was seen right away. Everyone is really helpful."
- The eye hospital's outpatient service was a very busy department, providing approximately 25% of all outpatient appointments in the trust. This equated to up to 8,000 appointments a month. The RTT target was not being met for some first-time appointments but the data provided by the trust showed that, overall, a target of 97.5% had been met for patients attending their first appointment within 18 weeks over the 12 months prior to the inspection. However, patients sometimes waited several months for follow-up appointments. The clinic coordinators we spoke with told us that they had escalated concerns regarding the booking of new appointments and the problems of meeting the capacity demand. Staff expressed their concern over the time patients had to wait for their first appointments. Staff told us that they were taking a high number of calls from distressed and angry patients frustrated by the difficulty of making appointments. We were told that staff had to occasionally cancel clinics and appointments at short notice. On one of the days we visited we observed that a clinical fellow asked the coordinator to cancel the last three appointments due to the overrunning of the clinic. This request was made without checking the individual clinical needs of the patients.
- Staff told us that improvements in the booking system had meant that more patients were able to link their appointments, meaning that they did not always have to make additional visits to the hospital. However, staff also felt that this one-stop system needed to be implemented more effectively and consistently to help further address some of the capacity issues in the eye hospital.
- Patients in some of the clinics were unhappy with the waiting times and the lack of information at times about the length of their wait and the reason for it.
- We found that the patient waiting times varied in the different clinics. For example, in the physiotherapy, audiology and radiology clinics, patients experienced very short waiting times for their consultations. In other clinics, such as ophthalmology and the fracture clinics, some patients had long waits to be seen. Two patients told us that they had waited over two hours to be seen in the eye hospital.
- Some clinics gave clear information to patients about the projected waiting times on whiteboards in the waiting rooms. We also observed staff explaining to people about the delays and how they would keep

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them informed. However, this was not the case in all clinics. One patient in the eye hospital told us that they had been waiting for over two hours and had no explanation for the delay. They described the management of the clinic as “chaotic – nobody seems to be overseeing the running of the clinic”. Another patient who had been waiting for two hours told us that a patient with an appointment after theirs had been seen before them because “the staff had made a mistake”. Frustration about waiting times was reflected in comments we received from patients and also in the feedback to the trust outpatient survey. The trust’s 2014 patient survey showed that only 47% of patients surveyed said that they saw information displayed about clinic waiting times and only 27% said that they were told why they had to wait. These responses represented a small improvement on the previous year’s survey: for example, in 2013, 40% said that they saw information displayed.

- We spoke with two patients who attended the phlebotomy clinic regularly to have blood tests completed. They both said that they thought the service was well organised and that they rarely waited longer than 10 minutes. One patient explained how his appointments were booked around the time he was able to attend using public transport.
- The clinics displayed information about DNA rates and also a poster encouraging patients to inform the clinic if they could not attend. The clinics did not display any other information about the efficiency of the clinics, for example the current figures on RTTs or the completion of staff training. The one exception to this was the eye hospital, where detailed safety information was displayed. However, this information was displayed sideways on the noticeboard, making it difficult to read.
- Patients also told us that parking issues added stress to their hospital visits. Parking could be difficult to access and costly. Not all patients we spoke with were fully aware of the hospital bus service that patients could access, although we saw that this was advertised widely in several of the waiting areas.

Meeting people’s individual needs

- Patients we spoke with told us that they were allocated enough time with clinicians for their outpatient appointment. Patients gave us examples of information they were sent prior to attending clinics and also the various information leaflets that were provided in the

various clinic waiting areas. Patients we spoke with said that the clinical staff were aware of their medical histories. We observed staff directing patients to information that was displayed. We saw a variety of material that had been produced by the trust to help inform patients about their treatment and the specialist service they were accessing. Patients we spoke with were very positive about the detail and information that clinical staff provided. The trust survey of outpatients also reflected this: 83% of patients said they got enough time to discuss their health or medical problem and 81% said that the clinician had all the information they needed to treat them.

