

Salisbury NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Good



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Salisbury NHS Foundation Trust provides care to over 240,000 people across Wiltshire, Dorset and Hampshire. This includes general and acute services at Salisbury District Hospital with specialist services including burns, plastics, cleft lip and palate, genetics and rehabilitation serving over three million people. In addition the Duke of Cornwall Spinal Treatment Centre serves South England's population of 11 million people.

Salisbury Hospital has 464 beds and is staffed by approximately 4054 members of staff. They provide care to around 240,000 people across Wiltshire, Dorset and Hampshire.

CQC uses an intelligent monitoring model to identify priority inspection bands. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Against this the trust was judged as a low risk, at level six (the lowest level) which it had been at since 2013.

We inspected this trust as part of our programme of comprehensive inspections of acute trusts. The inspection team inspected the standard eight core services as well as an additional service, the spinal service.

Overall, this trust was rated as requiring improvement. We rated it as requiring improvement for safety, being responsive to patients needs and for being well led and good for providing effective care and being caring.

Our key findings were as follows:

Safety

- Nurse staffing levels in emergency and urgent care, surgical wards, services for children and young people, including the neonatal unit, critical care, maternity and the spinal unit were not always meeting national guidelines or recommendations. This was a risk to patient safety.
- General infection rates in the Trust were low. There had been no new Methicillin Resistant Staphylococcus Aureus (MRSA) since October 2014. Rates of Clostridium Difficile were below the Trust trajectory as at October 2015. However there were

occasions where inspectors found variable compliance with infection control procedures such as wearing of gloves and aprons. In a minority of areas equipment was found to be dusty and in one area a commode was found to be dirty.

- The trust was not meeting its target of 85% for the percentage of staff receiving mandatory training.
- In some areas it was found that resuscitation equipment was not being checked every day as required.
- Patient records were not consistently written and managed appropriately. In particular, in the medical services, there was poor documentation of patient's weight and the management of intravenous cannulas and catheters. Charts were not kept secure and confidential at all times.
- In the emergency department patients did not always receive an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival.
- Patients whose condition deteriorated were appropriately monitored with action taken as required.
- There was a strong culture of reporting and learning from incidents. Staff understood their responsibilities to raise concerns, record safety incidents and near misses and to report these appropriately. Staff received feedback and lessons were learnt to improve care. There was a culture of being open and the duty of candour was well understood.

Effective

- In the majority of services, patient needs were assessed and care and treatment delivered in line with legislation, standards and evidence based practice. Performance in national audits was generally the same or better than the national average.

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- Mortality rates were as expected at 107 as measured by the Hospital Standardised Mortality Ratio (July 2015) and 107 for the Summary Hospital-level Mortality Indicator (March 2015).
- The majority of staff and teams worked well together to deliver effective care and treatment. Maternity services and theatres could do more to improve multidisciplinary working.
- The majority of staff received an annual appraisal. Improvements were needed to ensure the records about who had received an appraisal were robust.
- Consent and knowledge of the mental capacity act was good however the recording of this needed improvement.

Caring

- Staff provided kind and compassionate care which was delivered in a respectful way.
- The need for emotional support was recognised and provided by a clinical psychology service.
- In the spinal treatment centre some patients felt ignored and isolated, however also in this unit there were examples of staff going the extra mile such as arranging a wedding to take place in the unit for one patient.
- The majority of feedback from patients and relatives was extremely positive and although the response rate for the friends and family tests were below the national average the number of patients who would recommend Salisbury Hospital exceeded the national average.

Responsive

- Patient's individual needs were not consistently met. In spinal services there was disparity between the experiences of some patients, whilst some made good use of the gardens and away days others felt lonely and bored.
- Spinal patients waiting for video-urodynamics and outpatients experienced unacceptable waits for appointments and there was little risk assessment of the patients who were waiting.
- The trust did not provide mental health services. Vulnerable patients in the emergency department

with mental health needs, particularly children and adolescents who required assessment by a mental health practitioner, did not always receive a responsive service from the external mental health provider teams.

- The environment for children in the emergency department was not appropriate, with them being cared for in the adult area.
- The trust was not consistently maintaining single sex accommodation.
- Patients living with dementia were generally well supported.
- The investigation of complaints was comprehensive however there were areas that could be improved. These related to working with other organisations to provide a single response when required, the development of action planning and learning after the investigation.
- Overall the trust performed well in meeting national targets, including the time patients spent in the emergency department and referral to treatment times.
- The Benson bereavement suite facilities, and sensitive care provided to maternity and gynaecology patients and their relatives experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners.

Well led

- The trust had a governance framework which supported the delivery of care although there were some areas of weakness. The trust had recently undertaken a self-assessment against Monitor's quality governance framework however this had not clearly identified weaknesses or areas for improvement. A review had been undertaken to support board development. Additionally, an external review of the board assurance framework had been completed in May 2015 with 'substantial assurance' being attained.

Summary of findings

- Risk registers did not consistently identify all risks, mitigating actions or where it did the actions had not always been taken or where they had the risk had not been updated.
- One of the strengths of the trust was that staff had a strong sense of respect for each other and communicated well, however we heard of informal conversations between staff that lacked documentation to support an audit trail for decisions and actions.
- The trust had experienced a deficit for the first time in its history and staff were anxious about the future. A recovery plan was in place.
- There was an extremely positive culture in the trust, staff felt respected and valued. Many staff had worked in the trust for a considerable number of years and knew each other well. They frequently referred to themselves as being like a family and were very supportive of each other.
- Staff at all levels were very positive about the trust as a place in which to work and this was supported by the staff survey results (2014). Staff had contributed to the development of the trust values and lived these in their work. Staff spoke of being proud of working at the trust, were passionate about providing the best care they could.
- The chief executive had a very high profile in the trust and was known by all staff. Staff felt they were listened to and supported by their managers who were visible in the clinical areas.
- There was a stable executive team with all posts filled on a substantive basis.
- The Governors were fully engaged with the Board, felt supported in their roles and could see their influence when issues were raised.
- Although in the staff survey there had been some reports of discrimination from staff from black, minority and ethnic groups this was not the experience of those spoken with during the inspection who reported feeling supported.
- Innovation and improvement was encouraged and rewarded. There were award ceremonies at which innovative and caring practice was shared and

recognised, this was well publicised and appreciated by staff who were proud of their colleagues achievements. Participation in research was good and increasing.

We saw several areas of outstanding practice including:

- The surgery wards had identified link roles for staff in varied and numerous relevant subjects. A nurse and a healthcare assistant had been assigned together to the link role.
- The surgery and musculo-skeletal directorates had regular specialty meetings. A member of the care staff who would not otherwise attend these meetings joined the meeting each time to provide a 'sense-check'. They listened to the content, decided if it made sense and properly described the state of their service.
- There was an outstanding level of support from the consultant surgeons to the junior and trainee doctors and other staff including the student nurses.
- The maternity services strived to learn from investigations in order improve the care, treatment and safety of patients. This was evident with the robust, rigorous and deep level of analysis and investigation applied when serious incidents occurred. For example, the reopening of a coroners case as a consequence of the maternity service investigations. Further evidence of this was available in meeting minute records. In addition, a wide range of staff demonstrated that learning from incidents was a goal widely shared and understood.
- The Benson bereavement suite facilities, and sensitive care provided to patients experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners. The facilities were comfortable and extensive, enabling patients and their families' privacy and sensitive personalised care and support.
- In the services for children and young people a mobile APP was produced in conjunction with a regional neonatal network to provide information and support for parents taking their babies home.
- Sarum Ward staff worked across the hospital working with a variety of teams to improve services for children and young people. Examples were of

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developing a DVD for pre-operative patients, using child friendly surveys in other areas of the hospital, supporting any staff with expertise on the needs of children and young people.

- Nurse led pathways were being used. In one example a nurse led pathway was in place for early arthritis, this pathway had been ratified by the Royal College of Nursing. The pathway was evidence based that showed the quicker patients were diagnosed with arthritis, the quicker treatment could be started and the quicker patients could go into remission. This service came top in a national audit for patients with early arthritis. Staff had presented their service at national and international conferences including the Bristol Society of Rheumatology conference in 2015.
- We observed excellent professionalism from staff in outpatients during an emergency situation. Staff attended to the patient that needed immediate help and support. Staff also cared for and supported the other patients who had witnessed the emergency. Patients were moved away from the emergency into another department and kept informed of what was happening and offered lots of reassurance. When the emergency was over, patients were shown back into the waiting area with explanations on the subsequent delay to the clinic.
- The outpatients departments monitored how often patients were seen in clinics without their medical records. From January to July 2015 123,548 sets of patients notes were needed for the various clinic appointments across the trust. Out of these, 115 sets of notes could not be located for the appointment. The department identified that this was because the notes had been miss-filed, staff had not used the case note tracking properly or the notes were off site for another appointment. Overall, patients' medical notes were found for 99.91% of appointments, which was a small increase from the previous two years. This showed that there was an effective system in place for making sure patients' medical notes were available for their outpatient's appointments. Where they were not available, a reason was identified to try and reduce the likelihood of the issue happening again.
- In the spinal centre there were examples of care where staff went above and beyond the call of duty.

