North Bristol NHS Trust

Evidence appendix
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute hospital sites at the trust

North Bristol NHS Trust is an acute trust located in Bristol that provides acute hospital services and some community services. Cossham Hospital is also registered to provide low risk maternity services but was closed due to staffing issues at the time of our inspection and was therefore not inspected.

Southmead Hospital is a designated adult major trauma centre. Details of which are below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southmead Hospital</td>
<td>Southmead Road Westbury-on-Trym Bristol BS10 5NB</td>
<td>Full range of medical services including acute and urgent care, medical care, surgery, children and young people, maternity, gynaecology, outpatients, diagnostics, end of life and critical care.</td>
<td>Currently the trust serves a population of about 900,000 people in Bristol, South Gloucestershire and North Somerset. It also provides specialist services such as neurosciences, renal care, trauma care and plastic surgery and burns treatment to people from across the South West and in some instances nationally or internationally.</td>
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(Source: Routine Provider Information Request (RPIR) – Sites tab/ Acute RPIR – Context acute)
Is this organisation well-led?

Leadership
To write this well-led report, and rate the organisation, we interviewed the members of the board, including the executive team, and a range of senior staff across the hospital. We spoke with the non-executive directors as part of a focus group. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits, action plans, meeting minutes, papers to the board, investigations, and feedback from patients, local people and stakeholders.

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The trust was led by the chief executive officer (CEO) and the chair. They were supported by a board of executive directors and non-executive directors (NEDs). The chair led and was responsible for the effectiveness of the board; the chief executive led the executive directors and the organisation. The CEO was well known and respected across the trust. Staff at all levels were positive about her leadership and told us she was visible and approachable. The chair had been recently appointed and all leaders we spoke with were positive about her leadership and commitment to the organisation. We were told of examples of her impact since commencing in post, in particular around forging strong relationships with other partners and stakeholders within the healthcare community. Board members told us they felt well supported, as did all tiers of management we spoke with.

The trust board was relatively stable and were a group of individuals with a wide range of experience, knowledge and skills. Many members had been in their positions for some time, for example the chief executive officer had been in position since 2013; the medical director had been in position since 2009. Other longstanding executives included the director of finance in post since 2007 and the director of estates, facilities, and capital planning in post since 2000. There had also been a review of portfolios and some recent additions to the team, including an interim director of nursing since July 2018, a new chief operating officer since April 2018 and a new director of people and transformation since April 2019. The chair was appointed in September 2018, and there were six non-executive directors (NEDs) in post with a wide range of skills, knowledge and experience. One NED had been in post since 2010, one since 2015, one since 2016, two since 2017 and the most recently appointed had been in post since February 2019. There was a good mix of backgrounds ranging from public sector NHS including one medical practitioner, commissioning, local authority, finance, research and strategy, industry and consultancy.

The board was a unitary board, which meant decisions were made collectively. The board was responsible for:
- formulating strategy
- ensuring accountability for delivery of the strategy
- obtaining assurance that systems of control were robust and reliable
- shaping the culture of the organisation.

Executives we spoke with were clear about their roles and responsibilities and were able to articulate the recently refreshed accountability framework. The board members’ portfolios covered all key areas to manage the trust’s business. The size of portfolios and staff varied between executive directors. Directors told us they had the capacity to deliver with the support from the teams they managed. However, we were not able to ascertain who had responsibility at board level for the dementia strategy, which needed updating. In addition, we heard from some allied health professionals that although things had improved since the interim director of nursing had been appointed, more work was needed to ensure a strong voice on behalf of this group was heard at board level.
There was energy and commitment from the leaders to deliver the strategy and address risks to performance, however the trust acknowledged that further work was required to mature into a fully functioning unitary board, and this was being addressed with board development, with a bespoke programme commencing in September 2019. All leaders told us challenge was encouraged and welcomed, although some said there was room for improvement in terms of challenge between the executive directors. Leaders told us NED challenge at board was strong and during the year we observed rigorous and constructive challenge at a board meeting and noted scrutiny of performance by the NEDs in minutes of committees and sub committees.

We heard from leaders that relationships across the system had been transformed with a strong steer from the chair. We saw how this was working for example, at board level directors interacted with their counterparts at another local NHS trust on a one-to-one basis as required to ensure joined-up working within the local system. This approach was steadily filtering through the leadership levels at the trust with divisional leads successfully forging collaborative relationships with their counterparts, and we saw evidence of output from these meetings for example in safeguarding and research. There was a joint board away-day held in February 2019 designed to allow the two boards to get to know one another and explore the potential benefits and pitfalls of collaboration. A follow-up session was planned for June/July 2019 to focus on identifying specific areas where the organisations could collaborate more closely.

The chief pharmacist had worked at the trust since 2016 and led the department since 2017. The pharmacy department had recently recruited a new associate director of pharmacy and pharmacy operations manager who supported department. The chief pharmacist was the clinical director of pharmacy and head of professions in the core clinical services division. Both the chief pharmacist and their deputy had appropriate backgrounds and understood how collaboration of pharmacy services across primary and secondary care had a positive impact on patient care. The associate director of pharmacy was also the medicines safety officer and responsible for medicines governance in the trust.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. The trust had been realistic in their self-assessment against compliance with our regulations and were aware of and addressing most of the issues we raised. All board members we spoke with were aware of the challenges and risks the organisation faced and were clear about the trust’s priorities. Our interviews with the leaders confirmed common themes and challenges, which we saw reflected in board and subcommittee papers, and which largely correlated with what staff told us. Leaders described their focus clearly and were committed to integrating services for the future whilst ensuring the right outcomes for patients in the face of increasing pressures and demands on services. Leaders told us the board was moving from a reactive place, and now had time and space to look ahead more strategically, though all acknowledged there was still more work to do. Safe and high-quality patient care was reflected within all the priorities for the leadership and could be seen throughout trust documents. We saw discussions were taking place about longer term and more strategic planning.

There was a monthly programme of NED visits to services, and we saw evidence that these had taken place with between two and four sessions per month being undertaken throughout the year. There was a ‘back to the floor’ programme in place which was led by the interim director of nursing; this involved senior and mid-level managers spending time working alongside staff in the services. Feedback from these sessions was used to drive continuous improvement, and staff were positive about this process, telling us how they appreciated the opportunity to showcase their areas and discuss emerging or ongoing issues. Feedback from these sessions was shared with teams and key issues were escalated.

The pharmacy focus group had positive feedback about the pharmacy leadership team. Staff felt that pharmacy leaders were visible in the department and across the trust. However, they did not feel as visible to the trust directors and senior leaders and attributed this to being “locked in”.
In the 2018 NHS staff survey, the trust performed below (worse than) than the national average for NHS acute trusts in all indicators relating to managers, although most indicators had seen improvements. When staff were asked in the 2018 survey if they knew who the senior managers were, 82% said they did (this was the same as in the previous year). The national average was 83%. During our focus group with 43 staff (non-managers) from across the trust, all were able to name the CEO and at least two other senior directors, which suggested the trust has made some progress since the 2018 survey. In other questions relating to managers and the leadership, 41% of staff agreed or strongly agreed the organisation valued the work of staff (up from 37% in 2017). The national average for 2018 was 46%. We heard from staff that leaders were visible and approachable and demonstrated a commitment to understanding service issues. The exception to that was for women and children’s services; although we saw evidence that NED visits, listening events and back to the floor sessions had taken place, we heard from several sources they had felt somewhat overlooked and more needed to be done to connect with this service and understand/address their challenges.

The trust reviewed leadership capacity and capability on an ongoing basis. Executive directors at the trust underwent a formal induction process that comprehensively covered appropriate aspects of their role. Non-executive directors went through a modified induction process designed to meet the needs of their role. The skills, knowledge, experience and integrity of the board were evaluated on an ongoing basis through an annual analysis of the skills and knowledge base of the group. This was used to identify any gaps and inform development needs going forward. When vacancies arose in the senior leadership team, opportunities to review any deficits were taken and recruitment of candidates with relevant skills and competencies were considered.

One area the trust acknowledged was a potential to improve in terms of NED skill mix was the clinical experience on the board. The trust also acknowledged that diversity on the board was minimal and were aware this may mean that minority viewpoints were missed; this had been flagged as a priority for the coming year by the chair. Of the executive board members at the trust, none were black and minority ethnic (BME) and 62.0% were female. Of the non-executive board members none were BME and 29.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
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<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>62.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>29.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>46.0%</td>
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(Source: Routine Provider Information Request (RPIR) – Board tab)

The performance of the executive leadership team was reviewed and monitored through an annual appraisal process led by the chief executive to ensure they maintained the skills, knowledge and integrity to carry out their roles. We saw that all annual appraisals had been completed. The chief executive officer completed appraisals for the executive board members, and the chair had completed the appraisal for the chief executive. The chair had also completed the NED appraisals. Feedback was gathered from all board members as part of the process and a survey had been set up to collate a report to be presented to the remuneration committee for monitoring.

Succession planning had been undertaken at board and divisional senior team levels and the trust was in the process of developing this across the wider organisation. Career conversation sections had been added to annual appraisals and a fast track process for recruitment was being developed for critical roles. This was being picked up as part of the ongoing service line
management (SLM) implementation programme and a succession planning and talent management process had been proposed and agreed at the remunerations committee in July 2019, who were monitoring progress.

**Leadership development opportunities were available, and work was underway to include enhanced opportunities for staff below team manager level.** In line with the ‘One NBT Leadership and Management Development Programme’ the trust had a leadership framework, along with an improvement project overseen by a leadership steering group. The programme underpinned the trust’s strategic objectives around creating an exceptional workforce for the future and devolving decision making and had taken account of staff survey results linking leadership, management and staff engagement.

The trust board and senior leadership team displayed integrity on an ongoing basis. The leaders we spoke with at all levels demonstrated a commitment to make quality care the key priority of the organisation and were passionate in their desire to continuously improve. We found the leadership team to be open and transparent about their challenges and areas for improvement, and responsive to concerns we raised. Following the core service inspection, feedback we gave the leadership team was acted on promptly and we were provided with evidence of changes that had taken place as a result. We found there to be a strong and well-respected nursing and medical leadership base, and staff at all levels we spoke with confirmed this.

**Fit and Proper Person checks were in place.** The trust was satisfied that staff with director level responsibilities, including the non-executive directors, were fit and proper persons in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A new trust secretary had started in post in February 2019 and had taken over responsibility and oversight of the fit and proper person process. There was a fit and proper directors policy in place which had been reviewed, updated and ratified. The trust kept a register of gifts, hospitality and sponsorship which was up to date and monitored. Annual declarations of interest were reported to the board.

We examined the files of all executive and non-executive directors and found they were largely in order. There was an audit checklist for each file which had been appropriately completed. Records were kept of recruitment checks made for all executive directors. NHS Improvement appointed non-executive directors. The trust had commissioned an external provider to undertake checks on the probity of information provided by executive directors. This included financial, educational and employment checks. Executive and non-executive directors submitted an annual declaration to confirm that there was nothing, which would affect his or her fitness as a director of the trust.

Disclosure and Barring Service (DBS) checks were undertaken for all executive directors at the trust, however some had not been updated within the last three years as per the trust policy. The trust had identified this and had taken steps to refresh the DBS checks for those individuals, which were underway. The process for ensuring non-executive directors had appropriate DBS checks in place had been included in the refreshed policy, along with a new requirement for those checks to be at a standard level.

**The patient’s voice was heard at board meetings.** Many NHS trusts in England have introduced ‘patient stories’ to the board meeting. These are often derived from complaints and concerns, so the board hears directly from patients or carers who had cause to complain. They can also come from positive experiences. The NEDs told us patient stories were having a real impact and helping to drive quality and we saw evidence of these along with learning points in published board papers.

**Vision and strategy**

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust’s strategic vision:
'We will realise the great potential of our organisation by empowering our skilled and caring staff to deliver high-quality, financially sustainable services in state-of-the-art facilities. Clinical outcomes will be excellent and with a spirit of openness and candour, we will ensure an outstanding experience for our patients.'

The vision and values had been developed in consultation with staff and patients and had been implemented in 2016. Most staff could identify when asked what the values were, though some required prompting. However, they were readily visible around the site, on the website and were included on the footer of trust emails:

- Working well together
- Putting patients first
- Recognising the person
- Striving for excellence

There was a high-level strategy (for the years 2016 to 2021) associated with the vision and values which detailed eight strategic themes. The board developed the strategy through a series of workshops and away days which considered the organisational, system and national context within which the trust was operating. The board had incorporated a large amount of data around changing patterns of demand, for example forecast changes in national policy, demographics and population behaviours to assist in determining its response whilst maintaining its core values. The strategic themes were:

- Change how we deliver services to generate affordable capacity to meet the demands of the future
- Be one of the safest trusts in the UK
- Treat patients as partners in their care
- Create an exceptional workforce for the future
- Devolve decision making and empower clinical staff to lead
- Maximise the use of technology so that the right information is available for the key decisions
- Enhance patient care through research
- Play our part in delivering a successful health and care system.

The trust was three years into its five-year strategy and progress was reported to and monitored by the trust management team and the board throughout the year. We saw evidence of annual reviews and plans around delivery of the strategy with objectives aligned to the eight strategic themes, and the reporting to board of key achievements, for example improvements in patient flow and timely discharge (with 10% fewer stranded patients for more than seven days in 2018/2019 compared to 2017/18) and the implementation of service line management devolving authority to the divisional leaders. At the time of our last inspection, we were not assured there was a robust framework in place to deliver the overarching strategy. Since that time, the trust has developed a number of underpinning strategies for example in research, digital, sustainability and nursing & therapies. The patient experience and engagement strategy, estates strategy and the quality strategy were in draft and due for ratification. The draft quality strategy had been aligned with the overarching strategy and included priorities from the 2018/19 quality accounts, which had been widely consulted on and feedback incorporated. The 2019/20 priorities were to:

1. Eliminate delays in hospital to improve patient safety and reduce bed occupancy ('home is best')
2. Enhance the way patient involvement and feedback is used to influence care and service development
3. Continue improving the quality of end of life care across all specialities
4. Strengthen learning & action by embedding quality governance at specialty, cluster and divisional level
5. Demonstrate a stronger clinical understanding and application of the Mental Capacity Act and Deprivation of Liberty Standards.
All board papers submitted and policies we reviewed contained specific links to the strategic objectives. The trust had not developed a mental health or learning disabilities strategy but we saw key objectives for these had been incorporated into the new quality strategy, but it was not clear how these would translate into ward level strategies or policies. However, we saw evidence that significant work was underway to improve care for patients with learning disabilities following some serious incidents at the trust; for example patients were now offered double slots for diagnostic appointments and learning disabilities had been specifically added as a quality account priority for the coming year. Work was underway to refresh the clinical services strategy. However, some strategies were due for review and still needed to be aligned to the overarching strategy, for example, the strategy for dementia (2015). We found some areas of excellent practice not reflected in the out of date strategy during our inspection and a committed team of dementia specialist staff working to consider pathways across the trust for patients living with dementia.

The overarching strategy was aligned with local plans in the wider health and social care economy. The trust was active in developing relationships in the community with partners and stakeholders to drive the goal of providing better and more integrated care. This had matured considerably since our last inspection. The trust was a key member of the local Sustainability and Transformation Partnership (STP). The STP plan was an extensive project as part of NHS England’s drive to design health and social care systems to meet the needs of an area, and not the individual organisations operating within it. The STP plan included alignment around improving health and wellbeing for populations and communities and integrating models of care. All board members we met with were enthusiastic about the ongoing workstreams, future plans, growing relationships and the prospect of further joined up and collaborative working across the system. There was evidence of wide-ranging interaction with other member organisations for example, there was joint working with other providers and commissioners around the winter plan, and activity events were held to consider admissions, discharges and capacity across the system.

The chief pharmacist was part of the sustainability and transformation partnership (STP) medicine optimisation transformation group, along with pharmacy leads from other providers. The hospital pharmacy transformation plan (HPTP) was aligned to the trust strategic themes and was led at executive level by the medical director. Five projects were linked to the HPTP:

- Service review
- Workforce development
- Collaborative working
- Medication review
- Use of technology.

Within each project there were four workstreams aligned to national recommendations, such as development of an electronic prescribing and medicines administration system (ePMA), use of non-medical prescribers and specialist pharmacists. Each workstream had a named lead and regular meetings were held to review progress and to RAG rate (red, amber, green traffic light method). Progress on the HPTP was reported to Quality and Risk Management Committee (QRMC). Pharmacy staff understood the HPTP strategy and the priorities for medicines optimisation. Regular team meetings were held to answer any questions and concerns that developed. The trust had bid for capital to fund implementation of ePMA and were investigating using the same system as another local trust. This would improve sharing of records across the healthcare system.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy and had been involved in its development. Once the board agreed a draft strategy, it was subject to feedback from staff, the public, patients and key stakeholders. We heard that a dedicated meeting had taken place to share the draft with commissioners and to ensure it aligned with their commissioning intentions and priorities. Other opportunities were taken to present the draft to local partners such as the local health and wellbeing board, the local authority and other constituent partners including the police and crime commissioner. The draft strategy was made public on the trust website inviting staff and public
feedback. Divisions were responsible for ensuring their divisional strategies aligned to the overarching strategy and we saw evidence this was happening.

**Culture**

**Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. Staff mostly felt positive and proud about working for the trust and their team.** There was a positive culture in most areas that supported and valued staff, which had improved since our last inspection. Staff survey results suggested a lot of the workforce at the trust felt it was a positive place to work, and they received the respect they deserved from colleagues. During our core service inspection, staff were keen to tell us how proud they were of working at the trust, and during focus groups, many staff told us things had been steadily improving in terms of culture. The trust, overall, had improved NHS staff survey results in 2018 around culture, although with a reduced and below-average response rate. However, key indicators around culture were still mostly below (worse than) the national average for acute trusts, demonstrating there was more to do as follows:

- **60% of staff agreed or strongly agreed they would recommend the organisation as a place to work. This had improved from 54% in 2017. However, the measure was 3% below (worse than) the national average.**
- **31% of staff agreed or strongly agreed that they often thought of leaving the organisation. This question was not asked prior to 2018. The response was 1% above (worse than) the national average.**
- **71% of staff said they agreed or strongly agreed that they received the respect they deserved from colleagues at work. This question was not asked prior to 2018. The response was the same as the national average.**
- **88% of staff agreed or strongly agreed their role made a difference to patients. This was 1% below the result of 2017, and 2% below (worse than) the national average.**

Some concerns were raised with us via several sources and fed back to the trust in relation to staff morale in two key areas; maternity and facilities management. The trust acknowledged they were aware of this, and plans were in motion to address the issues.

**There was an emphasis in the trust on the safety and wellbeing of staff but there was more to do.** In the 2018 NHS staff survey, 27% of staff agreed or strongly agreed the organisation took positive action on health and wellbeing. This was an improvement from 23% in 2017 and marginally below the 2018 national average of acute trusts at 28%. However, 64% of staff agreed or strongly agreed their manager took a positive interest in their health and wellbeing. This was slightly worse than 2017 (65%) and below (worse than) the national average (67%).

The trust launched a wellbeing pilot programme in 2017 comprising an impressively wide-ranging, quality programme demonstrating its commitment to improving staff wellbeing. Initial evaluation of the pilot found that staff were reporting being too busy to take time out for wellbeing, and this was potentially reflected in the staff survey results, which although improving, were still not where the trust would like them to be.

The staff wellbeing programme provided comprehensive support for mental health, physical health, and positive lifestyle choices; the trust reports this has improved engagement and saved over £300,000 a year in reduced sickness costs. It was nominated for and won a ‘most improved employee wellbeing award’ in February 2019 in recognition of the wide-ranging support available to staff. Amongst the benefits on offer for psychological health are free counselling, a trauma focused peer support programme (TRIM), schwartz rounds (evidence-based forum for hospital staff from all backgrounds to come together to talk about and reflect on the emotional and social challenges faced) led by the psychology team, and employee assist for support with a wide ranging number of issues beyond work that may affect their staff. The trust has trained a number of staff to become wellbeing champions and mental health first aiders at work, and staff told us
during our inspection that this had contributed to bringing the conversations about mental health more into the open. Champions were introduced to signpost people through the services on offer, and to provide one-to-one sessions for individuals who had complex circumstances.

Physical health was addressed via a number of initiatives including physio direct, which enabled staff to seek direct support from physiotherapists; a health kiosk had been introduced where staff could check on their blood pressure, weight and body mass index; walking and other outdoor events were encouraged and organised, and a cycle to work scheme had been introduced. In terms of lifestyle, there was an impressive array of events that staff could participate in, for example, creative writing sessions, fresh arts programmes and projects such as the ‘kindness project’ where staff celebrated acts of kindness they had witnessed at work.

There were some staff who had experienced physical violence, harassment, bullying or abuse from staff, patients or members of the public, and fewer staff than average were reporting this. The 2018 NHS staff survey results reported 20% of staff (the same as the national average) had experienced harassment, abuse and bullying from other staff at the trust. This was slightly up on the 19% of staff reporting this in 2017. Twelve percent of staff said they had experienced this from managers, which was 2% below (better than) the national average. This was a 1% improvement over 2017. However, the number of staff reporting the most recent experience had declined from 46% in 2017 to 42% in 2018. This was slightly below (worse than) the national average for 2018 of 44%. Other key findings included:

- 15% of staff (16% in 2017) had experienced physical violence from patients, relatives or the public in the last 12 months. This was slightly above (worse than) the national average for acute NHS trusts of 14%.
- 60% of staff (68% in 2017) reported the most recent experience of violence. This was below (worse than) the national average of 66%.
- 28% of staff (same as in 2017) had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This was the same as the national average.

We saw these issues were being discussed at board level and addressed through the divisional governance structures as detailed below, and through leadership development and freedom to speak up arrangements.

Performance management of staff through the annual appraisals aligned to the trust's values and poor performance was being addressed where needed. There were processes for managers to follow if staff did not meet performance expectations or work within trust values. A large-scale leadership development programme was launched in May 2019 which included the development of positive management behaviours, skills and approaches as an alternative to bullying styles. The trust told us approximately 350 frontline and middle managers will access this programme on a priority / need basis assessed using staff survey data over the next 18 months. In addition to this:

- A new online Bullying and Harassment (B&H) course for managers was launched in January 2019
- A half day training event for managers around the practical skills required for managing B&H at work and having those difficult conversations was planned for August and October 2019
- Several Challenging Conversations workshops have been held over the last 12 months, giving managers the skills to manage challenging discussions or issues which arise at work
- Monthly manager advice drop in sessions were being run to advise managers handling claims of B&H to ensure fairness and best practice.
The relationship between the trust and the trade unions had improved but there was more to do. We met with an enthusiastic and experienced staff side team. They were supportive of the trust and trust values and told us they had seen improvements at board level and recognised there was more challenge and that challenge was increasingly welcomed. The director of people met with the group monthly. Whilst relations were building, more needed to be done around the links with the freedom to speak up leads, and representatives told us they would welcome earlier inclusion in plans for change, for example, they were reviewing relevant policies, but these could be circulated in a timelier manner. There was scope to raise the profile of the staff side work in that at times they had found it difficult to be released for training and had not always seen prompt actions where concerns had been raised, for example, in relation to bringing the violence and aggression training in line with national guidance.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns, but not all staff felt safe to do so. Freedom to Speak Up (FTSU) Guardians had been in place for approximately 18 months and were well established. We found the arrangements for speaking up had been strengthened and improved since our last inspection. There was an executive, and non-executive lead, and a FTSU report was presented to board twice a year; we found these reports to be comprehensive. The FTSU guardians met quarterly to discuss ongoing issues and concerns, and to provide support, they attended the board meetings and had regular contact with the chair.

There were 13 freedom to speak up guardians within the trust in different areas and job roles. However, there was no representation from portering, domestic or therapies staff groups, and although we were told they were well supported by their managers, FTSU guardians did not have protected time for FTSU work. The trust had a speak up policy, which was being refreshed and widely consulted on, and clear processes to follow when concerns were raised. A poster had been produced for staff including names and contact details for each guardian.

The number and type of concerns being raised were broadly in line with the national picture, although there were proportionally more concerns relating to patient safety and quality at the trust than nationally. In August 2018 the Trust Board completed the NHS Improvement self-assessment tool to assess their effectiveness around Freedom to Speak Up (FTSU) within the trust including concerns being raised around bullying. The trust identified a number of areas where further work was needed, which then led to a FTSU strategy, vision and action plan being established and published in November 2018. The trust told us support and engagement was good from the executive team and there was a real appetite to get the listening side of their culture right. Further work was needed in terms of some wider relationships, for example with trade unions.

Staff were made aware of the speaking up routes through a range of corporate communications including: email bulletins, the chief executives ‘Friday Five’ message, stands at the canteen and wellbeing festival, leaflets, posters, intranet pages, screensavers; and since last year, a new dedicated section of the mandatory corporate induction.

Staff mostly told us during inspection they knew who the guardians were and how to use the whistle-blowing process, but not all staff were confident about using it, and in some divisions and staff groups, knowledge of the guardian’s role was variable for example in surgery and pharmacy. The trust acknowledged they were aware of issues within the trust around staff feeling able to speak up when they have a concern, including concerns around bullying, and this was also identified in the staff survey findings for 2018 as set out above. In response to this, they had identified “Speaking Up” as one of the 5 key priority areas for action this year, which has been shared with staff. Some ongoing actions included:

- Launch of a staff feedback system called HappyApp – a web tool that enables staff to anonymously say how they feel each day. This enables staff to raise issues including problem behaviours, as well as enabling the Trust to identify ‘hotspot’ areas to address
targeted support

- Wellbeing Programme which supports staff who are encountering difficult situations at work, including a 24/7 Employee Assistance Programme helpline, and 1:1 Psychological Wellbeing support
- Human Resources Helpline, where staff can raise concerns about their managers, and are given advice about how to safely challenge, and signposted to other avenues of support as appropriate
- An “Itchy Feet” campaign has been running for the last year, where staff who are thinking of leaving the trust can call in confidence to talk about why they want to leave. The trust told us concerns around bullying have been raised and supported via this route
- There is a dedicated in-house Bullying and Harassment Helpline run by the Diversity and Inclusion Team, which has been in place for the last 5 years, receiving approximately 15-20 calls a year.

The trust recognised staff success by staff awards and through feedback. The trust held quarterly staff award ceremonies known as ‘NBT Heroes awards’ which were a way for staff to recognise their colleagues for the small but amazing things that they do, or the caring, compassionate ways they act on a daily basis. The awards were funded by the hospital charity and were presented by the chief executive. The charity also provided an afternoon tea and a bite to eat, giving winners an opportunity to meet their fellow winners and have a chat. In addition, the trust promoted ‘Hidden Heroes’ which was way of shining a light on teams across the trust who were doing incredible things but have perhaps gone under the radar due to working away in the background to keep things running. For example, in January 2019, a YouTube video was uploaded celebrating the domestic staff and their high standards. Areas of good practice noticed by the executives on their walkabouts were celebrated on the intranet, and future dates for listening events were advertised, including the option for staff to ask questions of the board on any subject; the answers were recorded onto a video that was then available for staff to watch on the ‘keep in touch with your board’ section of the intranet.