- The outpatient service had provision when appointments were booked for any communication needs to be identified. These could include visual impairment, learning disabilities, non-English speaking or speech impairment. The clinician triaging the referral was required to inform the clinic coordinator of any identified communication needs in the referral.
- Information was displayed at the entrances to clinics in different languages and staff explained how they were able to access translation services when required. We observed one person attending a clinic where it had been arranged for an interpreter to be present.
- There was a ‘hospital passport’ document that was available for people with learning disabilities or autism who were attending the hospital. This provided a range of information in an easy-to-read format and also had picture symbols. There was also a learning disabilities team that could be contacted by staff for advice and support.
- Once a month the radiotherapy department ran an open evening when people could visit the department, meet staff and ask any questions about treatments and the services provided.
- Clinics provided chaperones for patients where required and information about this was displayed in the clinics we visited.
- Clinic waiting areas we visited, other than the fracture clinic, appeared well maintained and provided a reasonably comfortable area for patients. There was generally sufficient seating, various reading materials were provided, and information about the clinic services was displayed.

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Learning from complaints and concerns

- The Patient Advice and Liaison Service (PALS) was located in the main reception area of the hospital. Information about this service was displayed in the clinic waiting areas.
- Staff said that they would deal with a concern directly if they could by talking to patients but would direct them to PALS if this was required.
- The trust recorded 68 complaints made in relation to outpatients between April 2013 and March 2014. Forty-four of these related to the eye hospital and an action plan had been put in place by the general manager and matron of the hospital. They had identified a need to improve what was called the 'patient-focused culture'. Actions included engaging with staff to obtain their feedback, training staff on communication and including clearer messages to patients in written communication about possible waiting times and the causes of delays. The plan also identified that the outsourcing of some services to the South Bristol Community Hospital could alleviate some of the capacity pressure on the main eye hospital site. A letter sent to staff stating that they could contribute their views anonymously suggested that some staff felt unable to express their views in an open forum.
- There was inconsistency in the feedback given to staff following complaints. Some clinic staff told us that their managers always provided feedback, information and any learning from complaints or reported incidents. However, some staff said that this information was not always timely and could lack clarity over the action to be taken. Two of the managers we spoke with also said that they received insufficient information from their line management. Staff working in the eye hospital told us that they did not receive enough feedback from their line managers regarding complaints or incidents; this included staff working in the medical records department. They had received a general letter from the manager and senior nurse detailing concerns about the volume of complaints.

Are outpatient services well-led?

Requires improvement



The various outpatient services and clinics were located and managed within different divisions. We found that at

the local or clinic level there were examples of good leadership and staff felt supported by their immediate line managers. However, not all staff were positive about the leadership above this, with several senior staff in clinics telling us that they felt unsupported at times.

We found that there were inconsistencies in monitoring and managing the quality of outpatient services across the various divisions.

We found that the managers of administrative and reception staff across a variety of clinics felt unsupported by their senior management. Administrative and reception staff felt pressurised at times by the public demand for the services they were running.

Satisfaction with leadership and communication varied across the different divisions. Overall, we judged that improvement was required.

Vision and strategy for this service

- The trust had implemented a change to the outpatient service, starting in 2011/12, which involved providing a more centralised booking system for appointments. Approximately half of the clinics used a new central booking centre, although these clinics were still involved in booking their own appointments. From August 2013, the trust had established outpatient standards. The aim of these was to improve operational processes and provide a more consistent service to patients. These standards covered reception, the preparation of patient notes and clinic coordination. As well as trust-wide standards, there were also locally developed standards for each clinic. A programme called Productive Outpatients had been completed in April 2014 and the trust was planning the next stage of the programme's development at the time of our inspection. This will involve more services using the new booking centre and a more centralised approach to the management of the outpatient service. At the time of our inspection, all outpatients were managed within the corresponding division.
- At the eye hospital's outpatient department, we saw a copy of the standards; these were detailed and covered all aspects of running the clinic. However, at several other clinics staff were unable to locate copies of the trust-wide standards. In three clinics, staff told us that there were not enough staff to ensure that the standards were always followed.

Outpatients

Governance, risk management and quality measurement

- There was a management structure for each outpatient department within each division. Risk management and quality measurement were monitored through these structures. There was no overarching management of the outpatient services.
- There were individual governance meetings held for each specialty but not for the outpatient service as a whole.