One example of this was where a patient got married in the spinal centre. Staff went with the patient's partner to collect and prepare food and on the wedding day was picked up by a member of staff in their classic car. The couple were then allowed the use of the discharge accommodation after the wedding.

- The 'live it' and 'discuss it' sessions were fully integrated into the spinal treatment centre. We observed one session where patients and relatives were given opportunities to discuss their concerns as a peer group as well as to professionals and ex-patients. It was clear that patients and their carers were being supported through a difficult time and were being educated on important topics preparing mentally and physically them for discharge.

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

Importantly, the trust must:

- Review nurse staffing levels and skill mix in the areas detailed below and take steps to ensure there are consistently sufficient numbers of suitably qualified and experienced nurses to deliver safe, effective and responsive care. This must include:
- a review of the numbers of staff and competencies required to care for children in the emergency department,
- a review of the arrangements to deploy temporary nursing staff in the emergency department,
- a review of arrangements in the emergency department to ensure that nursing staff receive regular clinical supervision, education and professional development.
- a review nursing staff levels at night on Amesbury ward, where the current establishment of one nurse for 16 patients, does not meet guidance and is not safe. Other surgery wards with a ratio of one nurse to 12 patients at night must be reviewed. Pressure on staff on the day-surgery unit, when opened to accommodate overnight patients, and still running full surgical lists, must be addressed.

Summary of findings

- ensuring there are appropriate numbers of, and suitably qualified staff for the number and dependency of the patients in the critical care unit.
- ensuring there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff deployed in areas where children are cared for in line with national guidance.
- ensuring there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.
- ensuring one to one care is provided in established labour in order to comply with national safety guidance (RCOG, 2007).
- Ensure staff across the trust are up-to-date with mandatory training.
- Ensure that all staff have an annual appraisal and that records are able to accurately evidence this.
- Complete the review of triage arrangements in the emergency department without delay and take appropriate steps to ensure that all patients who attend the emergency department are promptly clinically assessed by a healthcare practitioner. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Ensure staff effectively document care delivered in the patient's healthcare record at the time of assessment or treatment in line with the hospital's policy and best practice. This must include effective documentation with regard to intravenous cannulas and urethral catheters and the recording of patients' weight.
- Strengthen governance arrangements to ensure that all risks to service delivery are outlined in the emergency department's risk register, that there are clear management plans to mitigate risks, regularly review them and escalate them where appropriate.
- Ensure that all actions are implemented and reviewed to reduce patients being cared for in mixed sex accommodation.
- Ensure that daily and weekly check of all resuscitation equipment are completed and documented appropriately.
- Ensure there is a hospital policy governing the use and audit of the World Health Organisation surgical safety checklist. The audit of the checklist must be conducted as soon as an appropriate period of time has passed since its reintroduction. Results must be presented to and regularly reviewed at clinical governance.
- Ensure there is a sustainable resolution to the issue of holes or damage in the drapes wrapping sterile surgical instrument sets, and all sets are processed and available for re-use to avoid delays or cancellations to patient operations.
- Ensure patient charts are kept secure and confidential at all times.
- Must ensure there is effective management of the conflict between meeting trust targets for performing surgery and the impact this has on patients. Patients must not be discharged home from main theatres unless this cannot be avoided. Surgery must not be undertaken if there is clearly no safe pathway for discharging the patient. Operations must take place in the location where staff are best able to care for their recovery.
- Ensure staff consistently adhere to the trust infection control policy and procedures.
- Ensure that patients are discharged from the critical care unit in a timely manner and at an appropriate time.
- Ensure the process for booking patients an elective beds following surgery is improved and reduce the number of cancelled operations due to the lack of availability of a post-operative critical care bed.
- Ensure that the governance arrangements for critical care operate effectively, specifically that identified issues of risk are logged and that risk are monitored, mitigated and escalated or removed as appropriate.
- Ensure that care and treatment at the spinal unit is provided in a safe way relating to the numbers of spinal patients waiting for video uro-dynamics and outpatient appointments and reducing the risk of harm to these patients.

Summary of findings

- Ensure that risks associated with the spinal service are managed appropriately with the pace of actions greatly improved. In particular, to the management of the numbers of patients waiting for video uro-dynamics and outpatient appointments.
- Ensure care and treatment are delivered in a way to ensure that all patients have their needs met which reflects their preferences. This includes the training of agency staff, the availability of physiotherapy and occupational therapy sessions, and the availability of suitable activities for patients in spinal services.

Chief Inspector of Hospitals

Professor Sir Mike Richards

Summary of findings

Background to Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust provides care to over 240,000 people across Wiltshire, Dorset and Hampshire. This includes general and acute services at Salisbury District Hospital with specialist services including burns, plastics, cleft lip and palate, genetics and rehabilitation serving over three million people. In addition the Duke of Cornwall Spinal Treatment Centre serves South England's population of 11 million people.

Salisbury Hospital has 464 beds and is staffed by approximately 4054 members of staff. They provide care to around 240,000 people across Wiltshire, Dorset and Hampshire.

Salisbury NHS Foundation Trust has fairly stable executive and non-executive team. The chairman has been in post for one year supported by a board of non-executive directors with a range of skills and expertise, two of whom have been in post for seven years. The chief

executive has been in post for two years having worked in the trust since 1986. The director of nursing and chief operating officer are the newest recruits to the board at one year and six months respectively, with other members of the executive team having been in post three to five years, except for the director of finance and procurement who had been in post for 29 years.

We inspected this trust as part of our programme of comprehensive inspections of acute trusts. CQC uses an intelligent monitoring model to identify priority inspection bands. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Against this the trust was judged as a low risk, at level six (the lowest level) which it had been at since 2013.

Our inspection team

Our inspection team was led by:

Chair: Julie Blumgart; former Clinical Quality Director, South region.

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

The team included CQC inspectors and a variety of specialists: two directors of nursing, lead for safeguarding adults and children, registrar in emergency medicine, senior sister in emergency medicine, matron in trauma

and orthopaedics, consultant anaesthetist, critical care nurse, consultant in paediatric palliative medicine, ward sister, deputy medical director - consultant obstetrician and gynaecologist, head of midwifery, consultant physician, clinical nurse specialist, consultant radiologist, nurse, consultant neonatologist, senior manager for paediatrics and child health, consultant general surgeon and medical director, surgical nurse, specialist registrar, ST3 in immunology. The team also included two experts by experience, analysts and an inspection planner.

How we carried out this inspection

To get to the heart of patient's 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 eight core services as well as an additional service, the spinal service:

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

Summary of findings

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Salisbury Hospital. These included the local commissioning groups, Monitor, the local council, Wiltshire Healthwatch, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held two listening events in Salisbury on the 3 and 19 November 2015. More than 59 people attended the events. People who were unable to attend the event shared their experiences by email and telephone and on our website.

We carried out an announced inspection on 1, 2, 3 and 4 December 2015 and an unannounced inspection on 13 December 2015. We held focus groups and drop-in sessions with a range of staff in Salisbury Hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

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

This inspection was one of nine pilots which looked in more detail at the Workforce Race Equality Standard and our findings are documented in the well led section of this report. From April 2016 this and equality and diversity will be routinely inspected.

What people who use the trust's services say

We received information from people prior to the inspection through the listening events, emails, phone calls and through the "share your experience" section of our website. The vast majority of comments were positive, with patients and relatives stating that the nurses were busy but always helpful and courteous explanations from staff were good. Areas of concern included long waits for outpatients appointments, levels of noise on wards at night, car parking.

Between September 2014 and January 2015 a questionnaire was sent to 850 recent inpatients as part of the CQC Adult Inpatients Survey 2014, 502 responses were received. The trust was performing about the same as most other trusts and there had been little change from the previous year's results.

In the Cancer Patients Experience Survey (2013/2014) the trust scored in the top 20% of trust for six of the statements including patients rating their care as excellent or very good and in the lowest 20% for just one statement relating to being given the name of the clinical nurse specialist in charge of their care.

The response rates for the Friends and Family Test had remained constant for inpatients, had improved for maternity services but were low for the emergency department, day cases and outpatients. However the responses that were received were generally better than the national average in all but three months of the reporting period reviewed.

Facts and data about this trust

In 2014/15, the trust had 6,405 elective inpatient admissions and 28,494 emergency admissions. There

were 183,732 outpatient attendances, along with 43,998 attendances at accident and emergency. It had revenue

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of £355,014k, the full cost was £355,593k therefore there was a financial deficit of £579,000. This was the first year in its history Salisbury NHS Foundation Trust had reported a deficit.

Since the fourth quarter of 2014/15 the bed occupancy at the trust has been above the national average (85.9%). It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of the hospital. During the period from June 2015 to November 2015, the hospital's bed occupancy rate was on average 96%.


Salisbury's population is evenly distributed across age groups with each five-year age bracket comprising

between four and eight percent of the total up to the age of 79. Black and ethnic minority groups represent 4.3% of the population of Salisbury and 3.45 of the population of Wiltshire.