Staff achievements were celebrated and highlighted through feedback by the chief executive’s Friday Five messages, and the list was extensive. Some examples taken from these messages include the Purple Butterfly award, success of the kidney transplant team, the Hospital at Home service, launch of the My Pregnancy@NBT app, and a host of other national and prestigious awards.

Guardian of Safe Working Hours

Junior doctors were supported by a senior doctor. The trust had appointed a guardian of safe working hours (GSWH) to provide assurance to the trust board, the general medical council and health education England (and to the doctors themselves) that doctors in training were safely rostered. The guardian was required to raise concerns to the trust board and potentially to external bodies if this was not the case, and to report on breaches of contract due to safety reasons, excess hours or missed education sessions. The trust hosted a junior doctor’s forum which was attended by both the chief executive officer and the medical director. Attendance was said to be good with around 25 doctors attending.

We met with the current guardian who, as required, was a senior doctor within the trust, and independent from the management structure. They had been given protected time in their working hours to hold this post, as well as administrative support. A report was presented to the workforce committee (a subcommittee of the board) quarterly, and concerns arising were escalated to the board as required. The trust reported compliance with all requirements, including distribution of junior doctor’s work schedules within deadline and exception reporting, though some specialities were better than others in terms of embracing the processes. There was clinical oversight of the rota for junior doctors and the data produced within the reports was broken down to divisional level, enabling focus on areas of concern. Ongoing key issues included unfilled gaps in junior medical and surgical rotas which were proving difficult to fill, under
exception reporting and the need for an e-rostering system to support scheduling. The trust had taken steps to address these issues, for example options for an e-rostering system were currently being reviewed.

The guardian reported good relationships and links with other local trusts, had attended national training meetings (and is a member of the regional forum of safer working guardians) as well as having regular contact with a number of other guardians in the region to share updates.

**The trust applied Duty of Candour when necessary.** There was openness and transparency when mistakes were made. Duty of candour was well understood by staff and applied when required, and staff guidance was readily accessible. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff were prompted, when completing an incident report to consider duty of candour and this had been included on the new electronic incident reporting system.

We reviewed six serious incidents and were able to track duty of candour from the point of reporting through the investigation stages, where patients and families were invited to submit questions for consideration, to conclusion where verbal and written apologies and face to face meetings were offered. All serious incidents were discussed at the clinical risk operational group (CROG) and we were able to see from the minutes of those meetings that duty of candour was a standing agenda item and actions were monitored for each case. We saw examples where questions submitted by patients/relatives had been included in the terms of reference for the root cause analysis investigations, and the completed reports had been shared with them, including any learning, upon conclusion.

**NHS Staff Survey 2018**

The trust’s 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Health and wellbeing
- Safe environment – violence
- Staff engagement

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.
In total, 3362 staff took part in the 2018 survey. This was a response rate of 41% which is just below the average for acute trusts in England (44%), and a drop from 46% in the 2017 survey. Although in 67 of the questions, the trust scored worse than England average, there was an improvement seen from the 2017 results, and the trust had scored better than average in 22 questions, which was double the score from 2017 where the trust had scored better than average in only 11 questions. This places the trust behind the England average, narrowly in some cases, in six out of ten themes. However, results in four of the six themes had improved since last year, and two had remained the same, with no deterioration which suggests a trajectory of improvement. Those themes where scores had improved were health and wellbeing, immediate managers, safety culture and staff engagement. Areas of strength included pride in the quality of care, low levels of harassment, pride in the organisation, recognition and value, appraisal and sufficient resources to do work. These findings largely reflected what staff told us on inspection. Areas for improvement, and on which the trust intend to focus going forward included a continued emphasis on health and wellbeing, staff engagement, workload and demands on time (with a focus on care and the patient), management development and appraisals and encouraging and supporting staff to speak up.

**Staff Diversity**

The trust reported their staff diversity through submission of the Workforce Race Equality Standard (WRES) as part of the 2018 NHS staff survey. A breakdown of clinical and non-clinical staff by ethnicity as of March 2018 can be seen below.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Medical and dental staff</th>
<th>Clinical non-medical staff</th>
<th>Non-clinical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>737</td>
<td>4,192</td>
<td>2,000</td>
</tr>
<tr>
<td>BME</td>
<td>197</td>
<td>747</td>
<td>361</td>
</tr>
<tr>
<td>Unknown</td>
<td>23</td>
<td>29</td>
<td>16</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Staff Diversity tab)
Workforce race equality standard (WRES)

There was more to do to ensure staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce. The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard. The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:
- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts’ circumstances.

<table>
<thead>
<tr>
<th>WRES Indicators from ESR (HR data)</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8+</td>
<td>0.8%</td>
<td>4.4%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>1b. Proportion of non-clinical staff in senior roles, band 8+</td>
<td>1.1%</td>
<td>6.5%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>2. Proportion of shortlisted staff being appointed to positions</td>
<td>14.5%</td>
<td>22.3%</td>
<td>-6.0%</td>
</tr>
<tr>
<td>3. Proportion of staff entering formal disciplinary processes</td>
<td>1.5%</td>
<td>0.6%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>4. Proportion of staff accessing non-mandatory training and CPD</td>
<td>83.1%</td>
<td>70.8%</td>
<td>Not assessed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WRES Indicators from the NHS staff survey</th>
<th>Proportion of respondents answering “Yes”</th>
<th>Are there significant differences between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>BME staff White staff All staff BME and White staff? This trust and its peer group? Last year and this year? (BME staff)</td>
<td></td>
</tr>
<tr>
<td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust 24.7% 26.8% 28.3%</td>
<td>Peer group 29.9% 27.9% 28.7%</td>
</tr>
<tr>
<td>7. Staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust 64.1% 86.1% 84.0%</td>
<td>Peer group 69.8% 86.3% 83.3%</td>
</tr>
<tr>
<td>8. Staff experiencing discrimination at work from a manager / team leader or other colleague?</td>
<td>Trust 17.1% 6.3% 7.8%</td>
<td>Peer group 15.0% 6.7% 8.0%</td>
</tr>
</tbody>
</table>

Trust staffing numbers:

<table>
<thead>
<tr>
<th>9. [BME Voting Board Members] and Board compared to overall staff demographic</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>[N]</td>
<td>[N]</td>
</tr>
</tbody>
</table>

Key
- ![Statistically significant or negative finding](image)
- ![Not statistically significant](image)
- ![Positive finding](image)
- ![Statistical analysis not undertaken as less than 30 BME staff responded](image)
- ![Statistically significant improvement](image)
- ![No statistically significant change](image)
- ![Statistically significant deterioration](image)
As of 2018, four of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (0.8% of BME staff compared to 4.4% of White staff). This has decreased by 0.2% compared to the previous year, 2017, although this was not a statistically significant change over time.

1b. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) non-clinical roles (1.1% of BME staff compared to 6.9% of White staff). This has increased by 0.2% compared to the previous year, 2017, although this was not a statistically significant change over time.

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (14.9% of BME staff compared to 22.8% of White staff). This has increased by 6% compared to the previous year, 2017, which was a statistically significant improvement over time.

3. In 2018, BME staff were significantly more likely than White staff to be disciplined (1.5% of BME staff compared to 0.6% of White staff). This has increased by 1.9% compared to the previous year, 2017, although this was not a statistically significant change over time. This indicator looks at the relative likelihood of staff entering the formal disciplinary process, as measured by the start of a formal disciplinary investigation.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between white and BME staff:

7. 64.1% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 86.1% of white staff. The score has decreased by 1.5% when compared to the previous year, 2017, however this was not a statistically significant change over time.

8. 17.1% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey which was significantly higher when compared to 6.3% of white staff. The score has decreased by 3.4% when compared to the previous year, 2017, however this was not a statistically significant change over time.

(Source: NHS Staff Survey 2018)

During our inspection we held a BME focus group which was well attended by staff from across a range of departments and roles. Discussions confirmed the findings of the survey, and although there was wide recognition for the work the trust was doing, they felt more needed to be done, particularly around career progression. Other examples included the need for more rapid action to be taken when incidents related to BME were reported, and timely feedback to those involved. Some staff felt requests for their specific religious holidays were not respected, even though they had worked through Christmas and New Year holidays.

**Staff networks were in place promoting the diversity of staff.** There was an Equality and Diversity Policy (2018) in place, and the trust produced and publishes an annual equality report. An action plan was produced and monitored through the equality and diversity committee and the workforce committee. Part of the most recent plan was to increase the equality resource and recruit a senior specialist advisor post to lead the equality and diversity agenda at the trust; a head of equality, diversity and inclusion was subsequently appointed and commenced post in February 2019.

All trust policies aligned to the relevant protected characteristics which were also contained within employment contracts. Equality newsletters were published monthly and distributed internally and externally. The trust recently commissioned an external agency to conduct a ‘WRES’ deep dive to help understand the challenges faced and develop clear recommendations. Initiatives to raise awareness and celebrate diversity were considered and implemented, for example, black history
month was celebrated with an African drumming performance in the main hospital.

Whilst acknowledging there was more to do, work was ongoing to increase compliance with WRES. For example, the trust had relaunched the BME mentoring scheme, with senior managers invited to become mentors. A new BME champion had been appointed and a BME staff development group had been set up, which was chaired by a BME staff member. Three staff members had been supported to apply for places on the ‘Stepping Up’ programmes run by the local council; this was a positive action programme aimed at improving the representation of black, Asian and minority ethnic people, disabled people and women in senior leadership roles within Bristol and the wider region.

The trust was part of the Bristol Race Strategic Leadership Group which consisted of senior leaders from 11 public bodies across the city and was working in response to the manifesto for race equality, to work collaboratively to tackle the endemic issues. The key strategic challenge set by the group for 2017/18 was to work collaboratively to share equality related human resource data with the vision of producing a data picture of all public sector employment in Bristol, and the first ever public sector race equality data product had been published for Bristol.

The trust had allocated a mentor for an external BME person to gain experience to take up a place on the trust board. There was a staff equality group and all staff were invited to attend the meetings which took place quarterly; in addition, there were staff networks for lesbian, gay, bisexual and trans staff (LGBT), age, and for staff interested in religion and belief which covered both staff with and without a belief. There were separate career development groups for BME and disabled staff which also met regularly. Designated members of staff chaired these committees and there were executive and non-executive champions at board.

A range of equality events were held throughout the last year, and some of these included history months and international days for example against homophobia and transphobia, mental health week, a disability fayre and a rainbow faith day. There were two regularly updated equality notice boards at the trust, and an equality newsletter was produced and distributed widely each month.

**Sickness absence rates**

*Sickness and absence figures were not outliers.* The trust’s sickness absence levels from February 2018 to January 2019 were similar to the England average. The sickness absence rates at the trust followed a similar trend to the England average with higher rates in the winter months from November 2018 to January 2019.
The sickness absence rate was steady and a slight improvement was seen since last year (4.3% compared to 4.4% in 2018/19). The activity taking place to reduce sickness absence and improve wellbeing, including the wellbeing programme and staff vaccination programme, was continuing and expanding. The trust told us this was evaluating positively with impact seen around stress / anxiety / depression and musculoskeletal absence in particular, with less absence for these reasons on a rolling 12-month basis compared to last year. In maternity staff reported sickness levels were having an adverse effect on availability of staff (see core service report).

**General Medical Council – National Training Scheme Survey**

In the 2018 General Medical Council Survey the trust performed the same as expected for all 15 indicators (Source: General Medical Council National Training Scheme Survey.) The 2019 survey results just released showed a general improvement trend, particularly within the emergency department, with some areas of focus for example neurology and obstetrics & gynaecology. There was a structured and supportive framework for junior doctors and work was underway within the divisions to ensure the right balance between service pressures and education.

**Staff Appraisals**

All staff had the opportunity to discuss their learning and career development needs at appraisal. The trust set a target for annual appraisals at 90%. In the 2018 NHS staff survey, 85% of staff said they had an appraisal in the last 12 months. This was marginally below the 88% national average for acute trusts. However, it was up 6% from 2017. In other measures related to performance reviews:

- 18% of staff said their appraisal helped them to improve how they did their job. This was the same as in 2017, but 4% below (worse than) the national average.
- 31% of staff said their appraisal helped them agree clear objectives for their work. This was a 1% improvement over 2017, but 4% below (worse than) the national average.
- 30% of staff said their appraisal left them feeling their work was valued by the organisation. This was up 3% from 2017, but 2% below (worse than) the national average.
- 30% of staff said the organisation’s values were discussed as part of the appraisal process. This was down 2% from 2017, and 5% below (worse than) the national average.

The trust was meeting its target, with an overall compliance rate of 92.68% although leaders told us there a continued focus on appraisals in some areas for example in surgery and maternity (see core service reports). There was a 100% appraisal rate for pharmacy staff in 2018/19. At the end of February 2019, 94% of the medical appraisals and revalidations had been completed. Those with a missed appraisal were going through a missed appraisal process, which included appropriate escalation and action to address non-compliance.

**Learning and development**

Mandatory training was close to meeting targets, but not in some specialties (see core service reports). The trust set a target for mandatory training at 85% and was mostly meeting this, although further work was required in some divisions for example in surgery. There was a learning and development strategy in place which had been developed using the PERFORM methodology, and which linked back to the overarching strategy and key priorities. The integrated board report included an overview of training compliance and areas of focus were followed up through divisional governance.
In addition to mandatory training, the trust officially opened its clinical simulation space as part of its Improving Patient Safety by Healthcare Simulation initiative in November 2018. Funded by the hospital charity it had been able to provide training to 404 staff and planned to continue to provide general and specialised courses throughout 2019/20. The sim space utilised a state-of-the-art...
mannequin, audio visual debriefing technology, medical equipment, and the creativity of the sim space team to re-create real life medical and surgical situations. These were often based on the past experiences of the trainers and was designed to be a completely immersive experience.

Governance

Board structures and assurance processes

There were structures, processes and systems of accountability to operate a governance system designed to monitor the service and provide assurance. Since our last inspection where we raised some concerns about the success of implementation of changes to governance structures and the move to service line management, the trust had made significant progress. The governance structures had been reviewed and strengthened, and there was good evidence that they were well on the way to being fully embedded. Service line management structures and processes were readily articulated during this inspection by those leaders and managers we spoke with. The trust acknowledged that processes were still embedding and we found the trust leadership team were well sighted and acting on those areas requiring more intensive support to implement them.

The trust had commissioned two external reviews to support with this work, and we found they had taken prompt and proportionate action to implement and embed their recommendations. There was a comprehensive and well-designed governance improvement programme resulting from the reviews and other internal priorities, that had wide ranging support across the trust as well as amongst leaders. The documentation around the programme was excellent and very easy to understand at a glance, track and monitor, and had made some complex information more accessible to all. There was an accountability framework with clear lines of accountability, and clear workstreams which were reported on in terms of challenges and progress. There was an integrated governance structure with clear and tangible reporting lines from divisions and committees to the board.

There was a trust board annual cycle of business approved by the board, setting out key board business, including which sub-committee reports were expected in which months. In May 2019, the board approved the revised updated terms of reference (TOR) for each of the board’s committees. The TOR take account of the changes to committee structures, aligned to the strategy, the revised governance arrangements and the governance improvement programme approved by the board in January 2019. The various committees had reviewed and approved their revised TOR. As well as committee-specific changes, the TOR and standing agenda items had been standardised including format, a requirement for three non-executive members, upward reporting obligations and arrangements for secretarial support.

There were good arrangements to ensure the trust executive team discharged their specific powers and duties. There was a relatively traditional range of board committees, all of which were overseen by either the chair or one of the non-executive directors. The finance and performance committee oversaw delivery of the trust’s financial and operational performance, including forecasts, cost improvement programmes and use of resources. The audit committee ensured effective systems of internal control, integrated governance and risk management were operating in line with corporate objectives. The remuneration and nomination committee oversaw the performance and remuneration of the trust’s directors, along with the size, structure, composition and diversity of the board. The charity committee oversaw the effective operation of the hospital charitable activities and delivery of the trust’s fundraising strategy. There were two quality governance board sub committees; the quality and risk management committee (QRMC) and the patient experience committee (PEC). The quality strategy and improvement committee, drugs and therapeutics committee, clinical effectiveness and audit committee, patient safety and clinical risk committee and the safeguarding committee were executive assurance committees reporting into QRMC. The safeguarding committee also reported into PEC. The governance improvement programme could clearly be mapped via these committees, along with the sub groups and steering committees.
The trust had four front-line divisions plus a core clinical services division. Each clinical division was managed by a triumvirate including a clinical director, divisional operations director and head of nursing who were accountable for service delivery, including care quality and patient experience. The clinical directors met monthly with the chief operating officer. The heads of nursing were responsible for quality governance, which incorporated ward/theatre/clinic level safety, patient experience and patient care delivery, reviewed through the clinical leadership lines using quantitative (quality metrics) and qualitative intelligence (e.g. patient/family/carer feedback, staff feedback, observations). Divisional governance was exercised through the clinical operational lines (heads of nursing, matrons, ward sisters and clinical directors, consultant specialty leads, consultants and junior doctor teams) and operationally supported by the divisional operations directors and their support teams. There was a business partner model, for example each division had a finance and human resources business partner based within the divisions, who participated in twice weekly huddles with their respective executive directors. Divisional leaders we spoke with told us they felt empowered and supported and were very positive about the changes to the governance structures and processes.

Through the use of an accountability framework, the executive team held monthly performance reviews with each division, which provided the management level accountability and oversight for care quality. Within this divisional accountability framework, the divisions and the executive team scored their monthly performance against an agreed set of metrics and the level of confidence for delivery with appropriate mitigating actions agreed where improvements are required. The monthly Integrated Performance Report (IPR) was reported to the board with data on key quality metrics such as infection control, pressure injuries, falls, incidents, safe staffing, patient friends and family test and complaints. Any concerns at divisional or unit level were highlighted and actions summarised. Each trust board received either a patient or staff story and the board also commissioned its quality subcommittee (QRMC) to undertake ‘deep dives’ where further information or assurance was required.

The links within the different groups and committees ensured there was good medicine governance across the trust. The medical director had taken on the chair of the drugs and therapeutics committee, which reported to the quality and risk management committee (QRMC). The medicines governance group was recognised as not being as effective as it could be and this was being addressed. The newly appointed medicines governance pharmacist had taken on chairing this group and was updating the terms of reference and membership to make the group more proactive in identifying and tackling medicines risk. The chief pharmacist produced an annual report to QRMC and was professionally line managed by the medical director.

The trust had a medicines safety officer, who investigated and reported on all medicines incidents. Patient Group Direction (PGD) group was nurse led. PGDs due for renewal were assigned to a service lead clinician for review with input from a specialist pharmacist before approval. The pharmacy structure allowed for development and succession.

**Board Assurance Framework**

**Risks identified in the BAF were linked to the trust’s strategic themes.** The trust provided their board assurance framework (BAF), which detailed eight strategic themes that aimed to form the basis of plans over the next five years. A board assurance framework is a method of setting out the most important risks facing the organisation. It also should set out a control framework to manage them, and how the trust should satisfy itself that the controls are working as intended. When we spoke with senior leaders and managers about risks we found what they were saying was in line with the risks identified in the board assurance framework. A summary of these is below:

- They will change how they deliver services to generate the capacity to meet the demands of the future.
- They will become one of the safest trusts in the UK.
• They will treat patients as partners in their care.
• They will create a workforce for the future.
• They will empower their clinicians to lead.
• They will maximise use of technology so that the right information is available for the key decisions.
• They will increase their research contribution.
• They will play their part in delivering a successful health and care system.

(Source: Trust Board Assurance Framework – March 2019)

We saw from the board papers that the BAF was reviewed in accordance with the trust’s stated expectations.

Management of risk, issues and performance

The trust had systems for identifying risks and planning to eliminate or reduce them. Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. The trust had recently refreshed and revised the risk management systems and processes following a deep dive review; from this a risk management improvement plan was developed and on target for delivery. The new quality risk management strategy and policies had been ratified by the board in May 2019 and included a risk appetite statement, details of the executive risk sponsors. Risk tolerances had been reset at the annual trust board risk seminar. These documents clearly set out roles and responsibilities along with clear guidance for staff to follow when identifying, scoring or escalating risk. A new electronic risk register system was being implemented in stages, and this linked with the system for recording incidents and complaints. Risk management training was provided to relevant staff and monitored via annual appraisals. We found that risk was mostly being well managed, but in some areas for example maternity, not all key risks such as security and infection control, had been identified and escalated (see core service reports).

The trust had a pharmacy risk register which was reviewed by the medicines governance group. The medicines safety officer (MSO) role was held by the medicine governance pharmacist. Medicines alerts were received and actioned as appropriate with a summary of actions and learning fed back to the medicines management group and service leads. The trust also linked in with MSOs at the adjoining trusts to share information about medicines alerts. The medicines safety officer was informed of every incident involving medicines and developed education and learning for service specific teams as well as trust wide newsletters and advice. The chief pharmacist was the controlled drug accountable officer and attended the local Controlled Drug Local Intelligence Network meetings.

Trust corporate risk register

Strategic risks were entered onto the board assurance framework (BAF) and regularly reviewed and updated. When identified, risks were escalated and approved via the divisional governance meetings and managed within the originating division as far as possible if the score was lower than 12. Higher scoring risks (up to 25 maximum score), were escalated via an executive sponsor to the relevant accountable committees and added to corporate risk register for executive oversight. Leaders we spoke to had sight of the most significant risks facing the organisation and mitigating actions were in place. We saw from the minutes of the patient experience, finance and performance, people and digital, quality and risk management and workforce committees, as well as the board papers, that discussion and review of risks was a standing agenda item. Risks we heard about from front line staff were mostly reflected in the risk registers.

The trust provided their board assurance framework detailing 13 open risks. A summary of their five highest scoring risks which scored 15 or above (out of 25) is below.
<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIR1</td>
<td>Reduction in flow affects the performance of the hospital against the A&amp;E target, RTT, and DTOC. In turn this affects the financial performance of the organisation resulting in a loss of income and increased costs.</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>SIR15</td>
<td>A significant cyber-attack takes out the Trust’s I.T. systems leading to an inability to treat patients and a potential loss of critical data.</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>SIR10</td>
<td>Lack of investment in appropriate technologies and infrastructure in a timely manner impacts the ability of the Trust to deliver operational, financial performance and quality improvement.</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>SER1</td>
<td>If population need outstrips NHS/LA funding the financial sustainability of the local NHS may deteriorate further, resulting in increased cost pressures, possible service closure, fewer resources to deliver national targets and a lack of resources (people and estate) to deliver required capacity within the current models of service delivery</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>SIR11</td>
<td>Failure to deliver performance against financial and quality targets causes reputational damage and results in regulatory intervention.</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

(Source: Trust Board Assurance Framework – March 2019)

The relevant accountable committees owned their respective sections of the BAF and reports were received and reviewed by the board quarterly highlighting key risk changes and providing an update on actions to improve risk control and mitigation. The BAF also fed into the internal audit work programme, outputs from which informed further actions required, board committee work programmes and/or assurance that risks were controlled. The non-executive directors told us the BAF was much improved and was now being used as a live and meaningful document.

Performance

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. We saw evidence of the integrated performance report being presented, discussed and acted upon in the board meeting minutes. We also saw evidence of challenge around areas of concern. Where concerning trends had been identified, these had been included in the reports and monitored.

The operational performance at the trust was meeting some but not all national targets or standards for treating patients. However, it had performed better than the England average in some measures of referral to treatment times. We do acknowledge in this context the pressures the trust and the wider NHS had been under during the winter months, and the approval of lower trajectories for some targets or standards by NHS commissioners. The areas where the trust had been failing to meet standards were discussed at board meetings and included on the trust's risk register.
Accident and emergency

The trust was not meeting the NHS four-hour target and in the more recent data, was below (worse than) the national average. In the last six months of published data (January to June 2019), the trust had performed worse than the England average against the national four-hour target to admit, transfer or discharge at least 95% of patients attending the accident and emergency department (A&E).

Results were against a relatively steady number of A&E attendances with the trust seeing around 260 patients a day on average in the period April 2019 to June 2020, with a slight rise in the winter months.

The results of the 95% four-hour target shown against the England average since April 2018 are below. This includes the latest published NHS data for quarter one 2019/20 for type 1 (A&E admissions, so excluding any minor injury units in a hospital trust):

- Quarter 1 2018/19 (Apr to Jun 2018) – 86.5% (England 84.4%)
- Quarter 2 2018/19 (Jul to Sep 2018) – 76.9% (England 83.5%)
- Quarter 3 2018/19 (Oct to Dec 2018) – 81.5% (England 81.2%)
- Quarter 4 2018/19 (Jan to Mar 2019) – 74.3% (England 77.2%)
- Quarter 1 2019/20 (Apr to Jun 2019) – 72.8% (England 78.3%)

Referral times for treatment

The trust had been performing above average for the NHS consultant-led referral to treatment time target, although in some areas this had declined and were not meeting the standard overall at the time of our inspection. The trust had not met the 18-week referral to treatment standard for incomplete pathways (patients waiting to start treatment) for at least 92% of patients in any of the last six months (December 2018 to May 2019). However, in December 2018 to March 2019, the trust had been above or the same as the England average overall. But this had deteriorated in April and May 2019 to fall slightly below the England average:

- December 2018 – 87.4%. England average – 86.6%
- January 2019 – 87.6%. England average – 86.7%
- February 2019 – 87%. England average – 87%
- March 2019 – 86.7%. England average – 86.7%
- April 2019 – 85.2%. England average – 86.5%
- May 2019 – 85.1%. England average – 86.9%

Looking at the latest published data (May 2019) in some further detail, the trust met or exceeded the 92% target in five of its leading specialities (taking patient numbers of above 1,000). These were general surgery – 93.7%, gastroenterology – 93.4%, cardiology – 95.7%, dermatology – 92.2%, and ‘other’ (the largest category) – 94.5%. The exceptions in leading specialities were urology (90.1%), trauma and orthopaedics (68.2%), plastic surgery (82.2%), neurology (70.3%) and gynaecology (81.7%). However, of these, urology and plastic surgery were above the England average. Results were being most significantly affected by trauma and orthopaedics’ waiting times (England average 83.4%) and neurology (England average 85.3%). The 92nd percentile waiting time for trauma and orthopaedic patients was 34.8 weeks and for neurology patients, 28.5 weeks.