Leadership of service

- We saw evidence of good leadership at clinic level, but there was inconsistency in staff members' experience of leadership in their respective departments and divisions. The outpatient service was not managed collectively; each clinic was managed from within the division in which it operated. Not all staff we spoke with were entirely clear about the senior management structure of their division. While some managers, for example in the audiology and ENT clinics, said that they had regular and positive contact with divisional management and the senior management above that level, this was not the experience of all managers.
- We saw evidence of good leadership and communication in the various clinics. We attended a team meeting run by the manager of the outpatient appointment centre. This was a structured meeting with an agenda and minutes were completed.
- The nursing staff we spoke with in the dental hospital told us that they were well supported by their colleagues and had regular meetings which ensured that good communication was maintained.
- Divisional governance meetings were attended by the matron of the dental hospital on a monthly basis. The matron and manager of the dental hospital told us that they were well supported and had monthly one-to-one meetings with their line managers.
- In the physiotherapy clinic, we spoke with reception staff, therapists and managers. Staff were positive about communication within the team and the support that was provided. Staff told us that they were kept well informed about changes in the department and division and were able to report or discuss any ideas or concerns they had about the service provided.
- The fracture clinic was undergoing major refurbishment when we visited and concerns about safety were identified. While oversight of the changes was the

responsibility of the matron, it had appeared to the staff there had been little or no oversight by the senior managers in the division or at higher levels. Staff were unaware of when senior managers had visited to oversee the progress of the work and to observe the problems and difficulties that were being managed on a daily basis by staff working in the clinic. Staff were working in a difficult environment and felt unsupported. The building work had been in progress for five months and the completion date had been extended by a further two weeks. Staff we spoke with told us that the difficult environment made work stressful and at times upsetting.

- Staff told us that they had highlighted the impact on the clinic of the proposed centralisation of some local children's services a year previously, but they felt that their concerns had not been acted on or responded to at a senior level. Staff we spoke with told us that they thought the planning for the refurbishment had been poor.
- We spoke with a number of managers of administrative and reception staff. People were positive about cross-divisional working and the commitment of the teams they supervised. Comments were made about the administrative staff not being given sufficient consideration when changes were being implemented throughout the hospital. Several managers expressed the view that there was a lack of senior management presence throughout the administrative sections and that at times staff felt there was insufficient understanding from senior managers of what they did or the pressures they worked under. We were told by some managers that it was sometimes difficult for staff to speak to senior managers and staff felt that they were not always listened to.
- The divisional management structure did not always support robust and effective clinical and operational leadership. There was inconsistency in the auditing of the various clinics against the outpatient standards that had been introduced, with some clinics having had no audits completed. The trust supplied data stating that less than 1% of patient notes were missing in clinics but we found that the percentage was consistently higher than this in several clinics. Some teams told us that they received good feedback at team meetings regarding incidents, complaints and lessons learned, while others said that they did not. Other inconsistencies between

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clinics included the monitoring and managing of RTTs and patient waiting times in clinics, and the auditing and checking of safety equipment and the effectiveness of the partial booking system.

Culture within the service

- We saw that the key trust values were well advertised throughout the various outpatient clinics and all staff were aware of them. Staff told us that they saw the trust values being demonstrated on a daily basis by clinical and administrative staff.
- While some staff we spoke with were concerned about issues such as low morale and the frustration caused by slow staff recruitment, everyone was positive about their commitment to providing a quality service to patients attending the clinics. Staff told us that they were proud of the achievements of the hospital and some commented that they believed the trust did not promote or advertise these enough.

Public and staff engagement

- The trust had conducted annual outpatient surveys for the three years prior to our inspection. Some outpatient departments had conducted their own additional surveys, for example in the diagnostics and therapies division.

- Staff said that they felt engaged in that they could share ideas or concerns within their peer group and with their manager. Staff were given trust messages directly via email and through the bi-monthly trust magazine, Voices. Many staff we spoke with said that they felt well informed of developments and issues within the hospital and the wider trust.

Innovation, improvement and sustainability

- The major innovation for the outpatient services was the continued implementation of the centralised appointment-booking system. The plan also included greater centralised administration and management of the outpatient services. The extent of these changes were yet to be finalised or implemented.
- In the ENT outpatient area, there were plans for building work in order to accommodate more administrative staff. This was also one of the first areas introducing digital voice recognition to help with the completion of notes and letters. The clinic had also been identified as one of the first to implement electronic records when the trust begins implementation of a system in 2015.