The local authority of Wiltshire is ranked in the fourth quintile nationally in the 2010 Indices of Multiple Deprivation. Deprivation is lower than the national average, and though the local authority is ranked worse than average for melanoma, self-harm and road accidents, it is ranked on a par with or better than the England average for the other 29 measures used in the Indices of Multiple Deprivation.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Overall, we rated safety of the services in the trust as 'requires improvement'. For specific information, please refer to the report for Salisbury Hospital.</p> <p>The team made judgements about nine services. Of those, six were judged to be requiring improvement and three as good. Therefore the trust was not consistently delivering good standards of safety in all areas. There were concerns with nurse staffing levels in some areas particularly in emergency and urgent care, surgical wards, services for children and young people, including the neonatal unit, critical care, maternity and the spinal unit. Patient records were not consistently written and managed appropriately. Infection control procedures were not being followed in all areas. In a minority of areas equipment was found to be dusty and in one area the commodes were dirty. The trust was not meeting its target of 85% for the percentage of staff receiving mandatory training. Resuscitation equipment was not being checked every day as required to ensure it was fit for use.</p> <p>Staff understood their responsibilities to raise concerns, record safety incidents and near misses and to report these appropriately staff received feedback and learnt were learnt to improve care. There was a culture of being open and the duty of candour was well understood.</p> <p>Duty of Candour</p> <ul style="list-style-type: none">• Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. The trust had an adverse events reporting policy and a serious incident policy which were both updated in 2015 to reflect the requirements of the regulation. There was also a duty of candour and being open policy to support these.• The trust had an established culture of being open. A sample of incidents were reviewed, these demonstrated that duty of candour was considered and appropriate actions taken where required. <p>Safeguarding</p>	<p>Requires improvement</p> 

Summary of findings

- There were systems, processes and practices in place that kept patients safe which were understood and implemented by staff. There was one example in which we found a delay in actioning a concerning safeguarding issue which we requested the trust investigated.
- The trust had a safeguarding policy which identified the roles of key, senior personnel and their responsibilities in ensuring the hospital complied with relevant legal and statutory requirements. Safeguarding training was mandatory for staff with a trust target of 85% however compliance with this was not consistently met with compliance figures of level 1 training at 83%, level 2 at 75% in September 2015, and, level 3 was 41% at November 2015.

Incidents

- Staff understood their responsibilities to raise issues, to record safety incidents, concerns and near misses, and to report them appropriately. The rate of reporting incidents was higher than the national average. A higher rate of reporting can indicate a more effective safety culture, as it provides the opportunity for learning and improvement. Staff were encouraged and reminded to report incidents and received feedback. Lessons were learnt and improvements put in place to improve care.
- The adverse events incident policy and serious incident requiring investigation policy were both in date and aligned with the national requirements for reporting incidents. Incidents were themed and presented to the trust clinical risk committee which included directorate representation.
- Two serious incident reports and a 72 hour preliminary report were reviewed. It was evident that a nationally recommended framework was used to structure the reports which were of good quality with appropriate actions arising from the investigation.
- There had been four never events reported across the trust in the previous 12 months, one was under investigation at the time of the inspection. The investigation of the others was mainly appropriate and learning from these evident.

World Health Organisation Surgical Safety Checklist

- The audit of the World Health Organisation surgical safety checklist had in the recent past been inadequate. This had recently been recognised with a new audit and observation protocol. As yet there were no results to review to determine if the checklist was being used safely as it was early days with the

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new regime. There was, however, no evidence from our observations of the safety checks in theatres not being performed effectively. Policies and procedures for use of the checklist had not been developed.

Cleanliness, infection control and hygiene

- Ward and clinical areas were generally clean, tidy and well maintained although in a minority of areas some equipment was found to be dusty and in one area the commodes were dirty.
- There was variable compliance with the appropriate use of personal protective equipment. In the medical wards there was confusion over which patients were nursed in isolation. Signs alerting staff and visitors that patients were being cared for in isolation were in place that staff said were no longer relevant. Doors were open in some cases for patients who were in isolation albeit these were open intentionally for patients who became confused when they were closed.
- There had been no new Methicillin-resistant *Staphylococcus aureus* (MRSA) since October 2014. Rates of *Clostridium Difficile* were just below the trust trajectory in October 2015.

Environment and equipment

- Generally the design and maintenance of the environment kept patients safe. However the awaiting area for children in the emergency department was overlooked by and could be accessed by adults in the main waiting area. In addition there were restricted lines of sight to the children's waiting area. In the critical care unit none of the bed spaces met the Health Building Note 04-02 and that two bed spaces were restrictive. Whilst this had been considered at the time of refurbishment there were no risk assessments in place for the patients in these beds at the time of the inspection.
- The children's ward, Sarum, had been refurbished and provided very good facilities for children and their parents.
- Each ward and department had a resuscitation trolley containing emergency equipment and medicines in the event that a patient suffered a cardiac arrest. Wards kept trolleys secured so that medicines did not go missing and could be ready to be use in an emergency. Hospital policy stated that these should be checked daily to ensure reliability and to allow for the replacement of essential equipment. On some wards we found omissions in daily checks therefore there was a lack of assurance that this equipment was fit for use.

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- There were problems with damage occurring to the wrappings of surgical instruments, whilst the trust had taken actions to address these the problems had yet to be fully resolved. This meant that instruments were not always available when required.

Staffing

- Nursing staffing levels varied across the trust in meeting recommended levels. In emergency and urgent care the nursing establishment fell short of the nurse to patient ratio recommended by the National Institute for Health and Care Excellence (NICE), with levels at night sometimes as low as one to ten in majors. This was exacerbated by a significant number of vacancies and absences which meant the department relied heavily on temporary staff. Not all the temporary staff provided had the appropriate skills and experience to work in the emergency department.
- In the surgical unit there were particular issues with the established ratio of registered nurses to patients at night on Amesbury, Chilmark Suite and Downton Wards. Where shortfalls were identified bank and agency were used. It was noted the fill rate for such shortfalls had improved in the last few months.
- In the neonatal unit staffing levels were informed by the British Association of Perinatal Medicine and on Sarum ward by the 2013 Royal College of Nursing guidance on safer staffing for paediatrics. However in neither area were these followed consistently, during the inspection we raised a concern regarding staff numbers on Sarum ward and the trust took immediate action.
- In maternity services the midwife to patient ratio exceeded the recommended levels, which in October had risen to a ratio of one to 41 against a recommended level of one to 28. A number of midwives had recently been appointed and when they all started the ratio would improve to one to 32.
- There were occasions when nurse staffing numbers did not meet recommended staffing ratios. There were also high numbers of agency nurses being employed (261 shifts covered in six months ending November 2015).
- Nurse staffing levels in the spinal treatment centre were not meeting the NHS standard contract for specialised rehabilitation, with gaps being filled by bank and agency. Ventilated patients were not receiving the one to one care as recommended this was raised with the trust during the inspection who acted immediately.

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- Nurse staffing levels in the medical unit, outpatients and the palliative care team were in line with relevant tools and guidance where applicable. The levels enabled patients for receive safe care and treatment.
- Overall the trust has a higher percentage of consultants at 48% than the national average at 39%. There were however some shortages in some areas particularly in emergency and urgent care and spinal services. In critical care whilst the medical staffing met the intensive care core standards the way in which the rota was structured meant that the consultant for the unit could be available for three or four days in a row. In these circumstances the consultants worked well together to mitigate risks.

Records

- Patient records were not consistently written and managed appropriately. In the emergency department, particularly the short stay unit nursing documentation was generally poor. In the critical care unit there were examples of omissions in the patients' records. Audits in the surgical unit demonstrated good compliance with record keeping however there was some inattention to patient record safety and confidentiality. In the medical unit there was poor recording of weight and the management of intravenous cannulas and catheters. In addition some documentation had been frequently photocopied making the legibility poor. Other areas of the trust records were accurate, complete, legible and up to date.

Are services at this trust effective?

Overall, we rated effectiveness of the services in the trust as "good". For specific information, please refer to the report for Salisbury Hospital.

People's care and treatment was planned and delivered in line with current evidence based practice, standards, best practice and legislation. This was monitored to ensure consistency and the results were used to improve patient care.

The team made judgements about eight services, currently outpatients are not currently rated for effectiveness. Of those rated, seven were judged to be good and spinal services as requiring improvement. This means that in the majority of services patients had good outcomes because they received effective care and treatment that meet their needs.

Good



Summary of findings

In most services, patient's needs were assessed and care and treatment delivered in line with legislation, standards and evidence based practice. Performance in national audits was generally the same or better than the national average.

Staff and teams worked well together to deliver effective care and treatment. Maternity services and theatres could do more to improve multidisciplinary working. Not all staff were receiving an annual appraisal. Consent and knowledge of the mental capacity act was good however the recording of this needed improvement.

Evidence based care and treatment

- In the majority of services, patient needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance, for example National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines, and specialist guidance from the royal colleges. Some locally held policies needed to be updated.
- In the National Care of the Dying Audit in 2014 the trust had not achieved six out of the seven key organisational targets and had scored below the national average for nine of the ten clinical key performance indicators. Action had been taken to improve the performance in all these areas. The trust were in the process of completing the latest National Care of the Dying Audit at the time of the inspection.