The highest number of delayed patients was in trauma and orthopaedics, where 1,317 patients were waiting over 18 weeks (31.8%). This was higher than the England average of 16.6% delayed patients. In the smaller specialities for the trust, some patients were all seen within 18 weeks, while others, such as thoracic medicine (73.2%) were being significantly delayed. Of the 611 patients waiting for rheumatology services, 519 (84.9%) were within the 18-week standard. This was below (worse than) the England average for May 2019 of 89.6%.

Cancer performance

The trust had met only two of the five key cancer performance standards in the last 14 months reported by NHS England and had been below the national average in all but one
measure from early 2018. In the four quarters of the last financial year (April 2018 to March 2019) and including April and May 2019 (the most recent published data), the trust had a poor performance against both the key national standards for seeing and treating cancer patients and the national average. The trust had not met the two-week wait for all suspected cancers during this period and was below the national average. However, this was within a picture where the national waiting times for cancer treatment were the worst on record.

Taking May 2019 (still provisional data) for detail, the trust met one the five key standards listed below. It was above (better than) the England average in two standards.

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-week wait. All suspected cancers. Standard 93%</td>
<td>89.5% (91.4%)</td>
<td>90% (91.6%)</td>
<td>84.1% (92.8%)</td>
<td>85.9% (92.3%)</td>
<td>84.7% (89.9%)</td>
<td>83.4% (90.8%)</td>
</tr>
<tr>
<td>Two-week wait. Exhibited breast symptoms. Standard 93%</td>
<td>84.4% (83.9%)</td>
<td>93.4% (90.2%)</td>
<td>55.6% (88.7%)</td>
<td>65.2% (80.9%)</td>
<td>89.8% (75.5%)</td>
<td>88.8% (78.9%)</td>
</tr>
<tr>
<td>31-day wait for first treatment. Standard 96%</td>
<td>95.4% (96.6%)</td>
<td>94.5% (95.7%)</td>
<td>94.1% (95.6%)</td>
<td>91.5% (94.8%)</td>
<td>90.9% (94.9%)</td>
<td>98.2% (98.8%)</td>
</tr>
<tr>
<td>31-day wait for surgery. Standard 94%</td>
<td>93% (94.5%)</td>
<td>82.6% (93.5%)</td>
<td>88% (93%)</td>
<td>78.4% (91.8%)</td>
<td>80.7% (91.1%)</td>
<td>82.5% (92.2%)</td>
</tr>
<tr>
<td>62-day wait for first treatment. Standard 85%</td>
<td>84.6% (80.3%)</td>
<td>84.3% (78.3%)</td>
<td>86.5% (78.4%)</td>
<td>82.6% (76.7%)</td>
<td>87.1% (78.7%)</td>
<td>78.4% (76.5%)</td>
</tr>
</tbody>
</table>

Key:

- **Above standard**
- **Close to standard**
- **Below standard**
- **Above national average**

In the detail behind the two-week waiting time data for Q1, Q2, Q3 and Q4, the good performers among the larger patient groups (>300 patients) were gynaecological cancer, suspected skin cancer (although deteriorating over time), lower gastrointestinal cancer, and suspected urological malignancies (excluding testicular). These were above or close to the standard to be seen within two weeks.

North Bristol NHS Trust provides breast cancer care and treatment for the whole of Bristol and beyond (the old Avon area) at the Bristol Breast Care Centre. The other local NHS trust is not commissioned to provide this service. The waiting time for suspected breast cancer had failed to meet the target since quarter two 2018/19. In quarter three, at 55.6%, the trust had performed among the worst in the country. However, this had steadily improved, and although the trust was still not meeting the 93% standard, it was now above the national average for patients to be seen within two weeks of referral.

**Diagnostics**

There was a poor performance for diagnostic imaging against the national standard, which had deteriorated in 2019. Working to the national standard for diagnostics, the trust had performed below the standard in each except two of the 14 months from April 2018 to May 2019.
This standard stated that no more than 1% of all patients should wait more than six weeks for a diagnostic test. Patients had experienced the most delays of 4.3% and 5.5% of patients not seen within six weeks in April and May 2019 respectively. The last time the trust had achieved the 1% standard was October 2018 (0.8%) and prior to that, April 2018 (1%). In some of the other months, the trust had been below (better than) the England average, particularly in the early months of the reported period. However, since December 2018, the trust had not met the standard and had been above (worse than) the England average (February 2019 was the same as the average).

**Food standards**

**The patient view of the food had improved.** The patient-led assessment of the care environment (PLACE) score for food had improved from 90% in 2017 to 91.3% in 2018. Ward food scores had also improved from 91.5% in 2017 to 92.4% in 2018. The trust was below the national average when asking for the patient’s view of the environment in three of the four indicators. It scored well for people living with a disability. The patient-led assessment of the care environment (PLACE) scores for those areas related to the environment had deteriorated slightly for condition, appearance and maintenance and the environment for people living with dementia. Both were below the national average. However, cleanliness has increased marginally, although still below the national average. The view of the environment for people living with a disability had improved almost 10% from 2017 and was 3% above the national average.

<table>
<thead>
<tr>
<th>PLACE Subject</th>
<th>Trust score 2018</th>
<th>National average 2018</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>95.5%</td>
<td>98.5%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Condition, appearance and maintenance</td>
<td>91.3%</td>
<td>94.3%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Environment for people living with dementia</td>
<td>77.1%</td>
<td>78.9%</td>
<td>78.7%</td>
</tr>
<tr>
<td>Environment for people living with a disability</td>
<td>87.2%</td>
<td>84.2%</td>
<td>78.7%</td>
</tr>
</tbody>
</table>

**The trust had systems and processes in place to manage infection prevention and control.**

There was an infection prevention and control nursing team supported by a lead infection control doctor, consultant medical microbiologists and the director of infection prevention and control (DIPC), along with an audit practitioner and administrative support. A comprehensive programme of work had been developed and was progressed throughout the year. The DIPC chaired the bimonthly control of infection committee (COIC) and the fortnightly infection control monitoring group. During 2018/19 the COIC reported to the trust’s quality committee providing a detailed highlight report to each meeting. The board had oversight of infection control issues, hospital- apportioned infections and avoidable harm through the integrated performance report, and an annual infection control report, which adhered to the guidelines for reporting as set out by the department of health. There was a comprehensive training programme for infection control that was monitored and reported upon in the annual report.

The trust complied fully with the mandatory surveillance system for healthcare-associated infections including staphylococcal (MRSA and MSSA) and E. coli bacteraemia, C. difficile and orthopaedic surgical site infections. All serious untoward incidents associated with infection were reported to commissioners and Public Health England. There were some areas where infection control practice needed to improve, for example within maternity and some surgical areas where practice was not in line with policy and cleaning regimes were not clear (see core service reports).

**Infection control mandatory reporting during 2018/19 had variable results as follows:**

- Nine cases of healthcare-associated MRSA (methicillin resistant staphylococcus aureus) bacteraemia reported (against a zero-tolerance plan)
- 27 cases of healthcare-associated MSSA (methicillin sensitive staphylococcus aureus) bacteraemia reported (against the trust’s plan fewer than 19 cases).
• 39 cases of healthcare-associated Clostridium difficile reported (plan fewer than 42). 23 cases were classified, using the public health England criteria, as having contributory lapses in care.

Root cause analysis work was undertaken by clinical divisions for each case of MRSA and MSSA bacteraemia which had highlighted a recurrent theme of improvement required with the insertion and ongoing care and management of invasive devices, relating to both central and peripheral vascular access. Action relating to this had been a key component of the trust’s staph aureus action plan, and work was underway to review current policies and related practice. The trust also used nationally recognised audit tools such as the Saving Lives care bundles, to focus on the factors which cause infections, and acknowledged there remained a challenge in achieving 95% compliance in some areas and had targeted those areas for improvement. The trust had achieved 95-99% compliance with hand hygiene audit scores for 11 out of 12 months between April 2018 and March 2019, and had sustained a reduction in cases of Norovirus, for example for 2018/19 only one bed day was lost from a bay closure in February 2019, as compared to 48 bed days lost in 2017/18.

Incidents
The trust had systems in place to identify learning from incidents however, fewer staff than the average in the sector were confident about reporting unsafe clinical practice and in the response of the organisation. The 2018 NHS staff survey results in this area were below (worse than) the national average for acute trusts. However, some had improved over the results from 2017. In the 2018 NHS staff survey, 85% of staff agreed or strongly agreed the organisation encouraged reporting of errors, incidents or near misses. This was below (worse than) the national average for acute trusts of 88%. It was also slightly above the 2017 score for the trust of 84%. This measure came from a series of more detailed questions:

• 92% of staff said they knew how to report unsafe clinical practice. This was below (worse than) the national average of 94% and down 1% from the previous year.

• 57% of staff said they agreed or strongly agreed the trust treated staff who were involved an error, incident or near miss fairly. This was 2% below (worse than) the national average, although a 4% improvement over the trust’s results for 2017.

• 65% of staff said they agreed or strongly agreed the organisation acted to ensure errors, incidents or near misses did not happen again. This was 5% below (worse than) the national average, although an improvement of 2% over 2017.

• 67% of staff said they would feel secure raising concerns. This was below (worse than) the national average of 69% and a 1% decline over 2017.

• 54% of staff said they were confident the organisation would address their concern. This was below (worse than) the national average of 57% and the same as 2017.

The trust acknowledged the low (but improving) results in this area, and action taken included a newly refreshed incident reporting and management policy (2019) along with a refreshed serious incident reporting policy and procedure (2019), which aligned with the governance improvement programme. Serious incidents were identified and considered through the executive incident review group (EIRG) and the clinical risk operational group (CROG) in line with the national serious incident framework (2015). There was a 60 working day timeframe to investigate and provide a written report to the commissioners and there were no serious incidents breaching their reporting deadline in the last 12 months.

From March 2018 to February 2019, the trust reported five incidents classified as never events, four in medical care and one in surgery. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. All four of medical never events were categorised as medical equipment/ devices/disposables incident meeting serious incident criteria and related to the unintentional connection of a patient requiring oxygen to an air flowmeter. There was evidence changes had been made because of learning from these never events and the never
events were fully investigated. We saw a new standard operating procedure had been developed and implemented to prevent future occurrence. Trust wide audits demonstrated 100% compliance in each medical ward in March, April and May 2019.

Between June 2018 and May 2019, there were 72 serious incidents reported by the trust, which was within national parameters although the trust was noted to be in the lower quartile of similar NHS trusts. Incidents were analysed according to type and location and were reported monthly through the Integrated performance report to the board. Trends and themes were discussed at the patient safety and clinical risk committee and the clinical risk operational group (CROG). Incident themes were also discussed at divisional governance meetings.

The most prevalent type of serious incident was patient falls (30), followed by treatment or procedure (12) and maternity and obstetrics (10). The remaining categories were tissue viability (8), clinical assessment/review (6) and a category of ‘other’ (6). This ‘other’ category was interrogated and causes reported on for transparency. The trust had implemented a new electronic business intelligence system which provided frontline teams with detailed and quality information on trends and hotspots. Actions arising from serious incidents and trends were monitored by the relevant sub and board committees, for example, the trust falls group oversaw the actions around falls and reported to the patient safety and clinical committee.

We reviewed six completed serious incident root cause analysis reports and found these to be patient centred and of good quality, with a focus on learning. The trust told us as part of the review and refresh of the incident process, they had identified the need for wider learning across all areas; there had previously been a tendency to focus on specific learning from events in the relevant departments, and although the processes for learning were set out in the new policy and procedures, the system was not yet as mature as it needs to be. However, we saw learning from investigations was shared through discussions in committees and groups where recommendations and actions plans were scrutinised.

The use of LASER (Learning after significant event recommendations) posters were used to cascade learning. Each division had a governance and risk lead who was responsible for facilitating and sharing learning. The trust maintained a central resource of LASER posters and common themes were built into learning events through CROG and workshops. The trust told us learning from incidents fed into the annual safety priorities and quality improvement work and staff were able to provide examples of where changes had occurred in practice as a result of learning. Pharmacy staff felt empowered to raise concerns and report incidents and learning from medicines incidents was shared in huddles and with teams and across the trust. The trust had developed a new patient safety incident report which would be presented quarterly to the QRMC, and included analysis to divisional level, of the previous quarter’s incidents along with trends, themes and comparison with national data where available. The trust told us they had more to do in relation to triangulating this data with trends and themes from complaints, mortality reviews and other intelligence, and had plans to develop this work.

Safeguarding, mental capacity and deprivation of liberty
The trust recognised, acted upon and met its legal obligations to safeguard those people at risk from abuse, neglect or exploitation. The interim director of nursing was the board executive for safeguarding adults and children at the trust and represented the them at local safeguarding adults’ boards. The deputy director of nursing reported to the director of nursing and was the operational senior manager responsible for safeguarding adults and children. Interviews had recently taken place for the safeguarding adult lead post with a successful appointment in April 2019, and the named nurse for safeguarding children was leading and managing the safeguarding team and service. The team included two band 7 practitioners and administrative support. Midwifery services had a named midwife and lead midwife for safeguarding and the trust employed a named doctor for safeguarding children.

An adult and child safeguarding and mental capacity act operational group met a minimum of ten
out of 12 months each year to ensure required standards were met, planning and continuous improvement was in place, and for identifying, sharing and learning in the delivery of best practice and identifying and managing risks to patients. The safeguarding steering group met quarterly, bringing together the governance arrangements, attended by the divisional heads of nursing and relevant safeguarding professionals; this group reported into the trust’s quality and risk management committee, a sub-group of the board. There was an annual safeguarding work plan which reflected the areas of focus for the year ahead.

The safeguarding team reported a year on year increase in staff contacts and referrals to the team; for example, in 2014/15 there were 214, in 2015/16 there were 776, in 2016/17 there were 1,231, and in 2017/18 there were 1,501. The newly implemented electronic reporting system had been instrumental in supporting the team to capture activity more accurately. In addition to the reported contacts above, the safeguarding team provided training, telephone advice, case discussions and signposting to support front-line services.

We found the trust was not meeting its target for safeguarding children at Level 3 although it had improved slightly since 2018.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 1</td>
<td>2,847</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>2,752</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>3,452</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2</td>
<td>4,117</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>693</td>
</tr>
</tbody>
</table>

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS)

During our last inspection we told the trust it needed to make improvements in the management of MCA/DoLS and ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) practice. During this inspection, we found there was still work to do in ensuring documentation was completed accurately for example in medicine and end of life care (see core service reports). The trust commissioned an internal audit in May 2018 to specifically look at compliance with MCA/DoLS and DNACPR practice, which identified variable staff awareness and documentation of mental capacity assessments and DoLS. A focus group was held to hear the views of frontline staff in clinical practice in relation to MCA/DoLS within the trust and then a task and finish group was established led by the deputy director of nursing with key divisional representation including safeguarding practitioners. This group sought to understand the barriers to implementing best practice and how this could be delivered to large volumes of frontline staff. Four priorities were identified:

1. A trust wide MCA/DoLS improvement programme was to be established
2. MCA and DoLS policies were to be updated
3. A training package and a face to face training model was to be piloted
4. An evaluation of the pilot was to be undertaken to review suitability of both the above and next steps. We found good progress has been made towards the achievement of these goals, for example investment had been made in e-learning and the forms had been simplified although work was still underway.

The trust could provide assurance of compliance with Deprivation of Liberty Safeguards (DOLS); they met their 90% training target and referrals had been increasing year on year, with 981 referrals in 2018/19. There was a good understanding among the team leaders around recent legal rulings, which had widened the threshold for the application of DOLS, and policies and processes were under review to determine the implications and impact of the new legislation and to simplify systems. A thresholds review had taken place of all referrals to the local authority which found screening decisions taken were accurate and timely. The team had supported over
1,300 staff with DOLS concerns last year and had developed a bespoke e-learning package to assist with accurate completion of DOLS applications. The trust had met its 90% target for mental capacity act training, although acknowledged there was more to do as practice remained variable across the trust; we saw a further audit of practice and MCA documentation was planned as part of the annual programme of work, and cascade training was being developed along with a strengthening of induction training for medical staff.

Audit

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed (see core service reports). There was a systematic programme of audit that aimed to measure performance in key areas, such as quality, operational and financial processes. These were reviewed regularly by the audit group together with leads for audit within the trust. The trust participated in and reported on both local and national audits covering a wide range of areas, the programme being agreed by the clinical audit committee. The results of audits were entered onto dashboards, which were available to practitioners to inform quality improvement initiatives. Results from audit that gave cause for concern were added to the risk register to be mitigated and resolved.

Planning for risks and major incidents

The trust recognised and understood its risks in terms of business continuity and planned for major incidents. NHS England required trusts to have suitable and up to date plans when faced with disruptions but recognised these need to be proportionate. Disruptions could be, for example, from severe weather, failure of systems or power, or an outbreak of an infectious disease. The trust’s policy around business continuity set out clearly how to rate the risks it faced and what action to take if they were to deteriorate.

Estates

The risks of the environment and estate were well understood, although there was more to do in some areas (see core service reports). We met with senior staff managing the portfolio of estates, who described the challenges of the site, and past, present and future developments. There was an estates strategy approved by the board in November 2018, and healthier together estates climate change adaptation plan 2018-23, as well as a sustainable development management plan 2019. Whilst we were assured there was sound oversight of the strategic challenges, and plans in place to address them in a focused and forward thinking manner, we were not assured there was sufficient oversight of some of the day to day facilities management issues for example around the culture of the facilities workforce which comprised in excess of 850 staff, the end to end processes in the sterile services department, the environment in the mortuary and oversight of the cleaning, storage and readiness of equipment, for example in maternity. The trust recognised maternity was housed in a dated building which needed attention structurally, but in addition, processes needed to be reviewed for ensuring the environment, equipment and furnishings were fit for purpose.

Finances Overview

The trust’s financial position was stable, but it had been operating at a significant deficit for a number of years and it had a deficit target of £29.9m for this financial year. The trust had a strong culture of financial leadership and although it was in significant financial deficit it had achieved its control total for the previous two financial years. To achieve its deficit target, the trust is required to deliver £25m in savings in 2019/20 and when we inspected a significant part of this remained (circa 20%) non-recurrent in nature. Therefore, the financial position of the trust remained a concern, and risks remained to the trust achieving ongoing financial sustainability and its in-year plan. The trust was revising its strategy and developing a five-year long-term financial plan which we were advised was due to go to trust board in September 2019.
<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£530.1m</td>
<td>£574.5m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£42.9m)</td>
<td>(£15.7m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£573m</td>
<td>£590.2m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£48m)</td>
<td>(£18.7m)</td>
</tr>
</tbody>
</table>

The deficit decreased in 2017/18 compared to 2016/17. However, projections for 2018/19 indicate that the deficit will increase compared to 2017/18 with projections that this will decrease further in the next financial year 2019/20.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Board members on the whole demonstrated a good understanding of the financial issues and challenges. The finance department had the necessary capacity and capability and we heard that the finance business partners were embedded and operated well within divisions with a professional managerial line to the finance department. Divisions were held to account for their financial performance with the expectation that they would address adverse variances and financial information appeared clear, accurate, timely and relevant. We reviewed two business cases submitted to board and found them to be of good quality, and with evidence that potential impact on patient care had been carefully considered.

Information management

Information governance systems were in place including confidentiality of patient records but more needed to be done to ensure all areas were adhering to policy. The service was increasingly recording information electronically and reducing its reliance on paper records. This included the use of electronic patient records, which we found mostly to be secure with computer screens being locked when not in use, and access was password protected to prevent unauthorised access. However, security for confidential patient records and information was not always adequate. At our previous inspection we told the trust they must provide security for all confidential patient records and information. During this inspection we found records were mostly being stored securely. However, we found paper notes were not always stored in locked trolleys in the pre-operative assessment unit, although a new trolley was on order, in medicine we found some computer screens had not been locked down and in maternity we found several examples of notes not being stored securely (see core service reports).

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. Information management and technology was represented at executive level by a lead with the appropriate skills and experience to carry out this role. The trust was aware of its performance through the use of KPIs and other metrics which were reported through the trust’s integrated performance report. This data fed into the board assurance framework. There was a recently developed and board approved digital strategy and vision, overseen and implemented by the director responsible for the digital agenda, who had a solid infrastructure to support delivery. We were told the strategy was well owned by the board, and significant support and resource had gone into improving systems over the last 18 months, for example the introduction of e-observations, e-handover and e-flow. Of note was the evidence we saw of clinical input into the new systems and the focus on the patient being the centre of every decision. There was a comprehensive plan in place in the event of a cyber attack.
Information was in an accessible format, timely, accurate and identified areas for improvement. There were still challenges to overcome and these were reflected on the corporate risk register. Work was ongoing around ensuring data quality issues and the trust had a data quality reporting tool highlighting areas for review and remedial action. The Trust has a number of Data Quality Marshalls who work within the hospital to holistically look at data pathways from input stage to reporting, to identify and take action to correct issues. Their role is to also ensure that capability in the workforce is increased through the provision of on-going engagement and consultancy across the organisation. The trust also had a number of data validators working within each division to ensure key processes and submissions meet quality expectations.

In addition, the trust’s internal auditors, had undertaken a programme of data quality audit, achieving significant assurance with minor improvements in 2018/19, and with a further audit programme agreed at executive level for 2019/20. At a strategic level, the trust has committed to a significant investment in tools and technologies to improve reporting, analytics and data quality through the implementation of a new data warehouse and self-service dashboards.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Throughout 2018/19, new data and information products had been developed and published to enable executives, management, and clinical staff engage more immediately with organisational data to benefit patients.

At an operational level, the trust’s data quality tracker contained approximately 50 key performance indicators covering all elements of the Referral to Treatment (RTT) patient pathway. The data was reviewed on a regular basis by all specialities and any data quality issues were validated and amended to ensure accuracy.

The pharmacy clinical portal, used to prioritise high risk patients, was due to be upgraded to a new system during the summer, as the current system was no longer supported. There was a programme of internal clinical audit to monitor medicines optimisation processes and medicines safety. Complete and accurate records about patient’s medicines were maintained in line with professional guidance and were shared with other services when care was transferred.

The chief pharmacist reported controlled drug (CD) incidents to the CD local intelligence network and submitted quarterly occurrence reports. The trust had a bid under consideration by NHS Digital for an electronic prescribing and medicines administration system (ePMA). Consideration was being given to having the same system as a neighbouring trust and community providers to facilitate sharing of information when patients transferred between services.

The trust had completed the Information Governance Toolkit assessment. The trust met all the requirements to satisfy the Department of Health NHS Information Governance Toolkit assessment in 2017/18 (most recent), meeting all 45 measures. The trust had completed the assessment to describe how it saw its management and security of information. The trust self-assessed performance on measures of assurance, which extended to confidentiality and data protection, the quality of information, the secondary uses of information, and a measure of overall performance. In the 2017/18 declaration, the trust assessed its overall performance as ‘satisfactory’ due to meeting all the required level two assessments, and five achieving the highest level three status.

The overall score for 2017/18 was 70%, which was a slight decline over the 2016/17 score of 73%. However, the score was up from 2015/16 when the trust scored 65% and the trust rated its performance as not satisfactory as six areas had not reached the minimum of level two.

The trust was partially compliant with the Accessible Information Standard. From August 2016 onwards, all organisations providing NHS care are legally required to follow the accessible information standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. The standard sets out a specific, consistent approach for people using services (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, deaf, deafblind
and/or who have a learning disability. It also covers the needs of people who have aphasia, autism or a mental health condition which affects their ability to communicate. To comply with the standard, organisations must achieve five actions:

- Identify
- record
- flag
- share
- meet information and communication needs.

Senior leaders told us the trust had taken steps to comply with AIS. They had identified areas of good practice and gaps. The presence of gaps meant the trust was not compliant with AIS. A short life working group was established for the ongoing implementation and embedding of the requirements of the AIS, which reported to the patient experience group which reported in turn to the patient & carer experience committee (board subcommittee) and work was underway to achieve compliance, and progress was being monitored. The trust was in the process of making eLearning available for staff on AIS and had incorporated this into the induction programme. AIS information was not published on the trust website.

The trust was actively engaged with the deaf community and the representatives from the sight impaired community along with those with learning disabilities (LD) and autism, who were working with the trust to identify and consider gaps. Output from these groups have been incorporated into the digital strategy and have informed the work in the outpatient improvement program. Meeting the information & communication needs of the LD and autism groups was a key element of the LD and Autism Steering Group. Progress on written information was being made with letters (outpatients) in easy read and information on key services being progressed. Senior managers told us AIS was a priority in their work plan.

**Engagement**

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The trust had a Public Engagement Strategy (2019-20) which was aligned to the trust vision and objectives and set out a commitment to co-design. There was a plan in place to embark on a range of engagement activities, including large scale events, small bespoke round table events, workshops, surveys, social media and the use of a patient’s panel. A new and improved website was due to be launched in December 2019. The trust had a patient partnership group (consisting of current and past patients and carers) that had been in action for almost 20 years and we were told it had been the first of its kind in the country. This group had a unique role distinct from other volunteers at the trust, and they told us their advice, knowledge and experience were regularly sought on a wide range of topics.

They felt valued and respected by the leaders and staff and felt able to be open and offer challenge where needed. Representatives from this group were invited to sit on senior staff and consultant interview panels and focus groups, and they attended a wide range of committees and meetings, for example (though not exhaustive), patient safety and clinical risk committee, clinical effectiveness and audit committee, trust transfusion group, falls group, medicine governance group, resuscitation committee, patient experience committee, intensive care group, end of life steering group, outpatient communication group, nutrition steering group, clinical governance improvement programme, stroke group, VTE group, consent group and the quality strategy delivery committee. We heard very positive feedback from this group about the patient complaint review panel, which was led by the patient’s association and comprised volunteer patient partners, move makers and retired NHS staff. This involved reviewing past complaints and looking at the trust's responses and giving specific feedback about how the trust could improve the content and quality of those responses. This meeting was on hold temporarily whilst the complaints team was being reconfigured and resourced, though was due to be reinstated later this year, once the team has been finalised.

A good example of patient involvement and co-production was the Hospital at Home initiative that was designed and created by staff alongside patient feedback to provide acute healthcare to
patients in the comfort of their own home, as an alternative to being treated in an acute hospital setting. The Hospital at Home team worked closely with each patient and their team of doctors and consultants to develop a personalised care plan that can be delivered at home. The initiative was originally designed by staff in the surgical division as a scheme for supporting surgical flow and beds through the winter. Since its launch in January 2018, the service had looked after an average of 20 patients per night and had saved the trust a total of 3,402 bed days in 2018. The service had proved to be cost effective as well as highly recommended by all patients using the service. The aim for the trust was to expand to a wider range of elective and emergency care over the next two years, and to include technology to remotely monitor patients’ symptoms and vital signs within their own home. The team worked collaboratively with community partners to ensure patients received the right care, in the right place at the right time.