Outstanding practice and areas for improvement

Outstanding practice

- Teamwork in the A&E department was exceptional. Staff at all levels were committed, motivated and engaged. They worked very well with each other across all job roles and staff grades. They were cohesive and demonstrated excellent teamwork within their departments and with other departments.
- The maternity service (St Michael's Hospital) was an impressive and highly functional unit. Staff worked hard together to provide excellent services to the local populations and, as a regional referral unit, to the wider population of the South West and South Wales. Teams and individuals were highly flexible and the team was creative in finding ways to manage and mitigate the risks of working with a lower than optimal midwife-to-birth ratio. Multidisciplinary working within St Michael's Hospital, the local community and regional partners was well established, with the welfare of the mothers, babies and their families at the heart of the services provided.
- The children's hospital had outstanding safeguarding procedures in place. The safeguarding team had links in every department where children were seen. The trust considered child safeguarding issues in relation to adult patients in the Bristol Royal Infirmary: for example, A&E consultants checked all overnight admissions for safeguarding concerns. Weekly multidisciplinary meetings were held and there were clear links to the safeguarding board.
- The arrangements for young people to transition from children's to adult services, for example within oncology, were very good. The trust had a transition group that involved young people. This group highlighted and promoted good practice in order to replicate it in all areas.
- The trust had a paediatric faculty of education. This had been put in place to support the development and retention of staff. Specialist courses, accredited by the University of Plymouth, were on offer up to and including at master's degree level. Courses included paediatric critical care. All the staff spoken with by the inspection team were highly complimentary about this. The trust planned to allow access to the courses to children's nurses from other organisations.
- A process to review any death of a child had recently been implemented. A full review and debriefing of the case occurred within 24 hours of a child's death (whether expected or not). Parents were involved in the reviews and kept informed of progress.
- The specialist palliative care team was passionate about the service it provided and demonstrated excellent team working. The team facilitated weekly end of life multidisciplinary meetings with other professionals to discuss patients' care. In addition, the consultants regularly attended seven different condition-specific multidisciplinary meetings that were held every week.
- The specialist palliative care team was innovative and adapted to local needs and national policy by continually developing and evaluating tools and training to promote good end of life care for patients. The team shared its knowledge and learning within the trust and published its research. The team's responsiveness, support and skill were highly regarded by colleagues throughout the trust. The team was established in wider palliative care networks, including the local hospice and clinical commissioning group.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, including details of their current medicines. There was evidence that this was improving the quality of care.
- The computerised patient record system was an excellent innovation. This had been developed by the critical care unit and alerted the consultant and nurses if a patient's safety and wellbeing were compromised.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- Take action, with others as needed, to improve the flow of patients into and through the trust. This includes improving access to services, including A&E services, and ensuring that patients are cared for in the most appropriate place and that they are supported to leave hospital when they are ready to do so.
- Take action to ensure that staffing levels meet the needs of patients at all times in both wards and theatres.
- Ensure that staff are able to attend and carry out mandatory training, particularly annual resuscitation training, in order to care for and treat patients effectively.
- Ensure that people with mental health needs receive prompt and effective support from appropriately trained staff to meet their needs.
- Continue to improve patient flow through the Bristol Royal Infirmary to ensure that patients arriving at the A&E department by ambulance do not have to queue outside the department because there is no capacity to accommodate them.
- Ensure that the discharge process starts at an appropriate stage of a patient's care, so that discharges are not delayed due to the unavailability of care packages.
- Improve the flow of patients to reduce, as far as possible, the need for night-time moves and to reduce the number of patients nursed in areas other than specialist wards.
- Ensure that patients whose surgery is cancelled have their nutritional needs met.
- Ensure that the A&E department's observation ward provides same-sex accommodation so that patients' dignity is protected.
- Ensure that the privacy and dignity of patients who remain in the recovery areas overnight are maintained.
- Ensure that all resuscitation and safety equipment is checked regularly and that this is recorded and audited.
- Ensure that all medicines, including controlled drugs and fluids, are stored safely and appropriately.
- Ensure that records accurately reflect the time at which medicines are administered and taken.

- Ensure that fire exits are clear and accessible.
- Ensure that patient records are stored securely, maintaining confidentiality, and are available to clinicians when required.
- Ensure that appropriate risk assessments are in place when building work is undertaken in areas used by staff and patients.

Action the hospital **SHOULD** take to improve

- Ensure that nurse staffing levels are maintained consistently and that the use of temporary staff is minimised so that patients receive safe and effective care from suitably qualified and experienced staff.
- Ensure that the recruitment of additional senior nurses is undertaken so that the number of supernumerary nurses meets best practice guidance.
- Ensure that all patients receive a prompt assessment on arrival at the A&E department and that there are appropriate escalation procedures in place to ensure patient safety when delays are experienced in the minors area of the department.
- Ensure that inpatient areas are single sex, in line with national recommendations.
- Take steps to meet the national cancer target of 62 days for the first treatment following an urgent GP referral.
- Review the needs of people with dementia across the hospital to ensure that they are being met.
- Take steps to move to seven-day working for clinical nurse specialists: for example, some clinical nurse specialists are not available seven days a week and therefore support for patients is limited at weekends.
- Review the use of beds to prevent their inappropriate occupation outside specialties (for example, on the stroke unit).
- Complete an Abbey Pain Scale assessment tool for all patients with cognitive impairment who are unable to communicate their needs.
- Improve communication with histopathology staff and their involvement in the potential redeployment of the service to ensure that the service's vision and values are understood and fully supported by staff.
- Increase the opportunities for staff to express their concerns with regard to developments within the trust and how they affect their day-to-day work.