Patient outcomes

- Mortality rates were as expected at 107 as measured by the Hospital Standardised Mortality Ratio (July 2015) and 107 for the Summary Hospital-level Mortality Indicator (March 2015).
- In the majority of services, the outcomes of people's care and treatment were monitored. The trust participated in a number of national audits so it could benchmark its practice and performance against that of other trusts. This information was used to improve care.
- In emergency and urgent services performance with national audits was generally about the average compared with other trusts with the exception of the Royal College of Emergency medicine (RCEM) mental health audit where performance required improvement.
- Unplanned re-attendance in A&E was better than the national average at 2.5% compared to 5% (august 2015)
- The majority of patient outcome data for the medical directorate showed a performance in line with, or better than the national average. For example, the stroke services achieved

Summary of findings

a rating of 'B' in the June 2014 to July 2015 sentinel stroke national audit programme. A is the highest score and E the lowest. Stroke patients spent 90% of their time on the stroke unit versus a target of 80%. The hospital achieved good patient outcomes in the national heart failure audit and the m ().

- The hospital's endoscopy service held accreditation through the Joint Advisory Group (JAG) for gastrointestinal endoscopy.
- The hospital performed better than the England average in the national hip fracture performance audit, but performance had declined from the previous year. The hospital performed well in the national lung and bowel cancer audits in 2014. Post-surgery readmission rates were generally good, although this varied between planned and emergency surgery. The hospital performed relatively well in the patients' review of their outcomes following hernia and hip/knee replacement and varicose vein surgery. The hospital had, however, performed less well in the National Emergency Laparotomy Audits of 2014 and 2015. There were actions plans to address the shortcomings, but not all of these had been completed
- The critical care unit was performing as expected (compared to other similar services) in all the case mix programme indicators used in the Intensive Care National Audit and Research Centre Annual Quality Report (2013/2014).

Competent staff

- Staff were qualified and had the skills needed to carry out their roles effectively and in line with best practice. Staff were encouraged to develop and were given opportunities for professional development. Junior doctors in particular reported feeling well supported with regular education and supervision.
- The rate for medical appraisals was 92% however not all non-medical staff were being supported to have an annual appraisal with 59% having received an appraisal in the last 12 months. Significant work was being undertaken to ensure that all appraisal data was appropriately recorded, however it was noted that the rate had dropped between the October and December 2015 board reports.

Multidisciplinary working

- When people received care from a range of different staff, services and teams this was well co-ordinated. Staff, teams and services worked well together to deliver effective care and treatment. One of the trust values was patient centred care and staff enacted this value through working together for the benefit of the patient.

Summary of findings

- There were two areas where multidisciplinary working could be improved. In maternity services the midwifery and medical handovers were held at different times therefore the whole multidisciplinary team was not able to benefit from each other's handover. Many maternity staff thought there was a hierarchical approach between medical and nursing staff which was felt to have a negative impact on whole team working. The second area was theatres where there was some work to do to bring fully collaborative teamwork into theatre. This was recognised by senior managers and was being addressed.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent and knowledge of the mental capacity act was good however the recording of this needed improvement.
- There was a good understanding amongst staff of the Deprivation of Liberty Safeguards and when to apply them. Training and guidance was available and staff were aware of who to contact if they needed any advice for support.

Are services at this trust caring?

Overall we rated the caring aspects of services in the trust as good. For specific information please refer to the report for Salisbury Hospital.

The vast majority of feedback we received prior to, and during the inspection was positive. Staff were providing kind and compassionate care which was delivered in a respectful way. The need for emotional support was recognised and provided as required.

Compassionate care

- Care was delivered in a caring and compassionate manner, with staff respecting the privacy and dignity of patients.
- The trust strived to provide patient centred care and this was evident in the majority of services provided. In the spinal treatment centre some patients felt ignored and isolated, however also in this unit there were examples of staff going the extra mile such as arranging a wedding to take place in the unit for one patient.
- The majority of feedback from patients and relatives was extremely positive and although the response rate for the friends and family tests were below the national average the number of patients who would recommend Salisbury Hospital exceeded the national average.

Good



Summary of findings

- We received 88 completed comments cards during the inspection of these 82 contained positive comments such as “I think the staff are lovely and caring”; “very caring staff. Lots of dignity and respect”; “Staff were very attentive and helped me when I needed it”; “The staff were all very supportive and professional yet kind and compassionate, spending time to ensure I was being cared for well”. Many of the less positive comments related to system and process issues such as appointments and waiting times. Only one card related to poor manner and attitude of staff.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. Feedback from patients and relatives prior to the inspection was positive regarding the explanations they were given regarding their care and treatment. During the inspection this was confirmed in the positive interactions we heard between staff and patients.
- In the Cancer Patient Experience Survey 2013/14 the trust scored in the top 20% of trust for “Got understandable answers to important questions all/most of the time” and for “Patient was able to discuss worries or fears with staff during visit”.

Emotional support

- The need for emotional support was recognised and provided. There was access to chaplaincy services, support from doctors and nurses with specialist knowledge
- There were particularly good examples of care for the bereaved. The Benson bereavement suite facilities were staffed by midwives and the sensitive care provided to patients experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners. The facilities were comfortable and extensive, enabling patients and their families’ privacy and sensitive personalised care and support.
- In the emergency department a bereavement service was provided. Details of the service were sent with sympathy cards to bereaved relatives. A dedicated nurse worked in the emergency department one day a week providing support to bereaved relatives in person or by telephone.

Are services at this trust responsive?

Overall we rated responsiveness in the trust as requiring improvement. For specific information please refer to the report for Salisbury Hospital.

Requires improvement



Summary of findings

The team made judgements about nine services. Of those, responsiveness in the spinal services were judged to be inadequate, three services were judged to be requiring improvement and five as good. Therefore trust was not consistently planning and delivering services to meet the needs of patients.

Patient's individual needs were not consistently met.

In spinal services there was disparity between the experiences of some patients whilst some made good use of the gardens and away days others felt lonely and bored. Spinal patients waiting for video-urodynamics and outpatients experiencing unacceptable waits for appointments and there was little risk assessments of the patients who were waiting.

Vulnerable patients in the emergency department with mental health needs, particularly children and adolescents, who required assessment by a mental health practitioner, did not always receive a responsive service.

The environment for children in the emergency department was not appropriate with them being cared for in the adult area.

The trust was not consistently maintaining single sex accommodation.

The investigation of complaints was comprehensive however there were areas that could be improved relating to the working with other organisations to provide a single response when required, the development of action planning and learning after the investigation.

Overall the trust performed well in meeting national targets, including the time patients spent in the emergency department and referral to treatment times.

The bereavement facilities for maternity and gynaecology patients who experienced loss were outstanding.

Service planning and delivery to meet the needs of local people

- The trust works in partnership to scope and plan to meet the needs of the population served. As a provider of regional and supra regional services this partnership extends beyond the local clinical commissioning groups to the wider NHS England specialist commissioning team.
- Over recent years significant refurbishment had been undertaken to the critical care unit and the children's ward. Further work was planned to the maternity unit and the spinal treatment centre.

Meeting people's individual needs

Summary of findings

- Caring for patients with dementia was varied across the trust. Several medical wards at the hospital had undergone changes to make them dementia friendly such as different colours for different areas, non-slip, non -reflective flooring and different coloured ceiling lighting. The medical unit had received the Dementia Charter in 2013. However in the surgical wards communal corridors were very similar and plain with no triggers to help orientation. There were no specific prompts or much more than enhanced signage to assist people living with dementia. The emergency department had not taken adequate steps to support patients living with dementia, although they were trying to embed the use of an abbreviated mental test (AMT) score for patients over 75 years of age. There were also plans to adapt some cubicles in the emergency department to make them “dementia friendly”, although no funds had been identified for this yet.
- The ‘John’s campaign’ enabled carers of people living with dementia to stay with their relative round the clock and this permitted them to help care for the patient.
- Volunteers along with specialist staff ran a carers café twice per month. Carers with relatives or friends in hospital shared experiences and got support and advice from trained staff from the Alzheimer’s Society, Age UK and Care Support Wiltshire.
- Patients in the emergency department with mental health needs, particularly children and adolescents, who required assessment by a mental health practitioner, did not always receive a responsive service. This meant that these patients experienced long waits which could be detrimental to their mental health and they were sometimes admitted to hospital unnecessarily.
- The trust had a policy for adults with a learning disability attending hospital. There were links for staff to approved ‘easy read’ documents at the British Institute of Learning Disabilities, the University of Birmingham and Bristol University. There was no specific learning disability team at the hospital. The director of nursing was the lead for services for patients with a learning disability.
- In the emergency department children were cared for in the adults’ department which was not an appropriate environment from them because they were exposed to sights and noise which may cause them distress. The children’s waiting room, whilst bright and welcoming, was overlooked by and could be accessed by adult patients and visitors.
- There was a disparity between the experiences of some patients in the spinal unit. While some patients were making use of gardens and away days to, for example football matches;

Summary of findings

there was a cohort of patients who felt lonely. One patient described how the days felt very long as there was nothing to do. Access to therapists, the gym and the pool was limited and patients felt they could be doing more to aid their recovery.