The trust had 288 volunteers across wards and departments who actively engaged with patients, relatives and carers, and more were being actively recruited. One group of volunteers were called ‘move makers’ and they were highly visible around the site, with 144 in post, 27 of whom volunteered in the emergency department. Move makers were responsible for ensuring that patients were able to check in to their appointment and knew where they were going in the large hospital. This also included driving buggy’s up and down the main atrium of the hospital to get patients to the appropriate gate. Other volunteers worked as mealtime assistants, gardeners and arts and crafts volunteers. There was also a chaplaincy volunteer team of 105, and befrienders who were allocated to wards to talk to patients. The trust had an inclusive approach and had recruited and were supporting volunteers with learning difficulties.

Volunteers were also stationed in the radiography department, the discharge lounge, emergency department, breast care centre and the Macmillan wellbeing centre. They also ran the league of friend’s coffee shop. A weekly memory café was set up as a drop-in area for patients and their relatives to get support and information about living with dementia which was run by the dementia team, supported by an external charity. We met with a group of volunteers who were very positive about the trust and felt included and valued. They gave examples of issues they had raised which had been addressed, for example changes to the check-in screens in outpatients and adapting the signage (numbering and letting) in the atrium. There were also opportunities for businesses to volunteer at the trust, for example a local business were involved in working on the garden around Elgar ward. All volunteers at the trust had appropriate checks, induction and training for their roles. The trust was recruiting to a band 6 volunteer manager role to support recruitment and retention and ensure volunteers were in the right places with the right training.

All staff we spoke with were very positive about the contribution of the volunteers. In July 2019, the move makers had received the Queen’s Award for Voluntary Service, and the move maker manager had attended the Queen’s Garden Party in recognition of the team’s work. The trust also held an annual ‘thank you tea party’ for the volunteers.

Fresh Arts was a programme designed to enhance patient experience and maintain health and wellbeing for patients, visitors and staff. The trust had employed ten artists and musicians and ten volunteer pianists to deliver a four-pillar programme including visual arts, music programme (including professional performances), arts on wards and arts on referral. Arts on referral is a clinical referral process to creative activities for patient wellbeing, working with patients who have been through cancer treatment and chronic pain patients with a third group (either respiratory patients or those living with addiction) joining the programme in 2019. Patients joined a six-week programme of creative activity such as visual art, print-making or creative writing to equip them with tools to better manage their condition, learn new skills, improve their mental wellbeing and develop a sense of agency. Patients are then referred on to community arts groups across Bristol, creating a creative care pathway. In addition, the trust ran Creative Companions, with trained volunteers delivering creative activities at the patient’s bedside, providing distraction, engagement and increasing confidence and interaction.

**Friends and Family test**

The trust scored below the England average for recommending the trust as a place to receive care from April 2018 to March 2019. The Friends and Family Test was launched in April
It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

(Source: Friends and Family Test)

Information gathered from the friends and family test was analysed for trends and reported through the integrated performance report to the board. Whilst currently sitting below the national average, response rates had been slowly increasing but more work was needed to improve the inpatient response results, which were sitting at 19% against a target of 30%. We saw evidence of some triangulation of these results, for example friends and family test feedback in the emergency department was correlated with the feedback from the national emergency department survey around waiting times, and an action was plan developed focusing on improving communication, managing expectations and acknowledging patient anxiety during long waits to be seen. In those areas where patients scored a less than 90% recommend rate, a deep dive was undertaken and negative comments were triangulated with complaints and incidents to identify and address common themes. Areas that were flagging as a potential concern had actions plans developed and were supported to address the issues by the matrons.

Engagement with staff had some levels of success in this organisation and was improving. The 2018 NHS staff survey showed improvements in questions associated with staff engagement. All of these questions had improved since 2017, however, most were still slightly below (worse than) the national average.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2018</th>
<th>National Average</th>
<th>Trust Score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4b: I am able to make suggestions to improve the work of my team/department</td>
<td>75%</td>
<td>75%</td>
<td>73%</td>
</tr>
<tr>
<td>Q8d: My immediate manager asks for my opinion before making decisions that affect my work</td>
<td>51%</td>
<td>54%</td>
<td>50%</td>
</tr>
<tr>
<td>Q9b: Communication between senior management and staff is effective</td>
<td>36%</td>
<td>41%</td>
<td>35%</td>
</tr>
</tbody>
</table>
Q9c: Senior managers here try to involve staff in important decisions  
<table>
<thead>
<tr>
<th></th>
<th>32%</th>
<th>34%</th>
<th>28%</th>
</tr>
</thead>
</table>
Q9d: Senior managers act on staff feedback  
|          | 29% | 32% | 26% |

Note: for the above questions, the percentage featured is that of ‘Yes’ responses.

Staff were involved in decision making about changes to the trust services. The trust was working hard to improve staff engagement, for example a large-scale local staff survey / listening event about the winter plan had taken place across February / March / April 2018. This resulted in the identification of several key issues, including the need for better communication about the plan in advance, especially around staff rotas and ward swings; increased staffing over winter including in the emergency department; mental health liaison; the need for better support and co-ordination across the system and community health services; and better support for staff health and wellbeing over the winter period. These resulted in actions being taken against the issues, and the trust were in the process of repeating the exercise for 2019/20.

The Festival of Engagement was an opportunity for staff to meet with executives, leaders and other staff to find out about what was happening across the trust. It was well attended and positively received by staff. The trust had also launched a web-based system called HappyApp which provided live, anonymous feedback from staff. The issues raised varied from division to division and over time, but typically key issues were: pay and conditions (hours worked, shifts, and overtime); equipment / resources / environment (missing or problematic equipment or working environment, high workload inefficient systems); and team work (high workload, team dynamics / tension). These trends broadly confirmed those highlighted in local staff surveys, listening events, happy app data as well as the NHS Staff Survey. The trust had prioritised these themes for action in the coming year.

Learning, continuous improvement and innovation

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. Staff had training in improvement methodologies and used standard tools and methods. The trust had a quality and patient safety improvement team (QSIT) and a ‘Perform Academy’ that provided staff with the tools to make improvements in their areas. The philosophy and principles of the methodologies used by both teams were aligned as follows:

- Creating a vision centred around what matters most to the patient.
- Engaging teams with local problem-solving and small-scale testing and feedback.
- Coaching teams to enable them to deliver improvements.
- Sharing and celebrating success using measurement around outcomes and capturing shifts in culture and staff and patient experiences.

Both teams presented at staff induction and worked to improve staff's capability in improvement skills and the impact of this was evident in local and national awards as well as public feedback. QSIT held workshops teaching the model for improvement, process mapping, patient shadowing and experience-based co-design as well as problem-solving and creative engagement approaches.

Perform had originally been devised as a trial to minimise delays in patient care and enhance flow; the methodology had ten steps which through a coaching approach, encouraged behavioural change to optimise how teams function. The trial was successful in reducing length of stay and bed occupancy, along with enhanced patient care, prompting the board to develop a Perform Academy. The perform academy delivered bootcamps working in collaboration with an external partner on improving patient flow, coaching staff in what is called a ‘Perform Wheel’. Over 1,500 members of staff attended OneNBT boot camps that taught them the tools and techniques of working together. Throughout the year dedicated coaches were assigned to every
ward in the hospital for a ten-week period to embed the tools and techniques into teams’ day-to-day work. Staff we spoke with across all areas of the trust told us about Perform and were able to cite examples of how it was being used for quality improvement.

The trust, in partnership with an external company, won the Health Service Journal Partnership Award for Best Clinical Service and Treatment Pathway Project for its perform project. The judges said “this compelling project was an impressive demonstration of staff engagement around change. It focused on flow that then helped to transform the way staff feel about the organisation and in the confidence to make decisions to take control of where they work. The golden thread of clinical service and treatment pathway was throughout”.

The trust was actively participating in clinical research studies. Research and innovation were strong at the trust; in the past 10 years the trust had more than doubled the number of research grants, and had grown to become one of the largest, research hubs in the South West, with strong collaborative relationships across the system, including a shared director of research with another local trust. Research projects spanned all staff groups and nearly all departments, were linked with Perform, quality improvement and the transformation programme, and we heard from the team about the support and commitment from the executive board, which it was felt had been instrumental in helping to drive research and development forward to become an integral part of the trust’s daily business. For example, research and development was now a core activity item for the medical division.

There had been some innovative trials completed and over 30 underway at the time of our inspection. The trust was awarded funding to create a multi-disciplinary research team working with the trust and community service providers to deliver research across the integrated respiratory service. This team was providing increased opportunity for patients to participate in research across the region and was sharing research expertise in a community setting covering a broader range of long-term conditions. If this pilot is successful, the trust told us it would be rolled out across other providers and specialties in the region.

Members of the pharmacy team at the trust had recently presented two research posters at clinical pharmacy congress that highlighted projects to implement ward based clinical prioritisation by pharmacy technicians and redesigning the pharmacy weekend service. These projects had worked through a quality improvement methodology and led to improved patient safety at ward level. The chief pharmacist and medicine safety officer attend and feedback from regular regional and national meetings on issues relating to medicines optimisation. This information was used to review the organisations own medicines processes. Learning and improved processes from medicines incidents were circulated throughout the trust via bulletins, newsletters and face to face training. The research and innovation team had been awarded the Silver Investors in People award in 2018, and had scored 749 out of 900, which was above the national benchmark of 724.

Effective systems were in place to identify and learn from unanticipated deaths. The learning from deaths national guidance was published in 2017 and required trusts to publish its policy on learning from deaths, to provide quarterly reports including data and learning points to the trust’s public board and to incorporate the reporting into trust quality accounts. The trust was compliant on all of the above and we found the policy and associated processes to be robust. The trust’s policy expectation going forward was to screen all deaths, and to undertake a full mortality case review (MCR) on all deaths in the majority of specialities subject to appropriate screening and we found there were supporting tools being used to do this. As of July 2019, the trust scored themselves as 91% compliant against their target. The process in place flagged any cases with an overall score of poor, or very poor and these were automatically escalated for serious incident reporting. We reviewed six cases at random and tracked through two where care issues had been highlighted; in line with trust policy these had been reported as serious incidents and we saw learning and actions arising from these were detailed and shared. There were some additional amendments required to ensure a full and accurate tracking process was in
place, which the trust was aware of and addressing.

Complaints process overview

There were systems and processes in place to manage complaints and evidence learning was taken from them, but responses were not always timely. Since our last inspection, the trust had reviewed and refreshed the complaints systems and processes, and had invested in the team as part of the wider quality governance improvement programme; there was now increased support resource within clinical divisions (aligned to their divisional improvement plans) to improve the management of complaints and the trust had piloted a Patient Advice and Liaison Service (PALS), which had shown early promise in reducing the number of concerns escalated to formal complaints through swift and effective early resolution. The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for acknowledging patient complaints?</td>
<td>3</td>
<td>97%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>53%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>70</td>
<td>53%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td></td>
<td>963</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(28 February 2018 to 28 February 2019)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

For 2019/20, a divisional key performance indicator (KPI) requirement had been set to ensure that a minimum of 85% of complaints were responded to within the agreed time frame (agreed with commissioners as part of the quality contract). For context, the average monthly completion rates had varied between 53% and 76% during 2018-19. Of the cases closed in May 2019 only 33% were within the required timescales. We found there were recovery plans in place which included the development of a weekly tracker highlighting those complaints overdue and those approaching breach of target within 2 weeks and 4 weeks. Weekly meetings with the divisional complaints leads and the head of patient experience were taking place to monitor each divisional recovery plan and a performance dashboard had been developed for executive oversight.

The overall number of formal complaints in 2018/19 was 723 and a significant increase from 592 in 2017/18. We met with the head of patient experience who was very passionate and enthusiastic about the progress they had made; they told us this increase in complaints was due in part to the new electronic recording system which was more accurately capturing data, increased staff awareness of the processes and the provision of the PALS team, which previously patients could not access directly. The resource and capacity of the team had been carefully reviewed and the lead felt well supported and listened to in terms of what was required to continue to improve.

We reviewed six complaint letters and responses, and generally found them to be of a high standard. The issues had been investigated and apologies and explanations were provided as appropriate. There was evidence of learning from complaints and some examples given to us were in relation to staff knowledge around adjustments required for patients with learning difficulties in the emergency department, changes to outpatients letters with clearer content and improved patient information for care needs following discharge.
Number of complaints made to the trust

The trust received 752 complaints from March 2018 to February 2019. Outpatients received the most complaints with 294 (39.1% of all complaints received trust wide).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of complaints</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>294</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>153</td>
</tr>
<tr>
<td>AC - Medical care</td>
<td>97</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>82</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>43</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>40</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>5</td>
</tr>
<tr>
<td>Trust wide</td>
<td>752</td>
</tr>
</tbody>
</table>

The most common subject of the complaints was clinical treatment which accounted for 347 complaints (46.1%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From February 2018 to March 2019, the trust received a total of 8,435 compliments. The trust did not provide a breakdown of compliments at core service level.

The trust reported there is no standardised system for recording compliments. The trust intends to use their electronic incident management system for the recording of compliments to ensure an accurate figure for each area for each month however the roll out of the electronic system has concentrated primarily on the recording incidents, complaints, risks, inquests and legal claims as a priority.

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>AC – Medical care</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

North Bristol NHS Trust
Trust HQ
Southmead Road, Westbury-on-Trym
Bristol
Avon
BS10 5NB

Date of inspection visit:
25 June 2019 to 18 July 2019
2019

Date of publication:

Tel: (0117) 970 1212
Website: www.nbt.nhs.uk

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services
The emergency department is open 24 hours a day, seven days a week. It is the designated major trauma centre for the Severn region, which means it treats patients with multiple serious injuries that could result in death or serious disability, including head injuries, life-threatening wounds and multiple fractures. The department is equipped with X-Ray and CT scanning facilities and there is a helipad to enable air ambulances to land. Southmead Hospital is also a regional specialist centre for stroke, urology, plastics and vascular patients.

The emergency department sees patients over 16 years of age with serious or life-threatening injury or illness. Children with serious or life-threatening conditions are taken by ambulance to a specialist children’s hospital in central Bristol. The emergency department has a six-bay resuscitation area. One resuscitation bay contains equipment for children, although children requiring an ambulance are taken to a nearby children’s hospital. There is a major treatment area with 14 cubicles, including three isolation rooms.

There is a seated observation unit, adjacent to the emergency department, where some patients, who are not expected to require admission, are transferred, following assessment and investigations, for example, patients who are waiting for test results or who require a period of observation. Some patients, who are assessed on arrival as ‘fit to sit’ may also be accommodated here when the main department is busy.

The minor injury unit sees adults and children with a wide range of minor injuries. It is staffed by emergency nurse practitioners, advanced nurse practitioners and physiotherapy practitioners.

There were 91,678 attendances at the emergency department from February 2018 to January 2019. This represented a 5% increase, compared with the previous 12 months. Of these, nearly 35% arrived by ambulance and nearly 28% were admitted. There were approximately 9,000 child attendances.
The service was last inspected in November 2017, when we inspected only the safe and responsive key questions. The service was rated good overall. (Ratings for the effective, caring and well led key questions, which were all rated good, were carried forward from the previous inspection in 2015). The safe key question was rated good, whilst the responsive key question was rated requires improvement.

This was a routine inspection, which was unannounced (staff did not know we were coming). Although the service was previously rated good, we chose to inspect the service again because there had been a deterioration in performance against national waiting time targets. We inspected all key questions; is the service safe, effective, caring, responsive and well-led?

Before this inspection we reviewed information about the service and information provided by the trust.

During the inspection we visited the emergency department over two and a half weekdays. We spoke with staff, including doctors, nurses, administrative staff and managers. We observed staff handover meetings. We looked at 10 patients’ records, observed their care and spoke with them and their relatives/carers about their experience in the emergency department.

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at North Bristol NHS Trust compared to all acute trusts in England, January to December 2018**

From January to December 2018 there were 90,655 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

*(Source: Hospital Episode Statistics)*
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from January to December 2018

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills, including the highest level of life support training, to all staff and made sure most staff completed it.

Mandatory training completion rates

Nursing staff received, and were mostly up to date with, mandatory training to ensure they were familiar with key safety systems and processes.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory training courses as at April 2019 for registered nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As at April 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Infection prevention and control –</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>three-year expiry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-patient handling</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>114</td>
<td>117</td>
<td>97.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>119</td>
<td>127</td>
<td>93.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical blood transfusion training</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation *</td>
<td>117</td>
<td>127</td>
<td>92.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management (clinical)</td>
<td>106</td>
<td>116</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>116</td>
<td>127</td>
<td>91.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management (non-clinical)</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism (VTE)</td>
<td>105</td>
<td>116</td>
<td>90.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety – two-year expiry</td>
<td>104</td>
<td>117</td>
<td>88.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>110</td>
<td>127</td>
<td>86.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control –</td>
<td>105</td>
<td>123</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>two-year expiry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td>106</td>
<td>127</td>
<td>83.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>104</td>
<td>127</td>
<td>81.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia - level 2</td>
<td>101</td>
<td>127</td>
<td>79.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling</td>
<td>95</td>
<td>123</td>
<td>77.2%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall compliance rate was 88% for registered nursing staff. The 85% target was met for 13 of the 17 mandatory training modules for which registered nursing staff were eligible.

* We requested data to show whether staff had completed advanced life support training, appropriate to their role. Data provided showed a number of gaps where staff were overdue for refresher training.
A breakdown of compliance for mandatory training courses as at April 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As at April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>38</td>
</tr>
<tr>
<td>Infection prevention and control - two-year expiry</td>
<td>37</td>
</tr>
<tr>
<td>Falls</td>
<td>37</td>
</tr>
<tr>
<td>Fire</td>
<td>36</td>
</tr>
<tr>
<td>Dementia - level 2</td>
<td>35</td>
</tr>
<tr>
<td>Information governance</td>
<td>33</td>
</tr>
<tr>
<td>Health and safety</td>
<td>33</td>
</tr>
<tr>
<td>Non-patient handling</td>
<td>32</td>
</tr>
<tr>
<td>Resuscitation *</td>
<td>32</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>32</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>31</td>
</tr>
<tr>
<td>Waste management (clinical)</td>
<td>31</td>
</tr>
<tr>
<td>Patient handling</td>
<td>24</td>
</tr>
<tr>
<td>Clinical blood transfusion training**</td>
<td>18</td>
</tr>
</tbody>
</table>

In urgent and emergency care the overall compliance rate for mandatory training was 82.5% for medical staff. The 85% target was met for five of the 14 mandatory training modules for which medical staff were eligible.

* We requested data to show whether staff had completed more advanced life support training, appropriate to their role. Data provided showed a number of gaps where staff were overdue for refresher training.

** Data provided following our inspection showed compliance with blood transfusion training was 85%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training was comprehensive and met staff and patients’ needs, including children, patients with mental health needs, learning disability and those living with dementia. The mental health liaison team supported the induction programme for nurses and doctors.

Staff received protected time to complete mandatory training and it was their responsibility to ensure it was up to date. The electronic staff learning system sent automatic reminders to staff when their training was due for renewal. A monthly report was produced for managers, who maintained oversight of mandatory training compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Safeguarding training completion rates

Adult safeguarding training
A breakdown of compliance for adult safeguarding training modules as at April 2019 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As at April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Nursing staff - Safeguarding adults level 2</td>
<td>99</td>
</tr>
<tr>
<td>Medical staff - Safeguarding adults level 2</td>
<td>36</td>
</tr>
</tbody>
</table>

New intercollegiate guidance, *Adult Safeguarding: Roles and Competencies for Health Care Staff*, published by the Royal College of Nursing in August 2018, recommends all registered health and social care staff working with adults, who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns, should complete level three training. No data was provided to show how many staff had completed this level of training; we were told it was not mandatory, although we were told a few band six and seven nurses had completed it.

**Children’s safeguarding training**

The Royal College of Emergency Medicine’s Clinical Standards state: All emergency department medical staff and nursing staff should, as a minimum, have level two child protection training. All senior emergency medicine doctors (ST4 or equivalent and above) should have level three child protection training. All staff received level two child protection training as part of their induction. The emergency department offered level three child protection training to all staff.

A breakdown of compliance against the trust’s mandatory training target for children’s safeguarding training modules, as at April 2019, is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As at April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Nursing staff - Safeguarding children level 3</td>
<td>96</td>
</tr>
<tr>
<td>Senior Medical staff - Safeguarding children level 3</td>
<td>23</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding training (adults and children) was provided during induction. There was also quarterly safeguarding training provided in the emergency department. This included guidance on recognising female genital mutilation (FGM) and radicalism.

Staff training provided guidance on how to make a referral when there were safeguarding concerns. The emergency department had good links with community social care teams who routinely attended the quarterly training to provide further guidance on how and when to make safeguarding referrals.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

All staff we spoke with were able to describe examples of safeguarding referrals they had made or potential scenarios which might prompt a referral. They were able to explain the different categories of abuse and understood what happened to referrals that they created. There was a system operated to provide assurance that child safeguarding referral rates were appropriate. A
daily report of children’s attendances was sent to the named nurse for children's safeguarding and screened by a safeguarding administrator for children in care and those on a child protection plan. Flagged children would then have their records reviewed by the named nurse.

Safeguarding children training included guidance about adverse child experiences and child trafficking. The emergency department had been involved in identifying local child trafficking rings, using their internally-developed triage and clinical assessment safeguarding questions. These questions were a mandatory part of the electronic patient record system and were completed by different practitioners twice following a child presentation in the emergency department.

There were systems in place to alert staff to children who were frequent attenders of the emergency department, were on the child protection register or children in care. The electronic patient records system included a safeguarding flag, which alerted staff to children who were on the child protection register. The system also highlighted adults and children who were frequent attenders showing how many times they had attained the emergency department. The emergency department was continuing to work to improve this system in order to use the data to develop alternatives for people who frequently attended.

A team which specialised in domestic violence was based near the emergency department and was accessible to staff during office hours to provide additional advice to staff, and support to patients, regarding domestic violence. The team also attended the daily ward round.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings, which were clean and well-maintained.

The emergency department was visibly clean and we saw cleaning carried out regularly. Cleaning staff were available 24 hours a day, seven days a week and they kept records to show cleaning had taken place. Cleaning records were up to date and showed all areas were cleaned regularly.

Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. Cleaning audits took place each month. Data provided by the trust for the period April to mid-June 2019 showed some room for improvement, with an average compliance score of 93.8% and 92.8% respectively for the minor injury unit/reception and the major treatment/resuscitation areas. There was an action plan agreed with facilities management to improve these scores, which were currently rated amber.

Staff observed good hand hygiene practice. They used personal protective equipment when necessary and complied with the ‘bare below the elbow’ rule. Staff told us they would challenge colleagues who did not observe this rule. We saw all staff cleaned their hands before and after contact with patients. There were plenty of appropriately-sited wash hand basins and hand gel dispensers for staff and visitors.

The service completed regular hand hygiene audits and performed well in these. In May 2019 there was 98% compliance with hand hygiene standards.

The service also audited peripheral cannula and urinary catheter insertions. These are invasive procedures which carry the risk of infection. In May 2019 audits showed 92% harm-free care for peripheral cannula insertion and 100% harm-free care for urinary catheter insertion.

There were side rooms available, where infectious or immune-suppressed patients could be isolated.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The emergency department was designed in accordance with national guidance and was well laid out to allow for good circulation, access and good lines of sight. There was a designated ambulance entrance, which was a short distance from the ambulance parking bays and the helipad. This enabled easy access to the resuscitation and major treatment areas. There was a large u-shaped resuscitation area, which was well laid out to enable close observation of all patients. There were designated bays for the treatment of children, stroke and trauma. Within the department there was an imaging suite providing X-Ray, computerised tomography (CT) and ultrasound.

The waiting area for self-presenting patients was designed to enable good observation of patients in this area. There was a small play area, mainly provided for visiting children (who accompanied adult patients). Child patients remained in the waiting room until they had seen the triage nurse, at which stage they were directed to the secure, dedicated children’s waiting room, where there was audio and visual separation from adult areas.

Premises were well maintained and appropriately equipped. Equipment was well organised and easily accessible. Daily checks of emergency equipment were undertaken by the nurse in charge of each area. However, records showed these did not take place consistently.

Staff disposed of clinical waste safely. Waste, including sharps, was appropriately segregated and disposed of. There was a sluice for the disposal of clinical waste.

Patients, including those cared for in non-clinical areas of the emergency department, were provided with call bells so they could summon assistance from staff. We saw patients had these bells within their reach; we did not observe them in use.

There was a dedicated room for conducting assessments of patients with mental health conditions. This complied with national standards (Psychiatric Liaison Accreditation Network [PLAN]), developed by the Royal College of Psychiatrists. The room had two doors, which opened both ways and could not be locked from the inside. It was appropriately furnished, with furniture which could not be used as a blockade or a missile. The room had no ligature points and there was an alarm, which had been upgraded since our last visit to ensure it was flush with the wall and did not present a ligature risk. The assessment room was last inspected by PLAN in 2018 and staff told us the room was regarded as an exemplar.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Ambulance handover

Ambulance staff were able to swiftly hand over care of patients to staff in the emergency department.

We observed ambulance staff hand over patients to the accepting (streaming) nurse in the emergency department. This was mostly done promptly and efficiently, with only a few significant delays. The streaming nurse and supporting receptionist were able to see the details of incoming ambulance patients, which were conveyed electronically, and were often prepared for their arrival. This included pre-alerts of trauma and very unwell patients, who were transferred promptly to the resuscitation area or scanner. We saw paperwork and identity wristbands were
prepared and issued swiftly.

The integrated performance report presented to the trust board in June 2019 showed that 93.9% of ambulance-borne patients were handed over to emergency department staff within 15 minutes during May 2019 and 99% were handed over within 30 minutes. This was a slight improvement on April 2019, when 89.2% were handed over within 15 minutes and 98.2% were handed over within 30 minutes. There were no waits of one hour or more, known as a black breach, in May 2019, compared with 12 in April, which all occurred in one day.

**Number of black breaches for this trust**

A black breach occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From April 2018 to March 2019 the trust reported six black breaches. In April 2019 there were a further 12 black breaches, which all occurred on one day when the emergency department declared a critical incident due to a lack of physical space to offload patients in a timely manner (Integrated Performance Report to Board May 2019).

Reasons for black breaches from April 2018 to March 2019, reported by the trust, included higher than average ambulance attendances, patient flow through the emergency department and patient flow out of the department.

![Number of black breaches](image)

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

**Streaming and Initial assessment (triage)**

Patients were assessed promptly on arrival in the emergency department, in accordance with the Royal College of Emergency Medicine (RCEM) standard, which requires that all patients receive an initial assessment within 15 minutes of arrival in the emergency department. This ensured that staff were able to identify patients with serious or life-threatening conditions and prioritise them for treatment.