Outstanding practice and areas for improvement

- Consider improving access to information in languages other than English.
- Consider ensuring that an identified professional development budget is available for both the critical care unit and the cardiac intensive care unit so that professional development standards and best practice guidance continue to be met.
- Ensure that additional pharmacists are available to provide advice and assistance to both the critical care unit and the cardiac intensive care unit in order to meet best practice guidance.
- Consider making a critical care outreach team available to support deteriorating patients on the wards.
- Consider improving the management of medical notes in the ante- and postnatal ward as we saw some notes left unattended in the nursery.
- Ensure that there are always enough cleaning staff to be able to clean the delivery rooms as soon as required to ensure that the flow through the department is not interrupted.
- Consider extending midwife cover in the early pregnancy assessment unit to include weekends. This would ensure that a consistent service is provided.
- Ensure that there are sufficient resources available to enable children to have access to play specialists as necessary.
- Ensure that patients are kept informed of the waiting times in outpatient clinics.
- Take action to ensure the consistent monitoring of the quality of outpatient services across the different divisions and display information on safety and quality performance in the outpatient clinic waiting areas.
- Take action to improve patient satisfaction with communication relating to booking and arranging outpatient appointments.
- Take action to ensure that administrative staff in outpatient services are fully supported.
- Take action to ensure that there is consistent leadership across outpatient services.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises</p> <p>The provider had failed to ensure that service users and others were protected against the risks associated with unsafe or unsuitable premises.</p> <p>Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>Not all fire exits were clear and accessible.</p> <p>The fracture clinic was not a safe environment in which patients were to wait for and receive treatment. Patients and others were not protected from the risks associated with the ongoing building work.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment</p> <p>The provider had failed to ensure that service users and others were protected from the risks of the use of unsafe equipment by ensuring that equipment is properly maintained and suitable for its purpose and is available in sufficient quantities.</p> <p>Regulation 16 (1)(a) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>The trust had not ensured that all resuscitation and safety equipment was checked regularly and available for use in the event of an emergency.</p>

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p>The provider had not ensured that records in respect of service users' care and treatment were kept securely and could be located promptly when required.</p> <p>Regulation 20(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>Patient records in outpatient clinics were not always stored securely and were not always available to clinicians when required.</p>

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p> <p>The provider had failed to consistently safeguard the health, safety and welfare of service users, because they did not ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity.</p> <p>Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>There were not always sufficient numbers of suitably qualified, skilled and experienced staff employed on surgical wards and in operating theatres.</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities) Regulations
2010 Management of medicines

The provider had failed to protect services users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Regulation 13 of the Health and Social Care Act 2008
(Regulated Activities) Regulations 2010.

Medicines were not always stored securely in critical care areas and on medical and surgical wards.

Records of medicines administration on surgical wards were not always maintained to accurately reflect the time at which medicines were administered.

Regulated activity

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA 2008 (Regulated Activities) Regulations
2010 Meeting nutritional needs

The provider had failed to ensure that service users were protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs.

Regulation 14(1)(a) of the Health and Social Care Act
2008 (Regulated Activities) Regulations 2010.

Patients whose surgery was cancelled did not always have their nutritional needs met.

Compliance actions

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.

Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.

Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.

The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.

Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents.

Regulated activity

Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

The provider had failed at times to deliver care to patients that ensured their privacy and dignity were respected.

Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the A&E department's observation ward, same-sex accommodation was not provided in accordance with guidance from the Department of Health, to protect the dignity of patients.

Patients who remained in recovery areas overnight did not always have their privacy and dignity maintained.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and medical care to meet their needs and ensure their welfare and safety.

Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing.

This section is primarily information for the provider

Compliance actions

Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff.

The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so.

Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The provider had failed to have suitable arrangements in place to ensure that all staff were supported to receive appropriate training to enable them to deliver care and treatment to service users safely and to an appropriate standard.

Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Not all staff on medical wards were able to attend and carry out mandatory training, particularly annual resuscitation training, in order to care for and treat patients effectively.