- Maintaining single sex accommodation was a challenge for the trust. There was a policy for eliminating mixed sex accommodation in place. Breaches were reported to the trust board, were subject to root cause analysis and were reviewed with the commissioners however the number of non-clinical breaches had been in excess of 27 for each of the last eight months.
- The bereavement facilities for maternity and gynaecology patients who experienced loss were outstanding. Sensitive, individualised care was provided to patients and their relatives.
- The trust could organise rapid discharges for patients at the end of their life effectively but there were delays due to funding of care packages in the community. The trust had not yet completed an audit of patients achieving their preferred place of dying.
- There were innovations in nutrition, which endeavoured to support people who needed help with eating and drinking. Staff served food on blue plates for patients living with dementia, the elderly or those patients at risk of malnutrition. The contrast in colour was particularly helpful because it made food look more appetising and has proven to increase food consumption during tests conducted on a number of wards within the hospital. A gold tray was used for patients needing support with eating; this was less distinctive than the red tray used in many hospitals and therefore more subtle alongside the regular pale yellow trays. There were also green trays in use to highlight patients with food allergies or intolerance, although we did not see any of these in use. The trust changed menus each season and ninety-five percent of food provided to patients was produced on site. Wards had pictorial menus to help people make choices. The majority of patients complimented the food. The Patient-Led Assessments of the Care Environment (PLACE) surveys said the hospital had significantly improved for food provision.

Access and flow

- Patients in spinal services were frequently and consistently unable to access services including video uro-dynamics and outpatients in a timely way for diagnosis, follow up and treatment and experienced unacceptable waits for these services. There were 467 patients in a waiting list for video uro-

Summary of findings

dynamics and 1024 patients in a waiting list for an outpatient appointment with no clear understanding from the trust as to how the risks to these patients were assessed. There were no clear and detailed actions, with timescales to reduce these lists.

- Overall the trust performed well in meeting national targets. The emergency department was consistently meeting standards in respect of the time people spent in the department, and the time they waited for treatment, although this was becoming more challenging with increasing demand on the service. There were relatively few ambulance handover delays but at busy times, some patients queued on ambulance trolleys in the department and this impacted on their comfort, privacy and dignity.
- Referral to treatment times were being met and there were low rates of cancelled operations. There were challenges in meeting the two week wait for all cancers and symptomatic breast cancer which were just under the target of 93%.
- The emergency department worked well with the patient flow team and the rest of the hospital to minimise blockages and overcrowding in the department. However although this worked well for the emergency department this did not continue through the management of inpatient beds with patients being moved a number of times during their stay, sometimes after 10pm at night. Bed meetings were held two or three times a day and did not offer robust challenge as to why patients were moved during the night.
- There was good flow through the maternity care pathway; however there was concern that the escalation policy was not always used to its full effect.
- Outpatients and diagnostic imaging services were meeting or very close to meeting their targets on waiting times. In July 2015 only 67 patients out of 3,934 waited longer than the six weeks for diagnostic procedures. Once patients arrived at their appointment, 86% of them waited less than 30 minutes to be seen.

Learning from complaints and concerns

- There was a complaints policy in place dated 2010, which had been revised in December 2014 taking into account the requirements of the regulation on the Duty of Candour. The policy detailed the aim of the policy, the management of complaints considering statutory requirements, response timeframes, roles and responsibility of all staff, meetings as part

Summary of findings

of the resolution process (with guidance on how they should be structured) and information about the Parliamentary Health Service Ombudsman. Templates were included in the appendices to ensure consistency.

- Customer care reports were presented to the trust board quarterly. In the August 2015 report it is noted that from April to June 2015 inclusive the trust treated 16,477 people as inpatients, day cases and regular day attendees. Another 11,452 were seen in the emergency department and 43,742 as outpatients. 87 complaints were received overall which is 0.1% of the number of patients treated. This percentage remains unchanged from previous quarters. All complaints were acknowledged within three working days.
- The overall number of enquiries, comments, concerns and complaints response times were: 10 working days and under, 405 or 73%; 11-24 working days 87 or 15% and 25 days and over 63 or 12%. Reasons for some complaints taking more than 25 working days to respond to included, arranging meetings, complexity of the case and awaiting comments from key members of staff.
- Survey information relating to the experience of the complaints process was reported to the board every six months, in August 2015 the report stated that:
- 25% felt they did not receive responses in a timely fashion. According to the policy all complainants receive an acknowledgement letter which state a response time of 25 days. There is no negotiation with the complainant around the response time.
- 30% felt the response did not address the issue raised in the complaint.
- < >% stated they were not kept informed of the progress of the complaint. The policy states that if the initial date cannot be met then the complainant will be informed of the new date. This did not happen in the complaints reviewed.
- 50% felt the complaint response only partly met or had not met the issues raised in the complaint.
- 17% felt they were treated differently after making a complaint. The policy and the acknowledgement letter clearly state that making a complaint does not prejudice future treatment.
- 56% were satisfied with how the complaint was managed.
- In March 2015 the clinical governance committee discussed how to improve learning from complaints. One of the non-executive directors already reviewed a random sample of complaints each quarter but as a result of this discussion this was formalised using Patient Association standards. The

Summary of findings

findings of this review found responses to be clinically focussed rather than emotionally. As a result the trust focused on providing more personal contact with complainants in order to avoid long clinical letters with medical terminology. Staff confirmed that such meetings were taking place.

- We reviewed five complaints and found that the investigations had been comprehensive; the need for consent was recognised if it was not the patient making the complaint and all were signed by the chief executive. There were also a number of areas of weakness. The complaints policy refers to how different organisations should work together to provide a single response. This was not evident in two of the complaints reviewed. One of the actions in April 2015 was to develop joint protocols this was not done by the time a joint complaint was received in June 2015 and interim processes did not appear to be in place. The complaint acknowledgement letter reminds patients that future care will not be compromised by having made the complaint which is good however patient feedback (referenced above) does not support this.
- There was no evidence of discussion with the complainant regarding the timeframe for response; everyone was informed there was a 25 day response. The response letters offered an apology but they lacked emotion, they remained chronological and clinically focussed. There was no consistent development of action planning and clear learning after investigation.

Are services at this trust well-led?

The leadership, management and governance of the trust requires improvement in order to assure the delivery of high-quality person-centred care. Of the nine judgements across the trust five required improvement and four were found to be good.

The trust had a governance framework which supported the delivery of care although there were some areas of weakness. The trust had recently undertaken a self- assessment against Monitor's quality governance framework however this had not clearly identified any weaknesses or areas for improvement. A review had been undertaken to support board development however no external review of the board assurance framework has been undertaken in recent years. Risk registers did not consistently identify all risks, mitigating actions or where it did the actions had not always been taken or where they had the risk had not been updated. One of the strengths of the trust was that staff had a strong sense of respect for each other and communicated well, however we heard of informal

Requires improvement



Summary of findings

conversations between staff that lacked documentation to support an audit trail for decisions and actions. The trust had experienced a deficit for the first time in its history and staff were anxious about the future, a recovery plan was in place.

Staff had contributed to the development of the trust values and lived these in their work. Staff spoke of being proud of working at the trust, were passionate about providing the best care they could and supporting colleagues was very important to them. The chief executive had a very high profile in the trust and was known by all staff. There was a stable executive team with all posts filled on a substantive basis. The Governors were fully engaged with the Board, felt supported in their roles and could see their influence when issues were raised.

Staff felt they were listened to and supported by their managers who were visible in the clinical areas.

Although in the staff survey there had been some reports of discrimination for staff from black, minority and ethnic groups this was not the experience of those spoken with during the inspection who reported feeling supported.

Innovation and improvement was encouraged.

Vision and strategy

- The executive team articulated the strategy of the trust as always aiming to provide a first class service and working more with partners to provide this. There were four main corporate objectives:
- “To be the hospital of choice, we will provide a comprehensive range of high quality local services enhanced by our specialist centres.
- We will treat our patients with care, kindness and compassion and keep them safe from avoidable harm
- We will make Salisbury NHS Foundation Trust a place where staff feel valued to develop as individuals and teams
- We will be more innovative in the use of our resources to deliver efficient and effective care.”
- At the centre of the objectives were the values of the trust of being patient centred and safe, professional, responsive and friendly. Staff had been involved in the development of the values through consultation and focus groups in 2014 and clearly demonstrated them in their work.

Summary of findings

- Whilst staff were clear about the vision and objectives of the trust these were not well developed into local strategies within the clinical services.