Patients arriving by ambulance were greeted by a streaming nurse, based in an area known as the Crossroads. There was also a receptionist based here, who booked the patient in and created a patient record. Streaming is a system, recognised by the Royal College of Emergency Medicine, to allocate patients to the correct location or person to manage their clinical needs. The streaming nurse was an experienced nurse, who took a handover from the ambulance crew and directed them to the most appropriate part of the department. This was sometimes a cubicle in the major treatment area. When the department was busy however, and there was limited or no capacity in the major treatment area, a discussion took place with the nurse and/or doctor in charge to identify patients, who had been seen and were assessed as stable, who could be
accommodated in the corridor, freeing up a cubicle space where the incoming patient could be assessed. If this was not possible, patients were accommodated in the corridor and staff were allocated to this area to care for them. If the patient was deemed as ‘fit to sit’ they were transferred to seating in the corridor in the crossroads area or to the ED Observation Unit (EDOU) to await triage. Triage included the completion of a set of observations, and the calculation of an early warning score.

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was better than the overall England median in nine months over the 12-month period from February 2018 to January 2019.

In February and March 2018, the median time to initial assessment at the trust was worse than the England average. In August 2018, the median time to initial assessment at the trust was the same as the England average.

In the most recent month, January 2019, the median time to initial assessment was six minutes compared to the England average of nine minutes.

**Ambulance – Time to initial assessment from February 2018 to January 2019 at North Bristol NHS Trust**

(Source: NHS Digital - A&E quality indicators)

Self-presenting patients were greeted by receptionists, who recorded demographic information and a brief outline of their complaint. Reception staff told us they had received no training or guidance on ‘red flag’ presentations, which required immediate assistance, as recommended by RCEM. However, between 9am and 9pm there was a streaming nurse based at the reception desk. Following registration, patients were seen briefly by the streaming nurse, who was able to direct patients to the most appropriate part of the department. For example, we saw a patient who had a fallen and had a potential head injury, was transferred promptly to the major treatment area. Patients then waited for triage. Nurses received specific in-house training in order to be competent to perform triage. They were able to request X-Rays and ECGs to help reduce waiting times.

**Ongoing monitoring of patient safety**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff monitored patients’ vital signs regularly to ensure their safety and to identify signs of deterioration. The emergency department used a safety checklist for all patients in the major treatment area and the ED Observation Unit. This was a time and sequence-based checklist of tasks, which was completed for all patients, from initial assessment through to discharge or transfer. Tasks included hourly observations of patients’ vital signs and the calculation of a national early warning score (NEWS) on arrival and on transfer to another department.

Staff shared key information to keep patients safe when handing over their care to others. A handover sheet formed part of the checklist to ensure that, on transfer, staff in receiving
departments were made aware of any risks. Monthly audits of safety checklists showed that early warning scores were recorded on admission in 100% of records audited over the last 12 months. There was no similar audit information for NEWS scores completed at handover.

There were safety prompts for time-critical investigations, for example ECG, CT and X-Ray and for time-critical treatments/protocols, for example stroke thrombolysis, 'sepsis six' and diabetic ketoacidosis. There was a clinical frailty scale and prompts for staff to identify triggers which might identify the risk of deterioration in this patient group. A 'silver triage protocol' had been developed to prompt staff to consider injury in patients over 65.

There were prompts to perform risk assessments in respect of mobility, skin integrity and continence and to identify risks associated with cognitive impairment, sensory loss and risk of falls. We looked at a sample of records and saw staff had identified risks and taken steps to manage them, such as the provision of air mattresses for patients at risk of developing pressure sores and using safety rails to prevent patients from falling.

Staff knew about and dealt with any specific risk issues.

Sepsis

Staff were familiar with and alert to the signs and symptoms of sepsis. Sepsis is a life-threatening condition caused by the body’s response to infection. There were sepsis prompts within the safety checklist to ensure the time-critical treatment pathway (sepsis six) was followed. Compliance with this was monitored as part of the monthly audit of safety checklists. In the last 12 months (June 2018 to May 2019), compliance with the sepsis six pathway ranged between 92% and 100%.

Fractured neck of femur

There was a treatment pathway for fractured neck of femur, embedded in the safety checklist. This prompted staff to complete time critical investigations and allowed compliance to be monitored. In the last 12 months (June 2018 to May 2019) monthly audit of safety checklists showed patients with a suspected fractured neck of femur were consistently X-Rayed within 60 minutes. Compliance with the treatment pathway ranged from 64% to 100%, with an improving trend.

Chest pain

Patients with chest pain were reviewed promptly and an ECG was performed without delay. The safety checklist prompted staff to follow the chest pain pathway and monthly audit of the checklists showed compliance was mostly at 100% for the last 12 months (June 2018 to May 2019).

Stroke

Staff were prompted by the safety checklist to ensure time-critical investigations for patients with a suspected stroke took place. Monthly audits of the safety checklist showed in the last 12 months (June 2018 to May 2019) compliance was mostly 100%. However, compliance with hourly neurological observations showed some room for improvement, ranging from 66% to 98%.

Mental Health

The service did not have consistent 24-hour access to mental health liaison and specialist mental health support if they were concerned about a patient’s mental health. There was a mental health risk assessment tool to assess the risk of harm to self and others. Patients were rated red, amber or green, according to their presentation, and this prompted staff to ensure the appropriate support was provided. Patients rated red and amber were prioritised for assessment by the mental health liaison team and staff told us this service was responsive during daytime hours. They told us the highest risk patients were accommodated in the major treatment area, close to the nurses’ station, so they could be easily observed. On occasions, registered mental health nurses or nursing assistants were employed to provide one to one support. After 9pm, patients were referred to the
intensive service, run by the local mental health service, who would only respond to patients who were assessed as high risk (rated red on the mental health matrix). There was access to an on-call doctor for psychiatry, but staff told us cover was variable, doctors covered two hospitals, and some were reluctant to attend the emergency department.

**Children**

The ambulance service did not convey sick or injured children to Southmead Hospital and there was no paediatric team on this site. However, the emergency department saw approximately 9,000 children per year, of which a small proportion were seriously unwell and required transfer to the city centre children’s hospital. There were good links with this hospital and a written protocol which provided guidance on the types of presentations which would require transfer, the suggested mode and urgency of transfer.

**Safety oversight of the emergency department and management of crowding**

Oversight of safety in the emergency department was the responsibility of the consultant/senior doctor in charge. The nurse in charge undertook a coordinating role 24 hours a day, seven days a week and was supported by senior nurses in each area of the department. They were also supported by a healthcare assistant, known as the ‘co-pilot’, who undertook a range of administrative duties, such as answering the telephone and liaising with wards and speciality teams regarding reviews and transfers. The co-pilot maintained an hour by hour escalation status, showing the number of patients in the department and how long they had been waiting. This information was constantly reviewed by the senior staff in the department. The nursing team was supported Monday to Friday by the matron and ward manager, who liaised with the nurse in charge and joined ‘quality rounding walkabouts’ two to three times a day.

During the day, when there were more senior medical staff on duty, the consultant in charge was based alongside the nurse in charge at the department’s ‘red base’ and these two staff worked closely to ensure oversight of activity and risk in the department and escalation to site management when the department’s capacity triggered the ‘Surge Protocol’. This document set out a series of actions to be taken by the trust’s site management and the wider hospital when the emergency department was under severe pressure.

**Emergency Department Survey 2016**

The trust scored better than other trusts for one of the five Emergency Department Survey questions relevant to safety. The trust scored about the same as other trusts for the remaining four questions. Questions are scored out of 10.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q33. In your opinion, how clean was the emergency department?  
9.4  
Better than other trusts

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?  
9.8  
About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Nurse staffing levels and skill mix were regularly reviewed against the emergency department’s attendance and acuity profile. Nurses told us they were mostly comfortable with staffing levels, but when the department was under extreme pressure they struggled. They told us they felt confident that patients were safe but felt guilty that they were not able to provide the quality of care they aspired to.

The emergency department was mostly staffed to planned levels, albeit with a large proportion of bank and agency staff deployed to cover recent shortfalls in the rota. This had been due to a spike in staff turnover and a number of staff on maternity leave. Turnover was monitored by senior staff. They told us some staff had undoubtedly left because of the relentless pressure in the department. The leadership team was acutely aware of the risk of ‘staff burnout’ and staff welfare was a very high priority.

Nurse staffing levels were discussed at the daily 8am ‘huddle’ (patient flow meeting) held in the emergency department and attended by representatives from the emergency department and the rest of the hospital. Further discussion took place at subsequent bed meetings throughout the day. Staffing levels were adjusted according to the actual and anticipated demand and additional staff were deployed from other parts of the hospital, as well as bank and agency staff. Bank and agency staff were mostly regular but there was a structured induction for all new staff to the department. There was also a standard operating procedure for the deployment of staff from other parts of the hospital. Staff told us that, although they appreciated support from the wards, this was not always forthcoming and sometimes it took some time to arrange.

Staff told us if they were concerned about staffing or skill mix they would report this to the nurse in charge, who provided support. They told us the nurses in charge worked hard to ensure all staff were able to take adequate breaks.

Although the ambulance service did not convey children to the emergency department, the service ensured there was a suitably skilled nursing workforce to provide care and treatment to sick or injured children. The service employed six registered children’s nurses. This did not ensure there were always two children’s nurses on duty, in accordance with national guidance Facing the Future: Standards for Children and Young People in Emergency Care Settings (RCPCH June 2018). The service had not formally assessed its position against this guidance or developed a plan to achieve the standard. However, the lead nurse was confident that the risks were mitigated by the provision of training for adult-trained nurses. All adult-trained nurses received an
introduction to paediatrics as part of their in-house induction, which included paediatric life support training, and there were regular paediatric update days. In addition, many nurses had acquired more advanced skills. Twenty-one nurses had completed a course in Minor Illness and Minor Injuries in Children and emergency nurse practitioners and nurse prescribers had completed paediatric training as part of their training for the role. This included training to ensure they were skilled and confident to care for children. Twelve staff had completed paediatric intermediate life support training and some staff had completed advanced paediatric life support (APLS) training, with five staff trained as APLS instructors. Twenty-six staff had completed the European Trauma course, with a further 10 booked to complete it in the following year. Two staff per year were supported to undertake the Principles of Emergency Care course each year.

Staff rotas took into account the skill set of staff to care for children and ensured there were always suitable trained staff on duty.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The emergency department was staffed in accordance with guidelines issued by the Royal College of Emergency Medicine. There was consultant presence 16 hours per day (8am until midnight), with staggered shifts to cover this period.

The service employed one consultant with an interest in paediatrics, with a second consultant with sub-specialty training in paediatric medicine about to join the team. It was planned they would work one day a week at the local children’s hospital to maintain their skills and further enhance links with the children’s hospital.

Night-time cover was provided by a registrar (ST4 or above) or middle grade doctor, supported by a consultant on call. There were some concerns voiced to us by staff that having only one senior decision-maker at night was often not sufficient, when demand for services was high. They told us if there were acutely unwell patients in the resuscitation area, the senior doctor spent most of their time in that area and other patients waited too long to be seen. During our inspection we saw the emergency department started the day with long waits to be seen because there had been insufficient capacity to see them overnight. From August the service was going to staff night times with an additional junior registrar (ST3).

We spoke with a registrar doctor. They told us nights were challenging but they felt well supported. They told us consultants often stayed later than midnight to ensure that the workload was manageable. They told us they would not hesitate to contact the consultant on call and told us they would always come in if asked.

Although the service did not see many seriously ill or injured children, doctors were suitably skilled to provide stabilising care and treatments before transferring children to the specialist children’s hospital in the city centre. A consultant in paediatric emergency medicine had recently been appointed and there were good links with and support from local children’s hospital.

**Medical Staffing skill mix**

As of December 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the 43 whole time equivalent staff working in urgent and emergency care

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>44%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>21%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Core service annual staffing metrics
(March 2018 to February 2019)

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency or locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff</td>
<td>246.8</td>
<td>7.5%</td>
<td>31.4%</td>
<td>4.7%</td>
<td>6,990.6 (3.3%)</td>
<td>9,537.5 (4.5%)</td>
<td>-182.5 (0%)</td>
</tr>
<tr>
<td>Registered nursing staff</td>
<td>122.0</td>
<td>9.8%</td>
<td>24.2%</td>
<td>5.2%</td>
<td>9,033.9 (10%)</td>
<td>0 (0%)</td>
<td>14,800.7 (16.4%)</td>
</tr>
<tr>
<td>Nursing assistants</td>
<td>78.2</td>
<td>13.8%</td>
<td>30.4%</td>
<td>6.5%</td>
<td>3,641.9 (4%)</td>
<td>0 (0%)</td>
<td>-1,158.5 (-1%)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>37.3</td>
<td>-13.2%</td>
<td>55.6%</td>
<td>1.1%</td>
<td></td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>4.3</td>
<td>15%</td>
<td>0%</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab; Vacancy tab; Sickness tab; Nursing bank agency tab; Medical agency locum tab)

Vacancy rates

The trust set a target of 5% for vacancy rate. From March 2018 to February 2019, the trust reported an overall vacancy rate of 7.5% in urgent and emergency care. This did not meet the trust’s target. Vacancy rates for nursing staff were 9.8% and for medical staff were -13.2%, which indicates an over establishment.
Monthly vacancy rates over the last 12 months for all staff showed a shift from September 2018 to February 2019.

Monthly vacancy rates over the last 12 months for registered nurses showed a shift from September 2018 to February 2019.

Monthly vacancy rates over the last 12 months for nursing assistants showed a shift from September 2018 to February 2019.
Monthly vacancy rates over the last 12 months for medical staff showed a shift from September 2018 to February 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

The trust set a target of 15.6% for turnover rate. From March 2018 to February 2019, the trust reported an overall vacancy rate of 31.4% in urgent and emergency care. This did not meet the trust’s target. Turnover rates for nursing staff were 24.2% and for medical staff were 55.6%.

Monthly turnover rates over the last 12 months for all staff showed a shift from September 2018 to February 2019.
Monthly turnover rates over the last 12 months for nursing assistants showed an upward trend from May 2018 to September 2018.

Monthly turnover rates over the last 12 months for medical staff had been relatively stable from March 2018 to February 2019 with only random variation over the whole period. There was a noticeable spike in July 2018 when turnover for medical staff was 45% compared to a median of 1%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

The trust set a target of 4.2% for sickness rate. From March 2018 to February 2019, the trust reported an overall sickness rate of 4.7% in urgent and emergency care. This did not meet the trust’s target. Sickness rates for nursing staff were 5.2% and medical staff were 1.1%.

Bank and agency staff usage

From March 2018 to February 2019 the trust reported 6,990.6 of the 211,378.7 available hours for registered nursing staff were filled by bank staff (3.3%) and 9,537.5 hours were filled by agency staff (4.5%) in urgent and emergency care.

Over the same period, the trust reported 9,033.9 of the 90,398.1 available hours for nursing assistants were filled by bank staff (10%). None of the nursing assistant hours were filled by
agency staff.
From March 2018 to February 2019 the trust reported 3,641.9 of the 90,137.4 available hours for medical staff were filled by bank staff (4%) in urgent and emergency care. None of the medical staff hours were filled by locum staff in urgent and emergency care.

Monthly bank hours over the last 12 months for all staff showed a shift from September 2018 to February 2019.

Monthly bank hours over the last 12 months for medical staff showed a shift from September 2018 to February 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab; Medical agency locum tab)

Records
Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Staff kept accurate records of patients’ care and treatment. Records were stored to maintain easy access for staff and although not entirely secure, were not readily accessible to unauthorised others. In the major treatment area, paper records were kept with patients in their cubicles. For patients accommodated in the corridor, records were kept in a notes trolley at the nurses’ station (crossroads). In the minor injury unit notes were stored in wall-mounted racks.

Records were clear, up-to-date and available to all staff providing care. There was an electronic records system. Administrative staff input or updated patients’ personal and demographic details.
Staff were alerted to previous attendances and additional information which may indicate that additional support may be required.

A consultant had undertaken an informatics transformation programme, which had entailed a review and upgrade of the electronic patient record so that it provided a platform for clinical decision making.

In addition to the electronic patient record, there was a paper-based safety checklist completed for all patients in the major treatment area. This was a time and sequence-based checklist of prompts to ensure that essential tasks were completed every hour from initial assessment to discharge or transfer. The checklist was scanned to form part of the electronic record when the patient was discharged or transferred.

Completion of the checklist was audited each month. A total of 300 records (10 per day) were scrutinised and compliance against a number of performance indicators was monitored and reported each month. Overall, completion rates were excellent and had significantly improved since our last inspection. In the last 12 months (June 2018 to May 2019) compliance had ranged from 92% to 98%, with the last two months scoring 98%.

We reviewed 10 patients’ records. We found they were legible, easy to follow and up-to-date.

**Medicines**

*The service used systems and processes to safely prescribe, administer, record and store medicines.*

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, medicines requiring disposal were not stored securely and opening dates were not always recorded on medicines which had a reduced shelf life once opened.

There were Patient Group Directions (PGDs) and these were up-to-date. PGDs are agreements which allow some registered and appropriately trained nurses to supply or administer certain medicines to a pre-defined group, without them having to see a doctor. There was a range of medicines under these directions. Records showed some were under review and we were assured these were not in force. Similarly, some staff had not signed certain PGDs to show that they had been assessed as competent to administer these medicines. Again, we were assured that nurses would not administer these medicines until the necessary sign off had been completed.

Staff stored and managed medicines and prescribing documents in line with the trust’s policy. Medicines were stored in locked cupboards or fridges. Controlled drugs were appropriately stored and suitable records were kept. However, medicines requiring disposal were not stored securely.

Opening dates were not always recorded when liquid medicines were opened, to ensure they were discarded within the required time range. We found there was no opening date recorded on a bottle of oral morphine and a bottle of ibuprofen suspension.

Daily and monthly checks were completed of the contents of resuscitation trollies, which included emergency medicines. However, it was unclear from the sealed tag whether the trolley had been tampered with. Grab bags did have tamper seals with a serial number so staff could check whether they had been tampered with.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
Decision-making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They told us they were encouraged to do so. Staff described incidents they had reported, the most common being non-hospital acquired pressure ulcers, violence and aggression and medicines incidents.

Staff reported all incidents they should report. Senior staff felt there was a good reporting culture and staff understood their responsibility to report concerns.

Managers investigated incidents thoroughly. Patients and families were involved in these investigations, where appropriate. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We reviewed the investigation of an unexpected death in the emergency department in March 2018. A root cause analysis was completed, and the findings were shared with family members, who were invited to meet with clinicians and to ask any questions about their relative’s care and treatment.

Staff told us they received feedback following incidents and lessons were shared with the wider team. Incidents, learning and any relevant safety alerts were, for example, discussed at daily safety briefings, clinical governance meetings and reported in a monthly newsletter.

In the case of the unexpected death referred to above, although the findings of the investigation did not find omissions or poor practice which contributed to the patient’s death, the findings were shared with staff at clinical governance meetings and at safety briefings because the case was rare and there was some learning.

Managers debriefed and supported staff after any serious incident. Some staff had received individual feedback and support following incidents and they saw this as a positive experience.

The service had a good track record for safety.

**Never Events**

The service reported no never events. Never events are patient safety incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by healthcare providers.

From March 2018 to February 2019, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

Staff knew how to report serious incidents in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents in urgent and emergency care which met the reporting criteria set by NHS England from March 2018 to February 2019.

*(Source: Strategic Executive Information System (STEIS))"
Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance, which was displayed in the emergency department.

The safety thermometer data showed the service achieved 100% harm-free care for the last 12 months. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but departments can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the patient safety thermometer showed the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from February 2018 to February 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high-quality care, according to best practice and national guidance.

All staff in the emergency department had access to clinical policies and protocols via the department’s intranet. These were comprehensive and up to date. Staff told us guidance was easy to find.

There was regular audit to monitor compliance with best practice. The newly-developed and evolving electronic patient records system was an effective tool for prompting staff and data could be extracted for audit purposes. The emergency department regularly reported on its performance against key indicators for different conditions, for example chest pain, stroke and fractured neck of femur.

Staff protected the rights of patients who were subject to the Mental Health Act and followed the Code of Practice. They received annual training which covered the requirements of the Act and demonstrated a good understanding of this legislation. They were supported, where necessary, by the mental health liaison team in its application.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a handover meeting and heard staff discussing the psychological needs of several patients and the emotional needs of a patient who had recently suffered a bereavement.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

We spoke with patients and observed their care. Patients told us they were regularly offered food and drink. We saw housekeeping staff, nurses and volunteers offering and providing food and drink to patients. They recorded this on the safety checklist. Housekeeping and volunteer staff were aware of patients who were ‘nil by mouth’.

Monthly audits of the safety checklist showed that staff offered food and drink to patients within two hours of admission most of the time. From June 2018 to May 2019, the department scored above 80% compliance with this standard in all but one month (February 2019), when performance fell to 76%. We saw that some patients were served hot drinks in plastic beakers, to avoid spillage. A housekeeper told us they were alerted to patients who may need support. For example, patients living with dementia, who may not be aware that a drink was hot, so they were supervised and supported by staff.

Staff told us they completed fluid and nutrition charts where a risk of dehydration or malnutrition was identified.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored eight out of 10 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was better than other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. The emergency department had adapted this tool to include a visual aid for patients with communication difficulties. There were questions within the electronic records system which prompted staff to ask about pain.

We heard staff ask patients about their pain and patients confirmed this happened regularly and they had been offered pain relief without delay. Staff used pictorial aids to help assess pain in children or patients with communication difficulties. Pain was recorded on the safety checklist, which formed part of the patient record. We looked at 10 patients’ records and saw staff had assessed pain regularly, recorded a pain score (from zero to 10) and detailed any pain relief administered.

Patients received pain relief soon after it was identified they needed it, or they requested it.

A monthly audit of the safety checklist (300 records) showed that pain assessment at triage and reassessment within one hour took place consistently. The audit also monitored whether patients received pain relief at triage. This was mostly done well; there had been a downward trend in
January and February 2019 (76% and 51% respectively), but this had recovered in subsequent months.

The service regularly monitored its treatment of fractured neck of femur (broken hip). This is a very painful condition and it is recommended that pain relief is administered in 20 minutes. Performance had been variable; pain scores were consistently recorded at triage, but some delays had occurred in the provision of pain relief within 20 minutes.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.1 out of 10 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was better than other trusts.

The trust scored 8.4 out of 10 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was better than other trusts.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national audits so that it could benchmark its performance and use the results to improve services further.

Managers shared and made sure staff understood information from audits. Audits were discussed at clinical governance meetings and learning shared at staff teaching, staff briefings and via the staff newsletter.

The service mostly performed in line with other similar services in national clinical audits. Areas for improvement were identified and action plans were developed to ensure learning was put into practice.

Improvement was checked and monitored. Re-audits were carried out to assess the effectiveness of remedial actions.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- **Standard 4 (fundamental):** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 87.9%; UK: 77%.

The department was in the lower UK quartile for two standards:

- **Standard 3 (fundamental):** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 6.0%; UK: 25%.
- **Standard 9 (fundamental):** Discharged patients should have oral prednisolone prescribed according to guidelines. This department: 20.0%; UK: 52%.

The department’s results for the remaining standards were all within the middle 50% of results.

- **Standard 1a (fundamental):** O2 should be given on arrival to maintain sats 94-98%. This department: 22.0%; UK: 19%.
- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and
recorded on arrival at the emergency department. This department: 36.0%; UK: 26%.

- Standard 5a (fundamental): If not already given before arrival to the emergency department, steroids should be given within 60 minutes of arrival (acute severe). This department: 20.0%; UK: 19%.

- Standard 5b (fundamental): If not already given before arrival to the emergency department, steroids should be given within 4 hours (moderate). This department: 32.0%; UK: 28%.

(Source: Royal College of Emergency Medicine)

The action plan developed in response to these findings included the development of an asthma management sheet and an asthma discharge sheet. Asthma boxes were introduced into the emergency department, containing peak flow meters. A re-audit took place in January 2018 and results showed little change. There was continuing face-to-face education and documentation had been amended to include peak flow readings. There were plans to audit again in 2019.

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, the emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 22.9%; UK: 11%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 44.4%; UK: 10%.

The department was in the lower UK quartile for one standard:

- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 3.3%; UK: 12%.

The department’s result for the remaining standard was within the middle 50% of results:

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 20.0%; UK: 8%.

(Source: Royal College of Emergency Medicine)

The action plan developed in response to these audit results showed that the findings were shared at junior doctors’ induction and discussed at a clinical governance meeting. RCEM standards now appeared in the electronic patient records system as alerts or prompts to ensure consultant review.

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, the emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for three standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 98.0%; UK: 69.1%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 66.0%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one
hour of arrival. This department: 61.5%; UK: 43.2%.

The department’s results for the remaining five standards were all within the middle 50% of results.

- **Standard 2**: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 60.0%; UK: 64.6%.

- **Standard 3**: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 50.0%; UK: 30.4%.

- **Standard 4**: Serum lactate measured within one hour of arrival. This department: 62.0%; UK: 60.0%.

- **Standard 7**: Antibiotics administered: Within one hour of arrival. This department: 54.0%; UK: 44.4%.

- **Standard 8**: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 18.0%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

The actions taken in response to this audit focussed on the development of alerts or prompts in the electronic patient record system. The emergency department audited its management of sepsis on an ongoing basis, through monthly audits of the safety checklist and as part of the commissioning for quality and innovation monitoring system, which makes a proportion of a trust’s income conditional on demonstration on demonstrating improvements in quality and innovation in specified areas of patient care. Each month 50 patients with confirmed sepsis who were admitted through the emergency department were selected at random.

Results are shown in the table below:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A. Screened</td>
<td>150 (100%)</td>
<td>150 (100%)</td>
<td>34 (100%)</td>
</tr>
<tr>
<td>Part B. Antibiotics within the hour</td>
<td>131 (88%)</td>
<td>140 (93%)</td>
<td>33 (97%)</td>
</tr>
</tbody>
</table>

Trauma Audit and Research Network (TARN)

The table below summarises Southmead Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Ascertainment (Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</td>
<td>100%</td>
<td>Good</td>
<td>✓</td>
</tr>
<tr>
<td>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</td>
<td>14 minutes</td>
<td>Takes less time than the TARN</td>
<td>✓</td>
</tr>
</tbody>
</table>

64
(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)

| Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury | aggregate |
| Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding | 88.9% | Higher than the TARN aggregate | N/A |

| Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care | aggregate |
| Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists. | 48.0% | Higher than the TARN aggregate | ✗ |

| Risk-adjusted in-hospital survival rate following injury | aggregate |
| This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix. | 0.7 additional survivors | Similar to expected | ✓ |

(Source: TARN)

Unplanned re-attendance rate within seven days

From February 2018 to January 2019, the trust’s unplanned re-attendance rate to A&E within seven days was about the same as the national standard of 5% and better than the England average.

The trust’s performance peaked in April 2018, when the trust had a rate of 4.7% compared to an England average of 7.1%.

Unplanned re-attendance rate within seven days - North Bristol NHS Trust

(Source: NHS Digital - A&E quality indicators)

Managers carried out a comprehensive audit programme.
There was a continuing programme of audit to monitor compliance with best practice. The newly-developed and evolving electronic patient records system was an effective tool for prompting staff to follow best practice guidelines, and data could be extracted for audit purposes. The emergency department regularly reported on its performance against key indicators for different conditions, for example chest pain, stroke and fractured neck of femur, and mostly performed well. Results were discussed at clinical governance meetings and learning shared in the monthly newsletter. For example, there had been a recent concern about failure to record hourly neurological observations for stroke and head injury patients. In the March 2019 edition of the clinical newsletter there was a reminder to staff to complete these.

Similarly, audit of safety checklists had shown that patients with a fractured neck of femur were not always given pain relief within 20 minutes. A reminder was documented in the March 2019 newsletter.

The service had recently participated in 2018/19 RCEM audits, including Vital Signs in Adults. We saw learning points were discussed at the clinical governance meeting in April 2019.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction, tailored to their role before they started work.

There was an excellent comprehensive and structured induction for nurses, which included classroom training, self-directed learning and working supernumerary for two weeks, alongside a mentor. Nursing staff were very appreciative of the support they had received, no matter what previous experience they had. There was a week-long induction to support nurses to work in the resuscitation area. This was scheduled to take place approximately six weeks after starting work in the department. There was a programme of self-directed learning, with a guide and a checklist of tasks to complete during the week. This ran alongside a formal teaching session. Staff were expected to meet with a member of the training team to discuss their learning at the end of this process.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

There was a structured approach to continuous learning and acquiring further skills and competencies for nurses. There was a clear progression pathway for nurses, “Novice to Expert”, which set out a year by year programme for band five nurses to progress to band six and beyond. Nurses wore different coloured lanyards to identify what level of skills and competencies they had acquired. Staff told us this helped to ensure they worked at the level they were comfortable with and were not asked to perform tasks outside of their level of skills and experience.

Equally, staff were expected to progress and acquire new competencies and they were encouraged and supported to do so. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. They were supported by an allocated supervisor/mentor.

There were enough clinical educators to support staff learning and development.
There was a team of five nurse educators, who organised and led formal and informal teaching throughout the year. Each member of the team had an interest and supported different staff groups. Training courses were publicised in the clinical newsletter and staff told us there were many opportunities for them to progress and to develop personally and professionally. Many nursing staff told us the quality of the training and support they received was one of the main reasons they chose to work and remain working in the department. There were regular opportunities to undertake external training in advanced skills. These included an emergency nurse practitioner course and advanced life support training. A number of nursing assistants had been supported to study to become assistant practitioners.

There were training ‘themes of the week’ where nurse educators would carry out targeted training on the shop floor and post information around the department. During our inspection the theme of the week was Deprivation of Liberty Safeguards.

Staff were given opportunities to explore their interests and become champions in certain fields. Link nurses were employed in, for example, infection control, palliative and end of life care, bereavement and learning disability. A nursing assistant told us they had been encouraged and supported to take on some additional roles within the department. This included becoming a scribe during trauma episodes and supporting colleagues in this role. They were also given a shift per week to review and improve the environment for children who attended the emergency department, linking with a play therapist at the city centre children’s hospital and overseeing the provision of toys and activities for children.

Junior medical staff felt supported to undertake their roles with confidence and competence. There was a comprehensive induction and there was ongoing teaching, both structured and ad-hoc, throughout their placements. They were given weekly protected time for structured teaching and they told us this was “invaluable” and “brilliant”. During the day, when consultant presence was greater, there were numerous opportunities for ‘on the job training’ and this was equally valued. All trainee doctors were allocated an educational supervisor who supported them to develop their portfolio of skills. One doctor told us about the support they had received to develop their managerial skills; they had been supported to run the ‘shop floor’ and to attend managerial courses. Trainees regularly presented cases to their peers and seniors. This included presenting a case to a panel in an interview scenario, in order to practice and develop their interview skills.

There was regular multi-disciplinary training for doctors and nurses, including simulation training for certain scenarios.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work.

From April 2018 to March 2019, 88.4% of required staff in urgent and emergency care received an appraisal, compared to a trust target of 90%.

The breakdown by staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Allied health professional staff</td>
<td>3</td>
</tr>
<tr>
<td>Medical staff</td>
<td>22</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>60</td>
</tr>
</tbody>
</table>
Managers recruited, trained and supported volunteers to support patients in the service. There were volunteers employed in the emergency department, all of whom had received comprehensive training and were aware of their role and the limitations of it in relation to patient care.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They mostly supported each other to provide good care.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a morning handover/ward round attended by doctors, senior nurses and staff from other health care disciplines, including the mental health liaison team and alcohol advisors.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff reported a cooperative and responsive service during working hours, although there were difficulties out of hours (see the responsive section of this report). There were good links with the hospital’s learning disabilities team.

There were cooperative and collaborative working relationships with the Complex Assessment Liaison Service. This team, staffed by consultant physicians, advanced nurse practitioners, occupational therapists and physiotherapists, supported the emergency department by identifying patients for whom they could develop a treatment and rehabilitation plan to avoid admission or shorten their length of stay.

Medical staff reported good working relationships with some specialties, but others were not considered to be responsive when patients in the emergency department required specialist review. There were internal professional standards to ensure swift review of specialty patients in the emergency department, but compliance was not routinely monitored.

**Seven-day services**

**Most key services were available seven days a week to support timely patient care.**

Staff could staff access support from diagnostic services, 24 hours a day, seven days a week.

There were concerns about the level of support available for patients with mental health problems overnight and at weekends.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service promoted healthy lifestyles and signposted patients to sources of support, for example substance and alcohol abuse and smoking. There were information leaflets available in the reception waiting area.

The emergency department’s lead nurse took part in road safety campaigns with local fire and police services. They also delivered educational talks to local women’s’ institute groups.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There were prompts within the safety checklist and the electronic records system which ensured staff considered and recorded information about patients’ capacity to understand information given to them and their ability to make decisions about treatment. Nurses deferred to doctors for formal assessment of capacity. There were prompts within the electronic patient records system and a trust-wide mental capacity checklist, which was used as a tool to ensure appropriate use of the Mental Capacity Act and as a record of the decision-making process in relation to capacity.

When patients could not give consent, staff made decisions in their best interests, taking into account patients’ wishes, culture and traditions. Medical staff could describe how they would manage and record these situations.

Staff made sure patients consented to treatment based on all the information available. Many tests and interventions carried out in the emergency department required only implied or informal consent. We heard staff explaining what they were planning to do and why and seeking patients’ verbal consent.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The Gillick test allows staff to assess whether children under 16 have sufficient capacity and intelligence to fully understand what is involved in relation to proposed treatment. Fraser guidelines relate to contraceptive advice or treatment.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff received training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

As at April 2019, the trust reported that Mental Capacity Act and DoLS training was completed by 83.7% of all staff in urgent and emergency care.

A breakdown of compliance for Mental Capacity Act and DoLS training as at April 2019 for registered nursing and medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>36</td>
<td>39</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>103</td>
<td>127</td>
<td>81.1%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care met the trust target of 85% with a completion rate of 92.3%.

Registered nurses in urgent and emergency care did not meet the trust target of 85% with a completion rate of 81.1%.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and sensitive to patients’ privacy and dignity and took practical steps to maintain this. They followed policy to keep patient care and treatment confidential. They used curtains and screens when holding private conversations and during care and treatment. They spoke quietly when necessary to ensure confidentiality was maintained.

We observed staff interacting with patients and we spoke with patients and relatives. Staff were respectful and considerate of patients’ needs and wishes. They took time to interact with patients and to build a rapport with them. We saw a healthcare assistant supporting an elderly patient, who was reminiscing about their past. The staff member was engaged and interested.

Staff were at all times polite and respectful. They greeted people with a smile and always introduced themselves by name and described their role. They adjusted their communication style and tone appropriately and according to the situation. Staff used non-verbal gestures to provide comfort and reassurance.

We saw volunteers supporting patients. Employed by the trust’s pastoral care team, they had all been trained in listening skills. They told us they spent as much time as patients or relatives needed, providing an ear or just talking to distract or comfort patients. A volunteer told us when they entered a patient’s cubicle it was like entering someone’s front door – they respected it was a private space and they sought permission to enter. They told us patients often asked them things they felt they couldn’t ask the staff, for fear of being a nuisance. For example, a patient needed to charge their phone and didn’t have a charger. The volunteer was able to find one to help them.

We saw and heard about numerous examples of care where staff had ‘gone the extra mile’:

- We observed a receptionist supporting an elderly relative who was trying to locate a family member, who was attending another department. They spent some time trying to locate the patient on the electronic patient records system and eventually they were able to direct them to the right department. Shortly after the relative had gone, they saw a ‘move maker’ (trust volunteers who help visitors find their way around the hospital) in the department and explained they were not confident they would find their way. The move maker chased after the lady, caught up with her, and was able to escort her to her destination.

- A staff member had recently been nominated for a Positive Incident Management System (PIMS) recognition by a colleague, who wrote:

  - “H went above and beyond to care for an elderly couple. She walked them to the multi-storey carpark to make sure they got there safely.”

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They showed a non-judgemental attitude when caring for or discussing patients with mental health needs, including patients who were frequent attenders to the emergency department. We spoke with a patient who had attended the emergency department 12 times due to ongoing mental health problems. They told us the staff were always caring and understanding. They told us they often felt guilty and thought they were wasting staff’s time, but staff convinced them otherwise and told them they were always there for them.
We observed a patient with mental health problems being verbally loud and aggressive because they wanted to leave the department to have a cigarette. A nurse immediately responded to them in a calm, polite and respectful manner and explained where they could go to have their cigarette.

We spoke with a nurse who was caring for a patient who had attended the emergency department over 100 times in the last year. They described this patients’ complex mental health and social issues in a caring, non-judgemental and empathetic way.

We saw staff act with great compassion and sensitivity towards two refugees who were also victims of domestic violence and were very frightened and vulnerable. The two family members, although not seriously injured, were accommodated together in a side room because staff were sensitive to their social circumstances.

Staff were passionate about providing the best possible care. There were many examples where staff had undertaken fundraising events in their own time to provide things that would make a difference to patients’ experience - in end of life, bereavement, for patients living with dementia and autism, and children.

Patients said staff treated them well and with kindness.

**Friends and Family Test performance**

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. This was consistent with the positive feedback we received during our inspection. All the patients and relatives we spoke with told us they had been well cared for. One patient told us “The nurse who has looked after me has been wonderful. She has been gentle and reassuring and has really listened to me.”

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than or similar to the England average in eight out of 12 months from February 2018 to January 2019.

There was improvement in the trust's performance against this metric from August 2018 to January 2019 when performance was better than the England average. The trust’s performance peaked in October 2018 at 91.5% compared to the England average of 87.1%. Performance then dipped but recovered in December 2018.

In the most recent month, January 2019, the trust performance was 89.6% compared to the England average of 86.0%.

**A&E Friends and Family Test performance - North Bristol NHS Trust**

(Source: Friends and Family Test – NHS England)
Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help and emotional support when they needed it. They understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We heard them enquire about patients’ social and family support systems. We heard doctors and nurses explaining things to patients and relatives in a way they could understand and giving them time to ask questions.

We heard a doctor delivering some bad news to a patient and their family members. This was done with great sensitivity and the doctor acknowledged that they understood how hard the news was for them to take in. They offered to return and speak with them again after they had had time to reflect on the news.

We saw staff offer comforting gestures to patients and relatives who were distressed, by holding their hand, or rubbing their arm.

Staff supported dying patients with compassion and dignity and supported relatives and loved ones during this time and in their bereavement. The service had adopted the trust’s ‘purple butterfly’ logo and ethos to provide personalised end of life care to patients and support to their loved ones. Staff used laminated purple butterfly signs to alert others of patients and relatives who needed an appropriate quiet space and support. There was a resource trolley kept in the major treatment area. The emergency department had raised money to purchase a syringe driver so that there was no delay in providing pain relief required by patients at the end of their lives.

There were similarly resources available to support bereaved relatives. There was a bereavement team of three staff who championed this area of work and supported their colleagues. There were bereavement packs, which staff went through with bereaved relatives and they offered to contact them by telephone to see how they were doing and if they had any questions about their loved one’s care, treatment and death. The department sent a card to relatives on the anniversary of the deceased patient’s death.

There were memory boxes to be given to children who lost someone in the emergency department.

A staff member was recognised by a nurse colleague for providing excellent care. They wrote:

“Care for the dying patient was inspirationally good. J was involved in the medical treatment, then stayed with the patient and their family in resus throughout the patient’s end of life care. Nothing heroic or technical about the treatment given, just real genuine care for family.”

Another staff member wrote about a doctor colleague:

“A death is very hard for a family to accept when it is very fast but a death in the emergency department is so much harder for them. N comforted the family in a magnificent way, was very calming and explained what had happened to their loved one with so much compassion”.

We heard about a nurse who supported a family of a seriously injured young person and continued to support them when they spent time on the intensive care unit.

Staff were nominated by their colleagues for a PIMS recognition, saying:

“They recognised the mental health needs of the patient who had a recent loss and a chronic ailment. They asked for resources and provided excellent signposting. Demonstrating parity of esteem in the fullest. Another quality example of holistic care from the ED team”.
“C took time out of her busy shift to sit with a dementia patient. She wasn’t asked to do this but sat with them for a length of time and got the patient involved in folding bags.”

The service had received many cards and letters of thanks from grateful patients and relatives. Sixty-one positive messages had been recorded in the six months from January to June 2019 and had been shared with staff. Comments included:

“X’s one wish was to write to you all and thank you for your outstanding care, compassion and kindness.”

“I just wanted to say the nurse was wonderful in her skill and attitude, her cheerful and smiling disposition and her reassurance.”

**Understanding and involvement of patients and those close to them**

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Patients and relatives told us doctors and nurses had explained what was happening to them and discussed their plan of care and treatment. They told us this had been explained in a way they could understand, and they had been able to ask questions. Staff used communication aids where necessary to aid understanding.

**Emergency Department Survey 2016**

Feedback from the Emergency Department Survey was positive. The trust scored better than other trusts for 10 of the 24 questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 14 questions. Questions are scored out of 10.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>5.0</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>9.0</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren’t there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.6</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>8.0</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.7</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>7.1</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.9</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>8.2</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q45. Overall experience</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that did not always meet the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Facilities and premises were not wholly appropriate for the services being delivered. Demand for services frequently outstripped the availability of appropriate clinical spaces to assess and treat patients. This meant the major treatment area frequently became crowded and patients had to be accommodated in the corridor.

Patients arriving by ambulance were taken to the major treatment area, where they were assessed and directed to the most appropriate cubicle space. When the department was busy some patients were accommodated in the corridor. This was a regular occurrence and had become normal...
practice, in the sense that it was anticipated and planned for. Corridor spaces were numbered so that staff did not lose track of patients and where they were located. Some curtained spaces had been made available and elsewhere, temporary mobile screens were used to preserve people’s dignity within the confines of a corridor. Nevertheless, this was not a dignified or comfortable experience for patients. Staff agreed; although this was an everyday occurrence, staff did not view it as an acceptable practice and some spoke with shame about what they perceived to be letting patients down.

Staff worked together to try to identify the most suitable patients for the corridor. These were patients who had been assessed and were stable, but waiting for a hospital bed. They were moved to the corridor to free up cubicles for incoming patients. This was known as ‘reverse queuing’. At busy times, this was not always possible, and patients were accommodated in the corridor and assessed there.

The major treatment area had six cubicles, which had been designed with input from experts, to provide a ‘dementia-friendly’ environment. They had been wallpapered and decorated with old style photographs and large-face clocks to help people orientate themselves. There were plans to decorate all cubicles in this way, using charitable funds. There were side rooms, which were frequently used to accommodate patients who were distressed.

The emergency department was well signposted externally and internally. There was a carpark close by, although some relatives told us they had struggled to find a parking space. There was a drop-off zone where visitors arriving by car could park for 20 minutes while they accompanied patients to the emergency department reception. From the main hospital, patients and visitors on foot were directed by clear internal signage. There were often volunteers available to help direct them.

The waiting area for self-presenting patients was accessible, spacious and well equipped. During our inspection there was adequate seating for patients and visitors. However, staff told us the waiting area was sometimes so crowded that there was insufficient seating and some people had to stand. There was a small play area for children who accompanied adult patients and a separate, secure waiting area for children, which was thoughtfully decorated and equipped and provided a welcoming environment for children. There were plans to provide a sensory space. There were also child-friendly treatment cubicles.

The waiting room was equipped with Wi-Fi, a TV and some reading material. There was also a portable TV, which was preloaded with films and music and could be used to help distract people who were anxious or agitated. Patients had access to drinking water and other drinks and snacks were available in vending machines. There were toilets and nappy changing facilities available. Signage was clear and there was information displayed which explained the various pathways through the emergency department and what people could expect.

Patients could discuss their condition in private. There were signs requesting patients and visitors to stand behind a line on the floor, to prevent them overhearing others’ private conversations. Staff told us patients who were reluctant to discuss intimate details would be invited to speak in a side room. Support was available to patients and visitors whose first language was not English. There was an interpreter service in the hospital or alternatively they could call on some foreign language speakers employed in the emergency department.

There was a sensitively decorated and well-furnished relatives’ room to accommodate anxious and distressed visitors in a quiet and calm space away from the busy department. There were facilities where they could make drinks or prepare food. There was a viewing room, accessed by
an adjoining door, where bereaved relatives could spend time with loved ones who had passed away in the emergency department.

The ED observation unit was adjacent to the emergency department. This consisted of 16 cubicle spaces with reclining chairs and three side rooms, although one was currently being used as a primary care consulting room. There was no physical gender separation, although staff told us they tried to place male and female patients in cohorts where possible. There was one toilet and no bathroom facilities, which was not sufficient to meet the hygiene needs of 18 patients. We had raised this at our two previous inspections, but no improvements had been made, although staff told us a business case for improvement work was pending.

**Meeting people’s individual needs**

The service was mostly inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers but providers of mental health services out of hours were not responsive.

Patients who attended the emergency department in mental health crisis out of hours waited too long to be assessed by a mental health practitioner.

At our last inspection we reported on the outstanding work the emergency department had undertaken to support people with complex needs or those in vulnerable circumstances, for example people living with dementia, a learning disability or those experiencing a mental health crisis. This excellent work had continued; however, we had continuing concerns that patients who presented to the emergency department out of hours with a mental health problem did not receive timely support from mental health practitioners. We had raised this at our last inspection. There was limited understanding and application of the policy which requires services to meet the communication and information needs of patients with a disability or sensory loss or patients whose first language was not English.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

**Dementia**

Staff we spoke with were very knowledgeable about the needs of patients living with dementia and how they could support them. All staff, including housekeepers and porters, had received specific training to support this patient group and many staff had completed the Alzheimer’s Society Dementia Friends Campaign learning to become ‘dementia friends’.

Staff used forget-me-not stickers on patients’ records and on their wristbands to identify those patients who may need extra support. The forget-me-not symbol is a widely recognised symbol used to identify people living with dementia. Staff told us volunteers in the department often sat with patients to provide reassurance and distraction.

The emergency department had 30 dementia champions and they had developed numerous resources which staff were encouraged to use to support people living with dementia. These were stored in a ‘dementia trolley’, located in the major treatment area and included:

- ‘This is me’ booklets - produced by the Alzheimer’s Society, this booklet is designed to assist staff to assess patients’ needs and provide person-centred care to people living with dementia, those experiencing confusion, delirium or other communication difficulties.

- Leaflets entitled “What can I expect from the Emergency Department if I have Dementia?” explained in simplified language what steps the staff would take to support them.
- ‘Twiddlemuffs’ – a form of distraction therapy. These are knitted gloves which are used to reduce restlessness and agitation, often experienced by people living with dementia.
- A reminiscence computer – this provided distraction for agitated patients through music, activities and films.
- A range of word search puzzles and colouring books used to distract patients.

**Learning disability and autism**

The emergency department had developed resources to support people with a learning disability and those with autism. This included ‘This is me’ booklets as described above.

Patients with autism or a learning disability who may have required distraction from the emergency department environment were offered ‘bags of calm’. They contained sensory objects and ear defenders to help calm and distract patients. We saw a prominent poster at the reception desk publicising this resource and encouraging people to request it. There were also alerts on the electronic patient records system for patients who had attended the department before and who may benefit from additional support.

There was a link nurse for learning disability in the emergency department and she had recently promoted the use of the bags and other reasonable adjustments in the monthly clinical newsletter. Reasonable adjustments included identifying a quiet space to wait, prioritising patients to be seen sooner, adapting communication (there was a pictorial communication booklet), involving carers and contacting the trust’s learning disability liaison team for advice and support.

**Mental health**

There was a mental health liaison team which operated from 7.30am to 9pm, seven days a week. They aimed to respond to urgent referrals from the emergency department to assess patients with mental health needs within one hour and staff told us this was a responsive service. The service was highly regarded and supported ED staff with training, feedback and reflective practice on the management of mental health conditions and behaviours.

Outside of these hours, staff could refer patients to the community-based intensive service, who would only respond to patients who had been assessed as high risk, using the agreed mental health risk assessment matrix, and patients in the community were prioritised. There was a trainee doctor in psychiatry, who was on call for two hospitals. Staff told us there were frequent gaps in the rota and locums were of variable quality. Overall, the service overnight was considered to be inadequate and risky (this was on the emergency department’s risk register) and senior staff described this as a two-tier service. Patients mostly waited overnight in the emergency department or the observation unit for assessment. Neither were suitable environments for patients who were experiencing a mental health crisis. The lack of a responsive service overnight also created more problems for the mental health liaison team who picked up the referrals the following morning. Some patients had become more agitated overnight and they were more likely to abscond. Staff in the mental health liaison team told us that at least one patient per week left overnight without being seen. During our inspection there were a number of patients who had spent the night in the emergency department, awaiting assessment. They were resource intensive, requiring high levels of staff attention and supervision and were becoming increasingly agitated. The mental health liaison team had received approximately 15 complaints from patients over the last 12 months about long waits overnight.

Children and young people under the age of 16 who presented with mental health problems were transferred to the children’s hospital in Bristol (there was an agreement in place to support this). Young people aged 16 and 17 were referred to the child and adolescent mental health service, run
by another provider. Out of hours there was no service and young people had to be admitted to the acute medical unit or remain in ED. It was reported that a young person had spent 50 hours in ED the week before our inspection.

The service had been working with partners to secure a 24-hour service and had presented a case for funding to commissioners.

The service had developed care plans for patients who were frequent attenders to the emergency department, in accordance with guidance issued by the Royal College of Emergency Medicine. There were monthly multidisciplinary meetings to discuss all patients who attended the department more than three times in a month. A management plan was agreed and shared with the patient’s GP. There were alerts on the electronic patient records system so staff could immediately see if such a plan was in place.

**Accessible Information**

The service had not assessed itself against the standard which requires providers to identify and meet the needs of patients with a sensory loss. There was a range of good quality information for patients and their carers about medical conditions and injuries. This was not available in alternative formats, such as braille, and staff were unsure if they could arrange this on request.

There were interpreter services available in the trust and staff knew how to contact them. However, written information such as the leaflets referred to above were not available in other languages and staff did not know how to obtain translations. We raised this with the lead nurse, who acknowledged this was a gap and committed to investigate it.

**Food and drink**

Patients were given a choice of food and drink to meet their cultural and religious preferences.

We spoke with housekeeping staff who told us there was a variety of food and drink available to meet patients’ specific dietary needs, for example halal, gluten free and lactose and dairy free.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain. Questions are scored out of 10.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times for treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times to make sure patients could access services when needed and receive treatment within agreed timeframes and national targets. However, the trust was consistently failing to meet national standards in relation to the time patients spent in the
emergency department, the time they waited for their treatment to begin and the time they waited for transfer to an inpatient bed. This was in the context of a department which had seen a significant increase in attendances in the last year. In the Integrated Performance Report to the board in June 2019, it was reported that May 2019 had seen the emergency department’s highest monthly attendance rate ever. The report highlighted that bed occupancy in the hospital had increased and resulted in long waits for beds, and a crowded emergency department. On the morning of the first day of our inspection, the emergency department was struggling to meet demand after the previous day’s record daily attendance of 340 patients.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard over the 12-month period from February 2018 to January 2019. Over the same period, performance against this standard was worse than the England average. During our inspection we saw patients regularly waited in excess of six hours to be seen.

From February 2018 to January 2019 performance against this standard was over 90 minutes in all 12 months. Over the same time, performance against this standard ranged from 91 minutes (March 2018) to 132 minutes (July 2018).

In the most recent month, January 2019, the median time to treatment was 106 minutes compared to the England average of 63 minutes.

**Median time from arrival to treatment from February 2018 to January 2019 at North Bristol NHS Trust**

![Graph showing median time from arrival to treatment from February 2018 to January 2019 at North Bristol NHS Trust.](Source: NHS Digital - A&E quality indicators)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From March 2018 to January 2019 the trust failed to meet the standard and performed worse than the England average. Over the same period, performance against this metric showed a similar pattern to the England average. The year-end position for 2018/19 was 79.8%, which represented a slight improvement, compared with the 2017/18 annual performance of 77.1%.

In the most recent period (February to May 2019) the trust’s performance was as follows:

- February: 70%
- March: 74.1%
- April 2019: 69.7%
- May 2019: 76.2%
There was constant real-time monitoring of performance against this standard and it was reviewed at regular site meetings throughout the day. It was reported daily and a breach analysis was produced and reviewed by senior staff. This informed workstreams to look at ways of preventing patient admission and improving patient flow.

Patients who required admission to hospital following their emergency department attendance waited too long for this to happen.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From March 2018 to February 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average, with the exception of May to July 2018, December 2018 and January 2019.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - North Bristol NHS Trust**

The highest numbers of patients waiting over four hours were in November 2018 (618), March 2018 (604) and February 2019 (603).