Governance, risk management and quality measurement

- The trust had a governance framework which supported the delivery of care although there were some areas of weakness. Responsibility for the assurance of patient safety, clinical effectiveness and patient's safety was delegated to the clinical governance committee which was chaired by a non-executive director. To help promote staff engagement in quality in January 2015 a junior doctor and junior nurse joined the membership of the committee. It was noted the minutes did not detail the roles of the people attending only their names of those attending therefore it was difficult to see if the committee was quorate or if any professions were underrepresented. A review of the minutes for March and May 2015 demonstrated that not all actions were captured in the minutes therefore we could not be assured that all actions were taken forward and reviewed at subsequent meetings.
- The medical and nursing directors chaired a clinical management board which met monthly to discuss quality performance. The clinical directors, directorate senior nurse and managers attended this meeting. This board reviewed patient outcomes through the results of clinical audits and national confidential enquiries. At directorate level quality performance was monitored through directorate quality performance meetings held monthly. A detailed focus on quality took place three times a year at these meetings. Local clinical meetings fed into the directorate meetings.
- In September 2015 the trust had undertaken a self-assessment against Monitor's quality governance framework. The report set out its position against the framework but did not identify weaknesses or areas for improvement. Although a review had been undertaken to support board development no external review of the board assurance framework has been undertaken in recent years.
- Significant issues that threatened the delivery of safe and effective care were being identified through the use of the risk registers. However adequate action to manage them was not always taken. The corporate risk register detailed the risk, the level of risk however, not all entries contained actions, due date or who was the lead.
- Risks registers held at local and directorate level did not consistently identify all risks, contain mitigating actions or

Summary of findings

where it did the actions had not always been taken. In spinal services serious risks such as backlogs in video uro-dynamics and outpatients, and ventilated patients requiring one to one care were identified but the mitigating actions had not been implemented. Increased staff turnover and a need for recruitment had been on departmental risk register since January 2013 and was rated as a 12 (major risk which will probably occur). There was insufficient robust review. In critical care there were risks that were past the review date. Some risks had not been updated following improvements, which significantly reduced risks. In the emergency department the risk register did not adequately reflect either the range or the severity of the concerns that staff and managers reported to us or the risks that we identified during our visit. In outpatients the incidence of notes not being available were very low, however, this risk had been present on the register since February 2003.

- It was identified that ventilated patients required one to one nursing to ensure patient safety. However, during our inspection this was not happening increasing the risk of patient harm. When asked consultants were under the impression that the ratio should have been 1:2 which was not represented in any guidance or on their risk register.
- One of the strengths of the trust was that staff had a strong sense of respect for each other and communicated well, however we heard of informal conversations between staff that were not documented. Therefore there was a risk of a lack of a robust audit trail of where and how decisions were made. Minutes of the clinical governance committee and the board meetings detailed little challenge from non-executive directors although through interviews with senior managers and the executive team they confirmed they were robustly challenged at these meetings and indeed outside of the meetings.

Leadership of the trust

- The trust had a stable executive team with all posts filled on a substantive basis. As a team there was a range of experience from the finance director who had been in post since 1986 to the chief operating officer who was had been in this, their first post as a director, for six months. The chief executive had worked in the trust for 29 years having been in this post for the last two years. All staff spoke highly of the chief executive who they said was very visible in the trust and knew the staff by name.
- The non-executives were skilled and had a broad range of experience. They were engaged with the work of the trust chairing committees and taking part in walkabouts and in

Summary of findings

collecting real time feedback. Whilst they could provide examples of how they had challenged the board at sub committees and trust board meetings documentation of this was not robust.

- The board had undertaken some development work with an independent organisation whilst there were some outputs from this such as the introduction of 360 degree feedback for the non-executive directors there was not a comprehensive development plan in place.
- The Governors had, with support from the trust, developed a clear role and were contributing to the trust through their engagement with the Board and oversight of the non-executive directors. There was governor presence at the board and sub committees. Governors felt valued and communication with them was good.
- Staff told us they felt supported and listened to by their immediate line managers, directorate management and the executive board. Managers were described as approachable, and staff emphasised that this was at all levels. Nursing staff said they felt well supported by their senior directorate nurse who visited each area every day as well as the nursing director who they saw regularly. All said they could approach any senior manager with any concerns.
- Junior doctors also reported feeling well supported both in the clinical areas and with their training and development, some told us they chose to work at the hospital due to the reputation it had for support.

Equality and diversity

- In July 2014 the Equality and Diversity Council agreed new work to ensure employees from black, minority and ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workforce. There are two measures in place equality and diversity system 2 (EDS2) and the workforce race equality standard (WRES) to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. The trust employs nine per cent of staff from BME groups with the average percentage of BME residents in Wiltshire being 4.7%
- There was an equality and diversity lead in post who came from a BME group and worked 20 hours per week. They were

Summary of findings

accessible to all staff and there was a good working relationship with staff side. In addition there was a non-executive director who acted as an equality champion and one for bullying and harassment.

- The trust worked with partners to actively engage with the public, examples included taking part in the Wiltshire and Swindon Pride event and working with Stonewall. In addition there was a working group of equality and diversity leads across the Wiltshire and Swindon public sector who had developed a charter for collaborative working.
- There were equality and diversity workshops to provide staff with the opportunity to discuss openly equality issues in the workplace although we did not know how frequently these were held or what the level of attendance was staff did confirm that these took place and were positive events.
- Of Band 8-9 posts (very senior managers), 1% were from BME groups and staff had a 1.86 greater chance of being appointed if 'White' compared to the likelihood of appointment if they were from BME background for each of the last two years. At board level there were no BME staff, 50% of the executive team and 28.6% of the non-executives directors were female.
- There was a discrepancy between figures reported in the workforce race equality standard report and those in the NHS staff survey (2014) relating to discrimination. The trust reported that less than 3% of both white and BME staff reported discrimination by colleagues but the actual figures for 2013 were white 4.49% and BME 10.34% and in 2014, white 6.70% and BME 19.44%. The BME responses were worse than the national average and the gap between white and BME experience were worse than the national average. The trust has created an action plan which included reinforcing the message to staff that discrimination was unacceptable, development of dignity at work ambassadors, and a governor for "freedom to speak up". At the time of the inspection this action plan was waiting to be signed off. Despite the above figures BME staff we spoke to during the inspection said they felt there was equality between BME white members of staff, that there was equal opportunity for training and for development.
- There were also 11 equality champions for protected groups allocated four hours per month dedicated time for this role.
- There was a dedicated group for BME staff although it was noted that attendance had lessened in recent months, one member of staff commented that this was because they "felt the same as everyone else and did not need a specific group through which to raise issues".

Summary of findings

- The trust held award ceremonies throughout the year for staff who had achieved in various categories. At the awards ceremony held in December 2015 there was an equality and diversity award which was awarded to a group of staff who helped develop their service (switchboard) for a member of staff who was blind.
- Although the majority of the population was Christian the chaplaincy service was focused on being multi faith, with a multi faith area and core texts available for all faiths.
- Equality and diversity reports were presented to the board every six months; these reports are available on the trust website.

Culture within the trust

- There was an extremely positive culture in the trust, staff felt respected and valued. Many staff had worked in the trust for a considerable number of years and knew each other well. They frequently referred to themselves as being like a family and were very supportive of each other. Staff at all levels were very positive about the trust as a place in which to work and this was supported by the staff survey results (2014) in which the trust scored higher than the national average in a number of areas such as motivation at work, job satisfaction, and recommending the trust as a place to work or receive treatment. We heard examples of staff who travelled past hospitals which would have been much more convenient for them to work at, in order to work in this particular hospital.
- Staff understood the values and they were clearly important to them, they had been involved in their development and the culture centred on the needs and experiences of the patient.
- Working in this positive environment had developed a culture of candour, openness and honesty.

Fit and Proper Persons

- The trust had made preparations to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. This regulation came into force in November 2014. There had since been both non-executive and executive appointments to the trust board.

A paper was presented to the trust board dated 6 October 2014 entitled "Fit & Proper". This set out the background to the introduction of the draft regulation and described the requirements as they applied to existing and new directors. A further paper was

Summary of findings

presented on 2 February 2015 which set out the arrangements for ensuring that directors met and continued to meet the requirements. This referred to procedures to be followed for new appointments, the monitoring to be carried out through appraisal and the responsibility of directors to affirm their own compliance and to make appropriate declarations at board meetings.

· We reviewed the files of an executive and a non-executive director. These demonstrated that FPPR was part of the recruitment process and involved a combination of self-declaration and checks. The checks made included a disclosure and barring check for all directors, financial checks and references. Appointment letters and reference requests made explicit reference to the FPPR.

· The arrangements were in place ahead of the regulation coming into force and the trust had consistently followed the procedures that they had set for themselves.

Public engagement

- Patient's views and experiences were gathered and acted upon to improve services. The response rates for the Friends and Family Test (FFT) had remained constant for inpatients, had improved for maternity services but were low for the emergency department, day cases and outpatients. However the responses that were received were generally better than the national average in all but three months of the reporting period reviewed. To supplement the FFT there was monthly more detailed 'real-time' feedback from patient on the wards this was analysed and the comments were put into categories to look for any trends. More specific comments made by the patients were fed back to one of the members of the senior nursing team who addressed any areas identified as concerns or negative feedback. '
- Patients took part in the Patient-Led Assessments of the Care Environment (PLACE) these assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The trusts scores have risen steadily since 2013 for three of four measures. In 2015 the trust performed better than the national average for all four measures.
- Patients and their relatives were actively involved in the design and refurbishment of the critical care unit and the children's ward.
- The Governors were effective in representing the interests of their constituents with examples of action being taken in response to concerns and issues raised.