(Source: NHS England - A&E SitReps).
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from March 2018 to February 2019, 86 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in March 2018 (39) and November 2018 (26).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2018</td>
<td>604</td>
<td>39</td>
</tr>
<tr>
<td>April 2018</td>
<td>373</td>
<td>0</td>
</tr>
<tr>
<td>May 2018</td>
<td>107</td>
<td>0</td>
</tr>
<tr>
<td>June 2018</td>
<td>91</td>
<td>0</td>
</tr>
<tr>
<td>July 2018</td>
<td>170</td>
<td>0</td>
</tr>
<tr>
<td>August 2018</td>
<td>358</td>
<td>0</td>
</tr>
<tr>
<td>September 2018</td>
<td>434</td>
<td>0</td>
</tr>
<tr>
<td>October 2018</td>
<td>389</td>
<td>0</td>
</tr>
<tr>
<td>November 2018</td>
<td>618</td>
<td>26</td>
</tr>
<tr>
<td>December 2018</td>
<td>173</td>
<td>0</td>
</tr>
<tr>
<td>January 2019</td>
<td>568</td>
<td>0</td>
</tr>
<tr>
<td>February 2019</td>
<td>603</td>
<td>21</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From February 2018 to January 2019 the monthly percentage of patients who left the trust’s urgent and emergency care services before being seen for treatment was better than the England average, with the exceptions of February and March 2018.

Since April 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0%.

In the most recent month of the period, January 2019, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0%, compared to the England average of 1.8%.

Percentage of patients that left the trust’s urgent and emergency care services without being seen - North Bristol NHS Trust

(Source: NHS Digital - A&E quality indicators)
Median total time in A&E per patient (all patients)

From March 2018 to February 2019 the trust’s monthly median total time in A&E for all patients was higher than the England average. Over the same time, the trust’s monthly median total time in A&E for all patients ranged from 190 minutes in April 2018 to 221 minutes in February 2018.

In the most recent month, January 2019, the trust’s monthly median total time in A&E for all patients was 203 minutes, compared to the England average of 164 minutes.

Median total time in A&E per patient - North Bristol NHS Trust

(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

Patients we spoke with told us they had no complaints, but they felt they would feel comfortable raising concerns or making a complaint. Complaints leaflets were available in the emergency department, although these could not be found by the receptionist on the first day of our inspection. All staff we spoke with understood the policy on complaints and knew how to handle them. Staff told us if a patient or visitor indicated any kind of dissatisfaction they would alert a senior member of staff so that concerns could be ‘nipped in the bud’. They also knew how to refer people to the trust’s Advice and Complaints Team.

Staff knew how to acknowledge complaints and patients received feedback from the service after the investigation into their complaint. Complainants were fully engaged in and supported through the complaints process. All complaints were acknowledged on receipt. We saw in many cases complainants were contacted by telephone by the investigating manager. This allowed them to introduce themselves, explain the process and timescales and to ‘triage’ the complaint to ensure the concerns and expectations of the complainant were fully understood. The emergency department employed a retired nurse, who was a member of the patient support team and who had developed a triage checklist to help structure this initial contact. They attended the monthly clinical governance meetings, where complaints were discussed.

Managers investigated complaints and identified themes. They shared feedback from complaints with staff and learning was used to improve the service. Themes and significant learning opportunities were shared with staff at safety briefings, by email and via the monthly staff
newsletter. For example, in the May 2019 newsletter there was learning shared in response to a complaint about a failure to label a medicine prescribed for a patient to take home.

Summary of complaints
From March 2018 to February 2019 the trust received 82 complaints in relation to urgent and emergency care (10.9% of total complaints received by the trust). The main subject of complaints was clinical care and treatment (50).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>50</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>15</td>
</tr>
<tr>
<td>Communication</td>
<td>4</td>
</tr>
<tr>
<td>Access to services - clinical</td>
<td>4</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>3</td>
</tr>
<tr>
<td>Medical records</td>
<td>1</td>
</tr>
<tr>
<td>Quality of facilities</td>
<td>1</td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
</tr>
<tr>
<td>Discharge arrangements</td>
<td>1</td>
</tr>
<tr>
<td>Bereavement</td>
<td>1</td>
</tr>
<tr>
<td>Domestic services</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>82</strong></td>
</tr>
</tbody>
</table>

For the 70 complaints that had been closed at the time of data submission, the trust took an average of 32.8 working days to investigate and close these. This was not in line with their complaints policy, which stated complaints should be closed within 30 working days.

The 12 complaints that had not yet been closed had been open for an average of 50.8 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The specialty lead (consultant) and lead nurse in the emergency department were experienced clinicians, who were highly respected in their field. They had a wealth of managerial skills, qualifications and experience and were highly respected by the workforce as inspiring leaders and role models. The leadership team for the emergency department consisted of:

- Specialty lead (consultant), who had four hours per week in their consultant job plan for this role, provided strategic leadership for the medical workforce and the emergency department. Consultants had designated areas of special interest and responsibility, for example governance, education, audit, informatics, mental health.

- Deputy Head of Nursing/Lead Nurse for medicine (with primary responsibility for the emergency department and the observation unit). They provided strategic leadership for
nursing. They were supported by a ward manager, who was responsible for day to day management of the nursing workforce. There were also team leaders, who led in different areas, such as education and safeguarding and were responsible for staff development and pastoral care.

- General manager – this was an interim appointment, following an internal promotion and pending the start date of a recently-appointed permanent replacement.

The specialty lead and lead nurse had been in post and worked together for several years. Their mutual respect was clearly evident, as was their shared purpose. They met regularly, and worked collaboratively and cooperatively, although there were no formal or structured meetings.

The ED leadership team reported to the divisional leadership triumvirate. The divisional lead nurse led the daily ‘huddle’ in the emergency department; however, when we asked staff what support they had from divisional and executive leaders they told us they were not visible, and most would not be able to identify them.

All leaders had received managerial training and mentorship opportunities. There was succession planning to ensure resilience. The specialty lead was about to stand down to undertake a regional advisor role and a successor had been appointed. The ward manager was also about to leave shortly, and two band seven nurses had been appointed as a job share to fill this position internally.

Leaders fully understood the challenges faced by the service and clearly identified the actions needed to address them. They spoke confidently about workstreams and improvement plans which had been developed and were ongoing to improve performance.

The local leadership team were universally liked. They were visible on the ‘shop floor’ and were described as friendly, approachable and supportive. Staff told us that although the lead nurse and their deputy (ward manager) did not have clinical responsibilities, they frequently helped when the emergency department was busy. We saw during our inspection the ward manager was covering staff breaks.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply them and monitor progress.

The emergency department had developed a vision statement, with input from staff: “We will realise the great potential of our department by empowering our skilled and caring staff to deliver high quality, sustainable services in our department, leading by example from the top down. Clinical outcomes, nursing care and patient experience will be excellent.”

A series of objectives supported this over-arching statement, focussed on safety and operational performance, staff autonomy and decision-making, effective and efficient use of resources, recruitment, education and training, patient engagement and satisfaction, research, engagement with stakeholders and maximising the use of technology. Senior staff could clearly and confidently describe the streams of work that were ongoing to achieve these objectives and staff were engaged in numerous projects to realise the vision and objectives. There was a sense of aligned vision, shared values and universal commitment to improve services for patients.

There was an urgent care improvement plan, sponsored by the trust’s chief operating officer. Within this workstream was an emergency zone improvement plan and there was a range of ongoing projects, focussed on workforce, escalation and site management, internal professional standards, and alternative clinical pathways. The service was trialling primary care streaming at
the front door. This had begun in April 2019. A GP worked three days a week, based in the emergency department observation unit and reviewed patients who had been streamed under the category of ‘majors fit to sit’. If successful, there were plans to extend this service. There was also a ‘frailty at the front door’ pilot due to go live in August 2019. A consultant-led team would support the emergency department and acute medicine, with a view to reducing the number of unnecessary admissions to hospital.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Despite a gruelling winter, when the service faced unrelenting pressure from increased demand for services, staff morale was remarkably good. Staff felt supported and valued. They had a positive and optimistic attitude and spoke about their department and their colleagues with pride and passion. A registrar told us they and all their peers aspired to obtaining a consultant position in this department because it was considered such a great place to work. Student nurses and volunteers told us they loved working in the department because they were so well supported and welcomed in the department. Housekeepers and porters were part of the team.

This positive culture was encapsulated in the department’s philosophy, which was set out in the welcome pack for new nurses in the emergency department. It read: “Although we are a large and very busy unit, we pride ourselves on our high standards of care and professionalism. Every member of the team is valued for what they bring, without exception.” It went on to say: “This strive for excellence comes with an extra degree of pressure and we aim to counteract this by being one big family…..We look out for each other, we care for each other and when asked to help we say yes.”

There were cooperative, supportive and appreciative relationships amongst staff. They jointly recognised and celebrated others’ successes and equally supported those who experienced difficult times at work or outside work. We were struck by the number of doctors who wanted to tell us how highly they regarded their nursing colleagues and vice versa.

The emergency department participated in the trust-wide ‘Positive Impact Management System’ (PIMs) and regularly nominated colleagues for doing something excellent or ‘going the extra mile’. Since its introduction in November 2018, many nominations had been made. All nominees received an email and each month a winner was selected and awarded a coffee shop voucher. We saw numerous examples where staff recognised the efforts and achievements of their colleagues, some of which were shared in the monthly newsletter. Examples included:

“She recognised that staff in resus were having a tough/emotional shift and took them all tea/coffee and toast and made sure everyone was ok. Always going above and beyond to look after staff.”

“Ran the department amazingly, despite crazy pressures. Stood up for our patients, prioritised care and great with colleagues. Just brilliant. Rose to the challenge and proud to call her my colleague.”

“One of the scribes was upset after a particularly distressing trauma. Despite not even being involved with the case he spent time with the scribe afterwards to check they were okay. The scribe reported this back to me in general conversation and said how much better just a simple chat made her feel.”

A staff member from the emergency department had been nominated in the trust’s Exceptional Health Care Awards 2018 under the ‘Rising star’ category. Their nomination read:

“She has been an amazing advocate for patients and works hard to ensure all basic needs are met, as well as making them comfortable. S has studied and developed in their health care assistant role and was successful in applying to train as an assistant practitioner. Her dedication to
her studies has been admirable and she has recently qualified. She has done this while working full time and maintaining her high standards.

There was a staff communication whiteboard, where team successes were reported. During our inspection, successes related to the achievement of high scores in relation to safety standards (completion of the safety checklist, compliance with chest pain and sepsis pathways and recording early warning scores on arrival in ED).

There was a strong emphasis on staff wellbeing. This had been championed by a number of senior staff, who formed the wellbeing team. There was a wellbeing website and a blog for staff to follow, as well as a noticeboard in the emergency department signposting staff to sources of support, including a clinical psychologist. There were numerous examples of initiatives designed to support staff through social events, psychological and emotional support and practical tips, such as ensuring adequate rest and hydration. The emergency department had produced a ‘going home checklist’, which encouraged staff to reflect on what had gone well and not so well during their shift, check on their colleagues, seek support where necessary and focus on home, rest and recharge. The service organised numerous fundraising events and challenges to raise money, which was used to support staff wellbeing initiatives, such as buying coffee cups for all staff and planting tubs of flowers outside the emergency department. A nurse, who had recently returned from extended leave, told us how well supported they felt on their return to work, with a phased return. They told us the ward manager and the matron were “amazing” in the way they had supported them when they felt vulnerable and a little overwhelmed.

There were numerous social events publicised in the monthly newsletter and a closed ED social media group. Many staff spoke about these events and the positive effect they had on wellbeing and feeling part of a ‘family’. We heard about ‘education in the pub’, where training was combined with a social event. Doctors of all grades were asked to give a short presentation and then take questions from the group. The group then had dinner together. A consultant told us they had organised a pub quiz, with questions relating to previous presentations. Many staff told us about this “fun way of learning” and “morale booster”.

Staff told us they felt able to raise concerns without fear of retribution. They told us there was an open and ‘no blame’ culture, where mistakes were openly discussed, and learning was paramount.

**Governance**

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were well-embedded and effective governance systems to provide assurance of quality and safety.

There was a consultant lead for governance who chaired monthly clinical governance meetings. The governance lead maintained a governance dashboard, which was stored on the emergency department’s intranet, and which provided a holistic picture of quality and risk.

Clinical governance meetings were open to all staff. Dates were publicised in the monthly clinical newsletter, although meetings were mainly attended by medical staff, who had protected time for attendance in their rota. Minutes were made available to all staff on the emergency department’s intranet, where there was a link to a governance folder. Key messages were also summarised in the monthly clinical newsletter, clinical governance posters displayed around the department and at staff handover and safety briefings. During our inspection safety briefing messages included a reminder to check fridge temperatures, a reminder to ensure all patients with abdominal pain were ‘nil by mouth’, signposting to new guidance on Deprivation of Liberty Safeguards, and reminders about blood labelling and blood transfusion training.
Standing agenda items at the clinical governance meeting included incidents and complaints, mortality reviews, audits, and positive feedback. There was an action tracker to ensure actions were followed up from previous meetings.

There were reviews of unusual cases with unexpected outcomes, as well as monthly mortality reviews.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were clear and effective processes for managing risks, issues and performance. Staff and managers were well informed about the risks and challenges in the department and actions in place or planned to mitigate those risks.

The emergency department maintained a risk register which was discussed at monthly clinical governance meetings, along with incident trends. The top three incidents and top three risks were publicised on the department’s communication whiteboard. There was alignment between the risks recorded and what staff told us was on their ‘worry list’. Staff had been invited to tell the clinical governance committee what they thought the biggest risks were. These were discussed at the April 2019 meeting, when the risk register was reviewed. High and extreme risks were discussed at the divisional level governance meetings and escalated appropriately to trust level.

**Top risks on the risk register:**

- Four-hour performance and long waits to be seen (extreme risk). Controls and mitigating actions included a trust-wide escalation procedure, incorporating a surge protocol for the emergency department and a trust-wide improvement plan for urgent care, which was executive-led. There was a root cause analysis when the highest level of escalation was declared. High levels of compliance with the safety checklist and review of incidents provided assurance that no harm to patients had occurred due to long waits.

- Patients cared for in the emergency department corridor (high risk). Controls included additional staffing, numbering of corridor areas and provision of oxygen and suction and remote call bells. There was continuous triage and ‘reverse queuing’ where stable patients vacated cubicles for incoming patients.

- Patients with acute mental health problems who have been assessed as being at high risk of absconding or self-harm (high risk). Controls included prompt referral to the mental health liaison team and contact with hospital security and police when patients abscond.

- Delays in mental health assessments, particularly at night. Controls included the ongoing recruitment of registered mental health nurses and a bid to move to a 24/7 model.

Incidents were reviewed to identify trends. There was a ‘learning point of the month’, arising from review of incidents and this was communicated to staff. In April 2019 the learning point related to safe handovers to specialty teams.

There was real-time information recorded about activity and waiting times, which was constantly monitored by senior staff in the emergency department and the site management team. This fed a breach analysis report, which was monitored daily, weekly and monthly and reported to the board. This helped to identify the factors which contributed to waiting times and delays in care and to predict peaks in demand to inform staffing and other initiatives designed to improve patient flow.

There was an office-based ‘consultant of the day’, who was able to respond promptly to incidents and complaints, and who was responsible for reviewing radiology reports and following up on any missed findings.
Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There were robust information systems, which provided real-time and retrospective reporting of performance, safety, risk and quality, including patient experience. Information was regularly reviewed and refined to inform continuous improvement. Review of attendance and performance data had informed staffing reviews. For example, it had been identified there were more staff required during the late afternoon, early evening and at night. Breach analysis was a continuous process in order to identify joint solutions to the ongoing patient flow issue within and without the emergency department.

The governance dashboard provided an overview of safety, risk and patient experience.

There was a comprehensive intranet, which provided a wealth of information and was available to all staff in the emergency department.

The electronic records system had been re-designed and provided not only a clinical decision tool, with safety and best practice prompts and alerts, but enabled better quality data and better-structured clinical narrative, resulting in better quality audit and outcome data. The process for producing discharge summaries had also been streamlined and improved. There was ongoing work to produce a unified patient record for the major hospitals in Bristol and Weston-super Mare.

There were effective information governance processes and safeguards and staff understood their responsibility to safeguard confidential data.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In response to a patient survey, a project was developed which set out to improve information available to patients and visitors, so they knew what to expect when they visited the emergency department.

Thirty patients were invited to participate, of which approximately 15 engaged, along with a group of nurses. The result was a patient information leaflet, which was displayed throughout the emergency department and which set out the various patient pathways through the department. A survey was carried out before and after the introduction of the patient information leaflet and patients indicated they were better informed.

Staff told us they were well informed and felt their voice was important. There was effective communication with staff and they were encouraged to suggest ideas for improvement. A ‘communication hub’ noticeboard was updated each month, providing a range of information about performance, successes and areas for improvement.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges and needs of the population and to deliver services to meet those needs. The service had good links with the ambulance service and mental health providers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
Quality and improvement were everybody’s business. There was a strong emphasis on education, audit, research and quality improvement. The emergency department was proud of its achievements and of a proactive culture which encouraged and supported learning and innovative practice. Trainee doctors were required to undertake a quality improvement project as part of their placement and consultants described a cohort of motivated registrars who showed great enthusiasm for this. There were many opportunities for doctors and nurses to pursue interests. Consultants’ job plans were flexible to support them to lead research projects. The emergency department was one of the top recruiters nationally for research trials.

There was a lead consultant for research in the emergency department. They described to us a number of recent and ongoing research projects and studies:

- **Silver trauma** - a triage tool was developed to identify elderly patients at risk of injury.
- **Pain control in patients living with dementia** - using distraction therapy.
- **Re-design of the chest pain protocol** - using a routine blood test in a different way to reduce the diagnostic time in hospital.
- **Trial to develop interventions to help patients who have experienced major trauma return to work.**
- **PRESTO** - looking at the accuracy of troponin testing when it is used in the back of an ambulance.

One of the department’s long-standing consultants had recently been awarded a national award from the National Institute for Health Research and Royal College of Emergency Medicine. It was presented in recognition of his contribution to research in the field of emergency medicine throughout his career. One of his significant achievements had been a research project to develop an analgesic (painkiller) – intranasal diamorphine – which is used for children suffering with acute pain, such as that associated with a broken bone or abdominal problem. This was licensed for use in paediatric patients in 2016. He also had an interest in acute cardiovascular and stroke care and, having been involved in research in these areas for many years, was currently the Chair of the NICE (National Institute for Health and Care Excellence) Guideline Committee on the Management of Stroke and Transient Ischaemic Attack.

The emergency department put in a successful business case for the purchase of a video laryngoscope to aid intubation of patients with a compromised airway. There had been training sessions, including theatre sessions to improve doctors’ skills in this area and there were plans to audit this practice.

The service was working with two national improvement teams: Emergency Care Intensive Support Team (ECIST) and Getting it Right First Time (GiRFT).

Two staff had been nominated for the trust’s 2018 Exceptional Healthcare Awards, in the service transformation category:

- A consultant and a project manager led a team to develop an electronic patient record in the emergency department. The ‘PaperLite’ team was commended for

  “*a perfect demonstration of how detailed planning, preparation, attention to detail and a passion for delivering a quality product can transform an extremely pressurised service for the better.*”

- A nurse was nominated for developing the role of learning difficulties (LD) link nurse in the emergency department. The nomination read:
“The connection between the [emergency] department and the hospital LD liaison team has improved significantly over this time, staff are now more aware of the service provided by the liaison team and are quick to refer patients who attend the emergency department or require hospital admission. F undertakes teaching regularly. This focuses on the awareness of reasonable adjustments, the liaison team, consent and communication, the use of patients’ passports and carers’ awareness.”
Medical care (including older people’s care)

Facts and data about this service

The medical care service at North Bristol NHS Trust provides care and treatment for a number of specialties at one acute site, Southmead Hospital.

The trust provided the following information about medical care at North Bristol NHS Trust:

The hospital serves a population of just under 460,000 people, and provides emergency inpatient medical treatment, elective (planned) inpatient medical treatment and medical day case treatment. The trust provides medical care across a range of specialties including acute medical admissions, cardiology, respiratory, gastroenterology, renal medicine, diabetes, frailty and complex care of the elderly and clinical haematology.

The trust has 16 medical inpatient wards, all located at Southmead Hospital.

(Source: Universal Routine Provider Information Request (RPIR) – Sites tab / RPIR Acute – Context acute tab)

The trust had 51,846 medical admissions from January to December 2018. Emergency admissions accounted for 27,052 (52.2%), 1,038 (2.0%) were elective, and the remaining 23,756 (45.8%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 24,115 admissions
- Gastroenterology: 8,892 admissions
- Clinical haematology: 4,571 admissions

(Source: Hospital Episode Statistics)

The areas we covered for the medical care core service were relevant to two trust divisions, medicine and neurological and muscoskeletal sciences.

Medicine division:

- Acute medicine
- Medical day care
- Cardiology
- Care of the elderly
- Diabetes / Endocrinology
- Gastroenterology
- Respiratory
- Endoscopy
- Acute oncology
- Haematology
- Immunology / Infectious Diseases / HIV
- Palliative care
- Mental health liaison
(The medicine division also included emergency medicine which will be covered under the urgent and emergency care core service.

**Neurological and muscoskeletal sciences division:**

- Neurology
- Stroke

(The neurological and muscoskeletal sciences division also included specialities which will be covered under the surgery core service.)

During our inspection we visited medical care ward areas, escalation areas, and the discharge lounge. We attended meetings including: bed meetings, board rounds and leadership and flow meetings.

We spoke with approximately 82 staff. This included: divisional leaders, medical staff, nursing staff, therapists, pharmacy staff, discharge team, site team, and specialty nursing and clinical leads.

We spoke with eight patients and three relatives to discuss their experience of the care and treatment while they were cared for as inpatients within the medicine division.

We reviewed 25 patient records to review record keeping and consider specific areas of care and treatment.

We reviewed information, including data and trust documents, both before and after the inspection.

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**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

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**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff training compliance mostly met trust targets.

The mandatory training was comprehensive and met the needs of patients and staff. Training on recognising and responding to patients with mental health needs, learning disabilities, and autism was being introduced.

**Mandatory training completion rates**

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust set a target of 85% for completion of mandatory training.

Nursing staff received and kept up to date with their mandatory training. In medical care the 85% target was met for 17 of the 19 mandatory training modules for which registered nursing and midwifery staff were eligible. A breakdown of compliance for mandatory training courses as at April 2019 at trust level for registered nursing and midwifery staff in medical care is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at April 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Waste Management (Non Clinical)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Patient Handling</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - 3 year expiry</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>452</td>
<td>462</td>
<td>97.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food Safety - 3 yearly expiry</td>
<td>41</td>
<td>43</td>
<td>95.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Blood Transfusion training</td>
<td>386</td>
<td>405</td>
<td>95.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>434</td>
<td>456</td>
<td>95.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste Management (Clinical)</td>
<td>429</td>
<td>461</td>
<td>93.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - 2 year expiry</td>
<td>431</td>
<td>464</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>431</td>
<td>465</td>
<td>92.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food Safety - 2 yearly expiry</td>
<td>325</td>
<td>351</td>
<td>92.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>422</td>
<td>465</td>
<td>90.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>399</td>
<td>449</td>
<td>88.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Level 2</td>
<td>410</td>
<td>463</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>408</td>
<td>465</td>
<td>87.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire</td>
<td>403</td>
<td>465</td>
<td>86.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>392</td>
<td>462</td>
<td>84.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>371</td>
<td>458</td>
<td>81.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff received and mostly kept up to date with their mandatory training. In medical care the 85% target was met for eight of the 15 mandatory training modules for which medical staff were eligible. A breakdown of compliance for mandatory training courses as at April 2019 at trust level for medical staff in medical is shown below:
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could confidently talk us through the identification of safeguarding concerns and how to report these; they had support from the trust safeguarding leads.

Safeguarding training completion rates

All staff were required to complete adult and children safeguarding training, at a level appropriate to their role. The trust set a target of 85% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse. In medical care the 85% target was met for all four safeguarding training modules for which registered nursing and midwifery staff were eligible. A breakdown of compliance for safeguarding training courses as at April 2019 at trust level for registered nursing and midwifery staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 1</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>412</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2</td>
<td>412</td>
</tr>
</tbody>
</table>

Medical staff received training specific for their role on how to recognise and report abuse. In medical care the 85% target was met for two of the three safeguarding training modules for which medical staff were eligible. A breakdown of compliance for safeguarding training courses as at April 2019 at trust level for medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults - level 2</td>
<td>187</td>
</tr>
<tr>
<td>Safeguarding children – level 2</td>
<td>173</td>
</tr>
<tr>
<td>Safeguarding children - level 3</td>
<td>6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

There were nine medical staff who were not up to date with safeguarding children level 3 training. However, staff had access to relevant level 3 trained staff to contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding or child protection concerns.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. We observed all areas we visited to be visibly clean, with staff regularly cleaning the area.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. We reviewed some examples of checklists to confirm areas were cleaned regularly. There were also arrangements for deep cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using correct PPE and were bare below the elbow in clinical areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were seen on equipment when cleaned by staff to indicate it was ready to be used again.

An infection prevention and control team and governance structure ensured oversight of practice and reporting of compliance, ensuring compliance with the NICE quality standard QS61 to reduce infection rates and prevent avoidable deaths from healthcare associated infections. Infection control was audited monthly and presented within the control of infection committee highlight report. This report included mandatory reporting of trust acquired infections and review of cases, audit compliance by ward for example catheter and cannula care, environmental cleanliness, and training compliance.

The infection prevention and control team delivered infection prevention control education and teaching to both clinical and non-clinical staff.

Observational hand hygiene audits were undertaken monthly. Results were displayed on each ward, so staff, patients and visitors could see their performance.

National guidelines were followed for the screening of patients admitted to the medicine division. High risk patients would be screened for MRSA in line with relevant criteria. All hospital acquired infections for example, MRSA, were investigated to look for key themes. The trust monitored all of these.

At our previous inspection undertaken in November 2017 we told the trust they must ensure the use of additional escalation beds was in line with cross infection policy and does not compromise cleaning and risk of cross infection. Where additional beds were placed in bays this compromised the ability to clean effectively because of insufficient space between beds. The trust was now better managing their use of escalation beds, the additional beds in bays were used much less frequently and were used on a pre-emptive basis so patients would only be bedded in these areas for short periods of time while awaiting transfer. The trust monitored infection control incidents and did not report any harm to patients who were cared for in these additional beds.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded when called. At our last inspection we told the trust they must provide appropriate equipment for patients in areas of escalation. During this
inspection we saw patients were provided with appropriate equipment when in escalation areas, for example they had access to a call bell and oxygen if needed.

The design of the environment followed national guidance. There was appropriate room for patients to be cared for safely, and fire exits were clearly marked with no blocked exits. Patients who needed enhanced care were placed in four-bed bays, but most patients were in single side rooms. The side rooms did not always allow line of sight to patients for staff, however monitoring screens were used in the central nursing station. When patients were cared for in the acute medical unit corridors staffing was allocated to this area.