Staff engagement

Summary of findings

- Staff reported communication and engagement was good and their comments reflected the culture and values of the trust. The trust issued weekly newsletters and sent out an email broadcast to pass information and messages from the senior leadership team.
- There was a good level of interaction between staff and the board members and we heard a number of examples of how ward staff had interacted with the board to present ideas and proposals.
- The executive and non-executive directors and governors took part obtaining real time feedback therefore had a presence in the wards areas which further enhanced engagement opportunities.
- The trust held award ceremonies at which innovative and caring practice was shared and recognised, this was well publicised and appreciated by staff who were proud of their colleagues achievements.
- There was a policy on raising concerns, “whistleblowing” written in 2002 and last revised in 2013, it was due for review in August 2015 but this had not taken place. We heard of two concerns that had been raised in line with the policy both related to staffing issues and had been resolved satisfactorily.

Innovation, improvement and sustainability

- Innovation and improvement was encouraged and there were numerous examples of this, which included:
- The nurse led VTE and anticoagulation outreach service won a national Quality in Care Programme award. The service covers all aspects of a patient’s anticoagulation journey and a significant reduction in anticoagulation incident had occurred.
- The hospital was the first in the Wessex region to carry out laser surgery for patients with enlarged prostates, avoiding the need for open surgery in some cases and the side effects associated with more conventional surgery.
- A consultant surgeon as part of a partnership between radiologist, pathologists and surgeons won an award from a national medical journal of imaging team of the year for their work on improving outcomes for patients with rectal cancer.
- A mobile chemotherapy unit paid for by charitable funds visits local towns and locations has so far saved patients over 20,000 hours in travel and waiting times,

Summary of findings

- A wellbeing support programme for cancer patients provides a unique package of physical activities, information and shared support as part of an eight week programme. All patients have reported a reduction in anxiety, depression and cancer related fatigue.
- A carer's café for carers whose relatives or friends are in hospital is run twice a month with volunteers from the Alzheimer's Society, Age UK, and Carers support Wiltshire. At this there is the opportunity to share experiences, and get advice and support from specialist staff.
- Through an Engage programme funded by a charitable appeal, the Stars appeal, specially trained volunteers spend time in conversation with patients. There is evidence that it reduces anxiety and depression and can reduce length of stay.
- The trust participated in clinical research and work in this area had increased in 2014/15. Salisbury had increased its participation from 42 studies in 2013/14 to 54 in 2014/15. There were 877 patients agreeing to be included in these 54 research projects; the highest ever for the trust. Salisbury hospital was also one of the first sites in the country to be getting involved with the 12-year study into the effects of aspirin on cancer.
- The trust were one of 22 trusts nationally who took part in the Lord Carter staffing acuity work. Senior leaders working on this project told us staff on wards will soon begin using hand held computers to input staffing data and are piloting this in five wards. This project aimed to ensure staffing levels and skill mix were appropriate, safe and sustainable for the future.
- For the first time in its history the trust was facing financial challenges after reporting a deficit in 2014/15. Whilst staff were very positive about working at the trust they stated this was the biggest challenge they had faced and had some concerns about how this would be managed. There was a recovery plan in place and at the end of September 2015 the trust was broadly on course to deliver this.

Overview of ratings

Our ratings for Salisbury NHS Foundation Trust

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

Our ratings for Salisbury NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
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.

2. The spinal treatment services have not been included in the overall ratings for this provider due to the service size.

Outstanding practice and areas for improvement

Outstanding practice

- The surgery wards had identified link roles for staff in varied and numerous relevant subjects. A nurse and a healthcare assistant had been assigned together to the link role.
- The surgery and musculo-skeletal directorates had regular specialty meetings. A member of the care staff who would not otherwise attend these meetings joined the meeting each time to provide a 'sense-check'. They listened to the content, decided if it made sense and properly described the state of their service.
- There was an outstanding level of support from the consultant surgeons to the junior and trainee doctors and other staff including the student nurses.
- The maternity services strived to learn from investigations in order improve the care, treatment and safety of patients. This was evident with the robust, rigorous and deep level of analysis and investigation applied when serious incidents occurred. For example, the reopening of a coroners case as a consequence of the maternity service investigations. Further evidence of this was available in meeting minute records. In addition, a wide range of staff demonstrated that learning from incidents was a goal widely shared and understood.
- The Benson bereavement suite facilities, and sensitive care provided to patients experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners. The facilities were comfortable and extensive, enabling patients and their families' privacy and sensitive personalised care and support.
- In the services for children and young people a mobile APP was produced in conjunction with a regional neonatal network to provide information and support for parents taking their babies home.
- Sarum Ward staff worked across the hospital working with a variety of teams to improve services for children and young people. Examples were of developing a DVD for pre-operative patients, using child friendly surveys in other areas of the hospital, supporting any staff with expertise on the needs of children and young people.
- Nurse led pathways were being used. In one example a nurse led pathway was in place for early arthritis, this pathway had been ratified by the Royal College of Nursing. The pathway was evidence based that showed the quicker patients were diagnosed with arthritis, the quicker treatment could be started and the quicker patients could go into remission. This service came top in a national audit for patients with early arthritis. Staff had presented their service at national and international conferences including the Bristol Society of Rheumatology conference in 2015.
- We observed excellent professionalism from staff in outpatients during an emergency situation. Staff attended to the patient that needed immediate help and support. Staff also cared and supported the other patients who had witnessed the emergency. Patients were moved away from the emergency into another department and kept informed of what was happening and offered lots of reassurance. When the emergency was over, patients were shown back into the waiting area with explanations on the subsequent delay to the clinic.
- The outpatients departments monitored how often patients were seen in clinics without their medical records. From January to July 2015 123,548 sets of patients notes were needed for the various clinic appointments across the trust. Out of these, 115 sets of notes could not be located for the appointment. The department identified that this was because the notes had been miss-filed, staff had not used the case note tracking properly or the notes were off site for another appointment. Overall, patients' medical notes were found for 99.91% of appointments, which was a small increase from the previous two years. This showed that there was an effective system in place for making sure patients' medical notes were available for their outpatient's appointments. Where they were not available, a reason was identified to try and reduce the likelihood of the issue happening again.
- In the spinal centre there were examples of care where staff went above and beyond the call of duty. One example of this was where a patient got married in the spinal centre. Staff went with the patient's partner to

Outstanding practice and areas for improvement

collect and prepare food and on the wedding day was picked up by a member of staff in their classic car. The couple were then allowed the use of the discharge accommodation after the wedding.

- The 'live it' and 'discuss it' sessions were fully integrated into the spinal treatment centre. We observed one session where patients and relatives

were given opportunities to discuss their concerns as a peer group as well as to professionals and ex-patients. It was clear that patients and their carers were being supported through a difficult time and were being educated on important topics preparing mentally and physically them for discharge.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- Review nurse staffing levels and skill mix in the areas detailed below and take steps to ensure there are consistently sufficient numbers of suitably qualified and experienced nurses to deliver safe, effective and responsive care. This must include:
 - a review of the numbers of staff and competencies required to care for children in the emergency department,
 - a review of the arrangements to deploy temporary nursing staff in the emergency department,
 - a review of arrangements in the emergency department to ensure that nursing staff receive regular clinical supervision, education and professional development.
- a review nursing staff levels at night on Amesbury ward, where the current establishment of one nurse for 16 patients, does not meet guidance and is not safe. Other surgery wards with a ratio of one nurse to 12 patients at night must be reviewed. Pressure on staff on the day-surgery unit, when opened to accommodate overnight patients, and still running full surgical lists, must be addressed.
- ensuring there are appropriate numbers of, and suitably qualified staff for the number and dependency of the patients in the critical care unit.
- ensuring there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff deployed in areas where children are cared for in line with national guidance.
- ensuring there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) Regulation 18(1)
- ensuring one to one care is provided in established labour in order to comply with national safety guidance (RCOG, 2007)
- Ensure staff across the trust are up-to-date with mandatory training.
- Ensure that all staff have an annual appraisal and that records are able to accurately evidence this.
- Complete its review of triage arrangements in the emergency department without delay and take appropriate steps to ensure that all patients who attend the emergency department are promptly clinically assessed by a healthcare practitioner. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Ensure staff effectively document care delivered in the patient's healthcare record at the time of the assessment or treatment in line with the hospital's policy and best practice. This must include effective documentation with regard to intravenous cannulas and urethral catheters and the recording of patients' weight.
- Strengthen governance arrangements ED to ensure that all risks to service delivery are outlined in the emergency department's risk register, that there are clear management plans to mitigate risks, regularly review them and escalate them where appropriate.
- Ensure that all actions are implemented and reviewed to reduce patients being cared for in mixed sex accommodation.
- Ensure that daily and weekly check of all resuscitation equipment are completed and documented appropriately.
- Ensure there is a hospital policy governing the use and audit of the World Health Organisation surgical safety

Outstanding practice and areas for improvement

checklist. The audit of the checklist must be conducted as soon as an appropriate period of time has passed since its reintroduction. Results must be presented to and regularly reviewed at clinical governance.

- Ensure there is a sustainable resolution to the issue of holes or damage in the drapes wrapping sterile surgical instrument sets, and all sets are processed and available for re-use to avoid delays or cancellations to patient operations.
- Ensure patient charts are kept secure and confidential at all times.
- Must ensure there is effective management of the conflict between meeting trust targets for performing surgery and the impact this has on patients. Patients must not be discharged home from main theatres unless this cannot be avoided. Surgery must not be undertaken if there is clearly no safe pathway for discharging the patient. Operations must take place in the location where staff are best able to care for their recovery.
- Ensure staff consistently adhere to the trust infection control policy and procedures.
- Ensure that patients are discharged from the critical care unit in a timely manner and at an appropriate time.
- Ensure the process for booking patients an elective beds following surgery is improved and reduce the number of cancelled operations due to the lack of availability of a post operative critical care bed.
- Ensure that the governance arrangements for critical care operate effectively, specifically that identified issues of risk are logged and that risk are monitored, mitigated and escalated or removed as appropriate.
- Ensure that care and treatment is provided in a safe way relating to the numbers of spinal patients waiting for video uro-dynamics and outpatient appointments and reducing the risk of harm to these patients.
- Ensure that risks associated with the spinal service are managed appropriately with the pace of actions greatly improved. In particular, to the management of the numbers of patients waiting for video uro-dynamics and outpatient appointments.
- Ensure care and treatment are delivered in a way to ensure that all patients have their needs met which reflects their preferences. This includes the training of agency staff, the availability of physiotherapy and occupational therapy sessions, and the availability of suitable activities for patients.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>(1)The provider had not taken appropriate steps to ensure that the care and treatment of service users</p> <p>(a)appropriate (b) met their needs</p> <p>(3) (a) the provider had not carried out, collaboratively with the relevant person an assessment of the needs and preferences for the care and treatment of the service user.</p> <p>Emergency services</p> <p>Patients did not always receive an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival in ED. Guidance issued by the College of Emergency Medicine (Triage Position Statement, April 2011) states that a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. In addition observation of patients waiting to be assessed was not adequate which reduced the opportunity to identify seriously unwell, anxious or deteriorating patients and ensure they were seen promptly.</p> <p>Surgery</p> <p>The trust was not effectively managing the conflict between meeting surgery targets and providing patients with a service that safely met their needs and gave them a good quality experience. (9(b))</p>

Requirement notices

Critical care

Patients in Radnor Ward were not discharged in a timely way from the unit onto wards when they were ready to leave or at an appropriate time. Five patients (between April and June 2015) had been moved after 22.00hours.

The process the process for booking patients an elective beds following surgery did not consider the limit as to how many beds could be booked each day. In the three months to March 2015 11 elective cases were cancelled due to a lack of available post operative critical care beds.

The two corner bed spaces were restrictive. These did not provide:

- an unobstructed circulation space at the foot of each bed space to maintain the required bed separation for infection control reasons and aid positioning of equipment
- space to allow staff to manoeuvre the patient, themselves and equipment safely due to the close proximity of neighbouring bed spaces
- space to allow five members of staff to attend to the patient in an emergency situation
- space to accommodate the specialised beds that were used for the other critical care patients.

A consultant explained that the two bed spaces in question were adequate, especially for level one and two patients. However, during the inspection an intensive care (level three) patient was admitted into one of the bed spaces. A risk register was developed for the refurbishment. Insufficient space to meet current bed space recommendations was included and stated that 12 beds could be used during periods of escalation if risk assessments were undertaken to reduce risks to patients. However the issue of risk assessments was not included in the draft operational policy; neither was there a documented risk assessment for a patient cared for in one of these beds during the inspection

This section is primarily information for the provider

Requirement notices

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

10(2)

The provider must ensure the privacy of the service user.

Compliance was not consistently achieved for single sex accommodation.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

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

12(1) Care and treatment must be provided in a safe way for service users.

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

(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs.

Surgical services

There had not been a sustained resolution for the incidence of damage to or holes in the sterile surgical instrument packs so they were rendered unusable. Not all instrument packs were available when they were needed.

Care and treatment was not consistently provided in a safe way for patients.

Requirement notices

12(h) assessing the risks of and preventing, detecting and controlling the spread of, infections including those that are healthcare associated

Staff on Radnor ward were not consistently adhering to the trust infection control policy and procedures:

- Commodes when found to be dirty and there was no standard cleaning procedure in place for these on the unit
- There was not a hand basin for every bed space as recommended by Health Building Note 04-02 and this was not documented on the risk register.
- Staff were not consistently using personal protective clothing such as gloves and aprons appropriately, for example, not removing and replacing these when required, or not using them at all when required.

Patients and staff crockery were being washed together. There was dishwasher in place but it had not been plumbed in due to water pressure problems.

Trust wide

Regulation 12 (2) (e) care and treatment must be provided in a safe way for service users and without limiting paragraph one the things which a registered person must do to comply with that paragraph include – ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way.

The provider must make sure that equipment is suitable for its purpose, properly maintained and used correctly and safely. We found that resuscitation equipment was not being checked appropriately or within national guidance.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requirement notices

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

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

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

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of services users and others who may be at risk which arise from the carrying on of the regulated activity, and

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

The emergency service risk register did not systematically capture the range or severity of known risks to safety and quality.

Within the emergency department there was a lack of assurance that identified risks were regularly reviewed or appropriately escalated within the organisation.

The surgery services did not have a policy or any audit data yet produced following the recent reintroduction of the surgical safety checklist. The safety of the checklist was not considered by the theatre management clinical governance.

This section is primarily information for the provider

Requirement notices

There were potential breaches of patient confidentiality in surgery services from patients' charts on wards not being held securely at all times.

In the medical wards there was ineffective documentation with regard to intravenous cannulas and urethral catheters and the recording of patients' weight.

Some charts were illegible.

Trust wide

The governance arrangements across the trust were not consistently operating effectively. Not all identified risks were entered onto the risk register therefore they were not appropriately assessed, monitored and action taken to remove or mitigate the risk.

Risks that were on the risk register were not all reassessed and monitored, with some past their review date.

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

18(2) Persons employed by the service provider in the provision of a regulated activity must –

(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Requirement notices

There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in the emergency department.

There were insufficient numbers of staff employed in the emergency department who had received appropriate training to equip them to care for children.

Compliance with mandatory training in the emergency department was well below the trust's target rate of 85%.

There was a lack of assurance that nursing staff in the emergency department had sufficient opportunities for clinical supervision, education or professional development.

Arrangements for the deployment of temporary staff in the emergency department were not sufficiently robust to ensure that these staff were suitably skilled or experienced.

Nursing staffing levels in surgery services had not been adequately reviewed and, although were improving, were not yet established to safe levels. There were some areas where staff anxiety and stress were high due to feeling unable to carry out their duties to a high standard.

Staff employed in surgery services had not met trust targets for updating mandatory training. Non-medical staff in surgery services had not met the trust targets for being provided with an annual performance appraisal.

Occasionally due to staffing shortages, the unit did not maintain safe nurse staffing levels in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. The details of these occasions were not documented. However, the electronic reporting system was used to highlight shifts that were short staffed. There were 16 flagged short staffed shifts between August 2015 and November 2015.

There were not sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.

Requirement notices

There was a lack of assurance that there was sufficient staff in maternity services to provide one to one care in established labour 100% of the time. This was required to be compliant with national safety guidance (Royal College of Obstetricians and Gynaecologists, 2007)

There were not enough Registered Nurses (child branch) available to meet the changing dependency needs of patients in the children's services at all times.

There were not enough junior doctors in the children's services to cover the needs of all areas caring for children at evenings and at weekends, according to the British Association of Perinatal Medicine guidelines.

Trust wide

Staff were not receiving annual appraisals and the documentation to support the number of staff who had was poor.

staff were not all up to date with mandatory training.

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Section 29A HSCA Warning notice: quality of health care</p> <p>Care and treatment are not being provided in a safe way for service users.</p> <p>Systems or processes have not been established and are not operating effectively to :</p> <ul style="list-style-type: none">a. assess, monitor and improve the quality and safety of the spinal services provided,b. assess, monitor and mitigates the risks relating to the health, safety and welfare of spinal service users. <p>Patients in spinal services were frequently and consistently unable to access services including video uro-dynamics and outpatients in a timely way for diagnosis, follow up and treatment and experienced unacceptable waits for these services. There were 467 patients in a waiting list for video uro-dynamics and 1024 patients in a waiting list for an outpatient appointment with no clear understanding from the trust as to how the risks to these patients were assessed. There were no clear and detailed actions with timescales to reduce these lists.</p> <p>Effective measures to reduce or remove the risks relating to the wait for video uro-dynamics had not been introduced. In addition there was a lack of processes to minimise the likelihood of risks and the risks of any impact on patients.</p>