Staff carried out daily safety checks of specialist equipment. Following our previous inspection, we told the trust they must ensure emergency equipment is tamper-evident and checked daily in line with national guidance and trust policy. During this inspection we found resuscitation trolleys were consistently checked in full every month, with daily checks mostly complete.

It was unclear from the sealed tag on the resuscitation trolley whether the trolley had been tampered with as replacement tags had no serial numbers. Trolleys were tagged but could be easily broken and replaced between monthly full checks with no auditable trail. We also found on the acute medical unit there was no expiry date recorded on the checklist to clearly indicate equipment due to expire, and there was no indication of an expiry date for the breathing mask.

The service had enough suitable equipment to help them to safely care for patients. All equipment observed had been serviced to confirm safety for use. Appropriate equipment was available to staff to help manage risk, for example pressure relieving mattresses and fall prevention equipment. We did find on the renal ward (8b) the four dialysis machines checked had rusty water media panels. We were told there was a plan to replace these.

Staff disposed of clinical waste safely. We observed appropriate disposal and storage of clinical waste.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Safety briefings were held to ensure important information was shared between staff. We observed board rounds which appropriately discussed each patient to identify any risk areas, interventions required or those who were stable to step down from enhanced areas.

Staff completed risk assessments for each patient on admission, updated them when necessary and used recognised tools. We saw risk assessments recorded within patient paper and electronic records, as detailed below. Patients who were more acutely unwell or assessed as higher risk (for example for falls, pressure ulcers) would be bedded in the enhanced care bays rather than single rooms.

Staff knew about and dealt with any specific risk issues, this included:

**National Early Warning Score and Sepsis**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The national early warning score (NEWS) is a tool based on a scoring system reviewing six physiological measurements, a score is allocated and aggregated to determine a clinical response to acute illness. Staff could explain to us how they used this tool to identify a deteriorating patient, and who they would escalate any concerns to. The accurate completion and escalation responses using NEWS was audited monthly, and trust wide compliance reported.

The NEWS 2 (an updated version of the tool) was launched at the trust in October 2018. Staff
received training on the recognition of sepsis and the need for early escalation, which was
delivered alongside NEWS 2 training. A lead sepsis nurse was also appointed in September
2018 to provide sepsis support.

A sepsis tool was used to screen patients and escalate. We saw evidence of appropriate
escalation of patients suspected of having sepsis, and the sepsis screening tool completed.

The service audited screening for sepsis and administering of antibiotics. Trust data for inpatient
wards showed 100% of patients who met the criteria of the local protocol for sepsis screening
were screened for sepsis using NEWS 2. The percentage of patients who presented with severe
sepsis and were administered intravenous antibiotic within one hour of diagnosis of sepsis was at
89% (October-December 2018), 88% (January to March 2019) and 75% (April to June 2019).

A multidisciplinary simulation had been trialled from November 2018 to practice clinical skills.
This was going to be rolled out across acute medical wards.

**Venous thromboembolism**

All patients were risk assessed for venous thromboembolism (VTE) on admission to hospital and
reassessed within 24 hours of admission or whenever the clinical situation changed.
Thromboprophylaxis was indicated as required. The trust audited VTE risk assessments being
completed against a 95% target, and for March, April and May 2019 the trust achieved this target.
This was an improvement from our last inspection where we found VTE risk assessments were
not always carried out for patients in line with national guidance.

**Falls**

Falls were being managed in the medical care service both for prevention and the response to a
fall. Following a patient fall there was a ‘swarm’ approach, which was embedded in the trust’s
safety culture. A ‘swarm’ is a safety incident huddle which takes place as close as possible to the
time and place of the incident, allowing prompt review and investigation and allows blame free
investigation. The falls leads attended the swarm which was held within 24 to 48 hours of the
patient fall. For serious falls a root cause analysis was completed, for those which were less
serious or did not result from any failings in care and treatment a quality improvement
investigation was completed. On Elgar wards they completed a ‘hot swarm,’ which is an
immediate assessment of the environment after a fall.

Ongoing training was provided to staff for falls, intentional rounding tool was used to review
patients regularly and there were enhanced care protocols. Safety briefings were an opportunity
to discuss any falls risks. Relevant equipment was available, for example beds which could be
adjusted to be higher or lower to the floor to reduce falls risk.

The trust audited falls risk assessments being completed within 24 hours of admission for
patients over 65. Audit data between 1 April 2018 and 1 June 2019 averaged 72.9% compliance.

**Pressure ulcers**

Patients were risk assessed for pressure ulcers and management plans arranged with appropriate
use of preventative equipment.

The trust had identified the number of reported grade two pressure ulcers had increased over
time. A grade two pressure ulcer is classified as partial thickness skin loss involving the epidermis,
dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister. There
were actions to address this, a group had been set up to monitor with workstreams around
education and documentation. Each patient who was identified as having a grade two pressure
ulcer had an investigation completed on the ward. The outcome of the review and actions were
due to be presented to the board in July 2019.

**Frailty**

Frail patients received an interdisciplinary complex geriatric assessment (CGA) on admission to
hospital. The assessment was used to enhance a patient’s journey, decrease length of stay, and
reduce readmissions. The complex assessment and liaison service (CALS) included consultant geriatricians, advanced nurse practitioners and therapists. They supported the identification of frailty and provided CGAs in the emergency zone (emergency department and acute medical unit) to ensure patients were assessed timely at the front door. There was a seven day presence of the CALS team on the acute medical unit. The team supported patients within the bed base on the complex assessment unit (32a) for frailty short stay, care of the elderly wards (9a, 9b, 28a) and transitional care enablement wards (Elgar 1 and 2). They had also piloted a frailty ambulatory emergency care service within the emergency department. They worked effectively with the medicine division and wider cross organisation specialty teams.

We reviewed examples of CGAs completed by advance nurse practitioners, and found these to be very detailed, and included the multidisciplinary team. If a patient arrived in hospital with a completed previous CGA this could be used and updated as required.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). The service was provided to inpatients Monday to Friday. There was a trust risk associated with securing timely provision and access to mental health input for patients presenting with acute mental health issues on the acute medicine unit. There was an ongoing piece of work to look at the provision of mental health team and their input across the emergency zone. Staff were using policies, for example rapid tranquillisation protocol, and would escalate concerns to the on-call mental health liaison team. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

**Staffing**

The service had challenges in recruiting enough staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

**Annual staffing metrics**

**Trust Level**

From March 2018 to February 2019, the breakdown of whole time equivalent (WTE) staff in post in medical care is shown below.
### Core service annual staffing metrics
(March 2018 to February 2019)

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff</td>
<td>1,629.1</td>
<td>10.4%</td>
<td>22.1%</td>
<td>4.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered nursing and midwifery</td>
<td>513.0</td>
<td>16.8%</td>
<td>19.2%</td>
<td>3.7%</td>
<td>145,415 (18%)</td>
<td>37,668 (5%)</td>
<td>-5,452 (-1%)</td>
</tr>
<tr>
<td>Nursing assistants</td>
<td>535.1</td>
<td>9.6%</td>
<td>21.2%</td>
<td>6.2%</td>
<td>196,642 (26%)</td>
<td>7 (&lt;1%)</td>
<td>-98,138 (-13%)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>235.2</td>
<td>5.6%</td>
<td>45.8%</td>
<td>1.1%</td>
<td>27,296 (6%)</td>
<td>17,074 (3%)</td>
<td>-12,308 (-2%)</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>177.7</td>
<td>8.4%</td>
<td>10.3%</td>
<td>2.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab; Vacancy tab; Sickness tab; Nursing bank agency tab; Medical agency locum tab)

### Vacancy rates

The trust set a target of 5% for vacancy rate. From March 2018 to February 2019, the trust reported an overall vacancy rate of 10.4% in medical care. This did not meet the trust's target. Across medical care overall vacancy rates for nursing staff were 16.8%; for medical staff were 5.6% and for allied health professionals were 8.4%.

![Vacancy rate - all staff](chart.png)

Monthly vacancy rates over the last 12 months for all staff are not stable and may be subject to ongoing change.
Monthly vacancy rates over the last 12 months for registered nurses show an upward trend from October 2018 to February 2019. This could be an early indicator of deterioration.

Monthly vacancy rates over the last 12 months for nursing assistants show a shift from September 2018 to February 2019. This could be an indicator of change.

Monthly vacancy rates over the last 12 months for medical staff shows a shift from September 2018 to February 2019. This could be an indicator of change.
Monthly vacancy rates over the last 12 months for allied health professionals shows a shift from September 2018 to February 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The trust set a target of 15.6% for turnover rate. From March 2018 to February 2019, the trust reported an overall turnover rate of 22.1% in medical care. This did not meet the trust’s target. Across medical care overall turnover rates for nursing staff were 19.2%; for medical staff were 45.8% and for allied health professionals were 10.3%.

Monthly turnover rates over the last 12 months for nursing assistants shows a shift from September 2018 to February 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

The trust set a target of 4.2% for sickness rate. From March 2018 to February 2019, the trust reported an overall sickness rate of 4.1% in medical care. This met the trust’s target. Across medical care overall sickness rates for nursing staff were 3.7%; for medical staff were 1.1% and for allied health professionals were 2.5%.
Monthly sickness rates over the last 12 months for all staff shows an upward trend from September 2018 to January 2019. This could be an early indicator of deterioration.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From March 2018 to February 2019 the trust reported 145,415.0 of the 820,601.5 available hours for registered nursing staff were filled by bank staff (17.7%) and 37,667.5 hours were filled by agency staff (4.6%) in medical care.

Over the same time period, the trust reported 750,842.6 the 196,641.6 available hours for nursing assistants were filled by bank staff (26.2%) and 6.5 hours were filled by agency staff (less than 0.1%).

From March 2018 to February 2019 the trust reported 27,295.8 of the 492,803.2 available hours for medical staff were filled by bank staff (5.5%) and 17,073.9 hours were filled by locum staff (3.5%) in medical care.

Monthly bank hours over the last 12 months for all staff shows a downward trend from May 2018 to September 2018. This could be an early indicator of improvement.
Monthly bank hours over the last 12 months for nursing assistants shows a shift from September 2018 to February 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab; Medical agency locum tab)

Nurse staffing

Nurse staffing remains a challenge and a known risk, but managers regularly reviewed staffing to keep patients safe from avoidable harm and to provide the right care and treatment.

There was a clear focus on recruitment and retention, with staffing numbers in the pipeline improving vacancy rates and the division being innovative with roles. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. A live acuity tool was used to ensure safe deployment of staff and to manage the organisational staffing resources on a day to day basis. This worked on a RAG rating basis identifying where there was cause for concern. This tool was combined with professional judgement to ensure safe care was being provided to patients. Daily safe staffing meetings were held between divisions, overseen by the head of nursing. Real time data of actual staffing levels and patient acuity could be viewed, and staff redeployed as required.
The trust considered recommended benchmarks to plan staffing levels. The National Institute of Healthcare Excellent safe staffing for nursing in adult inpatients wards in acute hospitals recommends the registered nurse to patient ratio should not be greater than eight patients per registered nurse during the day shift. All inpatient ward establishments met this ratio during the day. At night, all wards were funded to one registered nurse to 10 patients, with the exceptions of 32a, Elgar 1 and Elgar 2. These wards had increased healthcare assistant support at night to deliver safe care and had been approved as being appropriate by the head of nursing and matron.

The medicine division held a divisional risk relating to the high numbers of staff vacancies. There was a recruitment plan to address this and new starters planned. The medicine division had both a high vacancy and turnover. Vacancy hot spots were in 27b, Elgar 2, AMU and 28a. Turnover hot spots were in 27b, AMU, 34A and Elgar 2. There was an understanding of why areas were hotspots and plans to address this.

In the neurological and muscoskeletal sciences division the acute stroke unit 7a staff vacancies was an area of concern and was on the divisional risk register. There had been an increase in funded registered nurses’ posts by 5.2WTE to support the expansion of thrombectomy services, this resulted in a 14.2WTE reported in the March 2019 safe staffing report.

The trust was focussing on recruitment and retention for both registered and unregistered nurses. Within the medicine division there was a full time recruitment matron who had been in post since May 2018. A recruitment event was held in February 2019, where 36 registered nurses (some who will be newly qualified) were offered posts. There had also been an international recruitment event in Dubai in December 2018, with first overseas candidates starting in June 2019.

Bespoke resourcing plans were used for difficult to fill areas. For example, in respiratory and complex care where high vacancies and turnovers had been identified.

Development of new innovative roles were either being considered, piloted or implemented to support nursing staffing. Ward based therapists were piloted in the medicine division, on the respiratory unit physiotherapists supplemented the band five ward workforce. There were plans to do the same with occupational therapists on Elgar reablement ward. In March 2019 a small number of band three therapy support workers were appointed into band three healthcare assistant posts to pilot the effectiveness of the role. Nursing associates were also in training across wards, with two cohorts each year. A nursing associate is a role to bridge the gap between health care assistants and registered nurses and provide progression into graduate level nursing. Proposals were also being considered for financial support for return to practice nurses.

On the acute medical unit four clinical band seven nursing roles had been created, recruited from the band six nurses. The clinical band seven nurses were supernumerary and were available to support staff in acute medicine with higher acuity patients. They also had responsibilities, for example with audit, or training. Speaking to a clinical band seven nurse they felt they had time protected for this role and it enabled personal development.

Specialist nurses were also available across the hospital to support the ward teams and review patients.

When agency nurses were used they were fully inducted, and staffing was arranged appropriately to ensure agency nurses were not concentrated into one area. Block booking of agency helped for consistency once they were familiarised with an area.
Medical staffing

Medical staffing was a known challenge for the service and vacancies were being recruited to. The medical staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. However, we were told there was a big reliance on clinical fellows, with approximately 20 in the medicine division.

As of December 2018, the proportions of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust were similar to the England averages.

Staffing skill mix for the 221 whole time equivalent staff working in medicine at North Bristol NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>31%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>21%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital - Workforce Statistics - Medical (01/12/2018 - 31/12/2018)

Some medical care specialities had issues with medical staffing to meet the needs of the service and any planned improvements. One action was to offer a better recruitment package. This was ongoing at the time of our inspection. The shortages in medical staff were reviewed regularly and specialty leads felt there had been proactive work to recruit to vacancies. There were advanced nurse practitioners who also helped support where medical staffing was challenged. For example, for stroke care where shortage of medical staff was a risk.

The service always had consultants on call during evenings and weekends. There was consultant presence on all wards Monday to Friday, and consultant wards rounds were completed daily. There were arrangements for the weekend to see new or unwell patients, or cover provided by the on-call medical team. The hospital at night team nurse practitioners supported staffing out of hours. They were able to review the patient and appropriately refer to the registrar or specialist team.

There were arrangements for medical staff to review medical patients who were placed on other non-medical wards due to the lack of available beds in the most suitable ward, outlying on other wards. There was an outlier team led by a dedicated outlier consultant supported by SHO junior doctors, who would rotate on a weekly basis. The number of junior doctors was determined by the
number of outlying patients. Virtual board rounds were held to discuss the patient cohort, and it was assured they were seen in a timely manner on ward rounds by junior doctors, with prioritisation of clinical need. However, these ward rounds were only completed Monday to Friday, over the weekend they were reviewed as required by the specialty on call team. We saw the patients outlying were discussed as part of board rounds. We visited a surgical ward where patients were outlying and confirmed review had been completed daily by the medical team.

**Records**

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, mostly stored securely and easily available to all staff providing care.**

Security for confidential patient records and information still needed to improve. At our previous inspection we told the trust they must provide security for all confidential patient records and information. During this inspection we found records were mostly being stored securely, however we did find some records on wards which were left unattended. We also saw a few computers being left unattended without signing out or locking the computer, risking the public access to confidential information.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 25 patient records. Not all fluid charts were completed in full, which meant a detailed record of patient fluid intake and output was not available.

When patients transferred to a new team, there were no delays in staff accessing their records. Medical and nursing records were transferred with the patient. The service used transfer documents to inform the new ward of the patient’s needs.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines. However, medicines were not always in date within medicine trolleys or opening dates were not always recorded on liquid medicines to ensure they were discarded when required.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines stored on the wards were being replenished by the distribution team in pharmacy. They were also responsible for checking expiry dates of medicines in the medicine cupboard. However, we did find some medicines which had expired in the medicine’s trolleys. There was no procedure for checking the medicines stored in the trolleys. Opening dates were also not being recorded on liquid medicines to ensure they were discarded within an appropriate timeframe. We found a number of opened medicines across wards which did not have an opening date recorded.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. However, access to medicines requiring disposal were not always restricted to authorised staff. We saw on ward 28a and 7a blue bins for disposal of medicines had not been locked away. When we informed staff of these concerns staff locked these medicines away.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report, how to report them and reported all incidents they should report. Staff spoken with were clear on the processes they followed to report incidents. They were able to talk to us about the learning which had been shared following incidents on their wards, or within their division. We saw evidence of incident outcomes on wards for staff to follow and learning needed from these. For example, on discharge of one patient a care package had not been re-started when discharged, this resulted in the patient being re-admitted. There were listed actions staff must take to prevent this from happening again.

Mortality case note reviews were completed for any incident related to deaths. Senior staff told us incidents involving mortality were investigated and any learning shared with all staff. We were given an example of one incident which involved more than one speciality.

Staff received feedback from investigation of incidents, both internal and external to the service. This was shared through safety huddles, team meetings, newsletters and briefings.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2018 to February 2019, the trust reported four incidents classified as never events for medical care.

All four of these were categorised as Medical equipment/ devices/disposables incident meeting serious incident criteria and related to the unintentional connection of a patient requiring oxygen to an air flowmeter.  

(Source: Strategic Executive Information System (STEIS))

The four never events all related to patients being unintentionally connected to air instead of oxygen, patients suffered no harm as a result of these incidents. The incidents occurred on 26 June 2018 and then 8, 10 and 26 January 2019. The common theme was that all occurred following transfer of the patient into a ward. The trust practice of removing all air ports from the walls had not been adhered to, resulting in air flow meters remaining available next to oxygen flow meters. In response to the incidents the trust reviewed processes and circulated changes to senior clinical and nursing leaders within the learning after significant event recommendations. Staff were reminded that all air flow meters were to be removed from inpatient wards in between each administration of nebulised medicines, and this was audited with a target of 100% compliance. Only registered nurses caring for the patient were permitted to connect a patient to oxygen following transfer back to an inpatient bed.
There was evidence changes had been made because of learning from these never events and the never events were fully investigated. Trust wide audits demonstrated 100% compliance in each medical ward in March, April and May 2019. During our inspection we observed portable nebuliser boxes, to deliver nebulised medicines, now being used and caps on airflow meters. This would prevent the same incident occurring. Staff were aware of the never events and the subsequent learning and changes to practice.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England from March 2018 to February 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>6</td>
<td>33.3%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>5</td>
<td>27.8%</td>
</tr>
<tr>
<td>Medical equipment/ devices/disposables incident meeting SI criteria</td>
<td>3</td>
<td>16.7%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>3</td>
<td>16.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

There was evidence changes had been made because of learning from serious incidents. We discussed with staff the serious incidents, the pressure ulcers and falls which met the serious incident criteria. Staff spoke about the learning shared from these incidents, for example falls risk assessments and care plans being reviewed and improved. We saw these linked with the risks identified for the wards and division.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed the trust reported 70 new pressure ulcers, 13 falls with harm and 26 new urinary tract infections in patients with a catheter from February 2018 to February 2019 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at North Bristol NHS Trust

<table>
<thead>
<tr>
<th>Total Pressure ulcers (70)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Falls (13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total CUTIs (26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only
(Source: NHS Digital - Safety Thermometer)

We saw wards displayed information about their safety performance, so this information was clearly displayed for patients, visitors and staff. The safety thermometer was discontinued in April, and therefore the local audit programmes were used to monitor patient harm.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Standards relevant to each specialty were being followed. There were programmes of clinical audit to review compliance with standards and identify areas for improvement.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, as well as the physical care, staff referred to the psychological and emotional needs of patients, their relatives and carers. This was also referred to at board rounds where appropriate.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. They worked with dieticians who were based at the hospital to ensure patients nutritional and hydrational needs were met.

Staff completed patients’ fluid and nutrition charts where needed although fluid charts were not always completed in full. Not all fluid charts were complete, which meant a detailed record of patient fluid intake and output was not available.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. In records we saw these were completed and scores were given for a patient’s risk of malnutrition.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. For example, on Elgar 2 ward dieticians were giving out build up drinks and biscuits to patients in the afternoon to improve their nutrition and fluid intake.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. The Abbey Pain Scale was used for patients living with dementia, which is a tool which can be used for non-verbal patients who had difficulties communicating.

Patients received pain relief soon after requesting it. Patients told us their pain was well controlled.

Staff prescribed, administered and recorded all pain relief accurately. We saw evidence of this when reviewing prescription records.

The multidisciplinary pain team worked across the trust and were able to support patients admitted to hospital with pain review and pain management if required.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The service performed comparably in national clinical outcome audits. Where performance was below national averages or expected outcomes managers used the results to improve services further.

Examples of accreditation for the service included: the allergy service had recently been accredited in improving quality in allergy services, having met standards and been granted accreditation. Endoscopy had also achieved joint advisory group on gastrointestinal endoscopy accreditation.

Relative risk of readmission

Trust level

Elective admissions

From December 2017 to November 2018, patients at the trust had a higher than expected risk of
readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in nephrology and gastroenterology had a higher than expected risk of readmission for elective admissions.
- Patients in clinical haematology had a similar to expected risk of readmission for elective admissions.

**Non-Elective Admissions – Trust Level**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions.
- Patients in nephrology had a higher than expected risk of readmission for non-elective admissions.
- Patients in respiratory medicine had a lower than expected risk of readmission for non-elective admissions.

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

**Sentinel Stroke National Audit Programme (SSNAP)**

North Bristol NHS Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in the latest audit, covering the period from October 2018 to December 2018.
North Bristol Hospitals

Team centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>D</td>
<td>D</td>
<td>D↓</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>C↑</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C↑↑</td>
<td>E↓↓</td>
<td>E</td>
<td>D↑</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D↑</td>
<td>E↓</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>E↑</td>
<td>D↑</td>
<td>C↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>D↓↓↓</td>
<td>B↑↑</td>
<td>A↑</td>
<td>B↑</td>
</tr>
<tr>
<td>Team-centred total key indicator level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
</tr>
</tbody>
</table>

Overall Scores

<table>
<thead>
<tr>
<th></th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London - SSNAP audit)

We discussed the SSNAP audit and data with the stroke consultant lead. There had been an increase in out of hours therapy, which was now provided seven days a week, to include speech and language therapy. As a result, the trust had seen improvements with their stroke care. The January to March 2019 SSNAP data showed the trust had now improved their overall performance to level B.

The stroke service had recently been visited by the Getting It Right First Time (GIRFT) programme by NHS improvement. GIRFT helps to improve the quality of care within the NHS by bringing efficiencies and improvements. This is where NHS services are assessed, and areas of good practice shared, and they help trusts to improve areas of concern. The aim is to improve patient outcomes. This was ongoing at the time of our inspection.

Lung Cancer Audit

The table below summarises North Bristol NHS Trust’s performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist</td>
<td>72.6%</td>
<td>Does not meet the audit aspirational standard</td>
<td>×</td>
</tr>
<tr>
<td>(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate</td>
<td>38.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
(Adjusted scores take into account the differences in the case-mix of patients treated)

<table>
<thead>
<tr>
<th>Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients treated)</th>
<th>17.9%</th>
<th>Within expected range</th>
<th>✓</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</th>
<th>67.4%</th>
<th>Within expected range</th>
<th>✓</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</th>
<th>53.9%</th>
<th>Within expected range</th>
<th>✗</th>
</tr>
</thead>
</table>

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

Southmead Hospital

The table below summarises Southmead Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>N/A</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good</td>
<td>57.1%</td>
<td>Amber</td>
<td>✗</td>
</tr>
</tbody>
</table>
The falls leads included the head of therapy and a quality improvement and patient safety nurse lead. We discussed the latest National Audit of Inpatient Falls data with the falls leads. They felt the crude proportion of patients assessed for the presence or absence of delirium had been improved with the implementation of the National Early Warning Score 2 which now includes delirium. The crude proportion of patients who had a lying and standing blood pressure assessment was a Commissioning for Quality and Innovation (CQUIN) focus, so the trust would be working to record and capture this information to comply with the CQUIN.

The National Audit of Inpatient Falls has now transitioned from its previous methodology, snapshot audit in 2015 and 2017, to a new methodology to enable continuous audit. The new audit will focus on patients who sustain a hip fracture while in hospital. The trust have volunteered to participate in the initial stages of this audit, and are comparing well to other organisations. Participation allows them to look and learn from other organisations.

Up to date information about effectiveness of falls care was shared internally and externally. A falls group was held, the agenda included; a review of serious falls, training and compliance, and compliance data and audit. Results could be discussed and used to improve care and treatment.

**Chronic Obstructive Pulmonary Disease Audit**

**Southmead Hospital**

The table below summarises Southmead Hospital’s performance in the 2018 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission? (Specialist input improves processes and outcomes for COPD patients)</td>
<td>79.5%</td>
<td>Better than national aggregate</td>
<td>✓</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Hospital performance</td>
<td>Audit’s Rating</td>
<td>Meets national standard?</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------</td>
<td>----------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) (Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</td>
<td>100.0%</td>
<td>Better than national aggregate</td>
<td>✓</td>
</tr>
<tr>
<td>Percentage of patients receiving non invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</td>
<td>Not available</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</td>
<td>15.1%</td>
<td>Worse than national aggregate</td>
<td>✗</td>
</tr>
<tr>
<td>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</td>
<td>92.6%</td>
<td>Better than national aggregate</td>
<td>✓</td>
</tr>
<tr>
<td>Percentage of patients with spirometry confirming FEV1/FVC ratio &lt;0.7 recorded in case file (A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</td>
<td>61.8%</td>
<td>Better than national aggregate</td>
<td>✓</td>
</tr>
</tbody>
</table>

(Source: Chronic Obstructive Pulmonary Disease Audit)

**National Audit of Dementia**

The NHS Improvements 90 day collaborative was reviewing the early identification of dementia and use of cognitive care tools, which the trust participated in. Audits had shown inconsistencies across wards. Work was being done to engage champions and share learning, to then re-audit and present results.

**Southmead Hospital**

The table below summarises Southmead Hospital’s performance in the 2017 National Audit of Dementia.
<table>
<thead>
<tr>
<th>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</th>
<th>60.0%</th>
<th>Worse</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/service able to respond to the needs of people with dementia as they arise?” (This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</td>
<td>74.0%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium (Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</td>
<td>98.0%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</td>
<td>93.3%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Audit of Dementia)

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development, however appraisal compliance was not meeting trust targets.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Competencies relevant to the ward specialty and staff role were completed on induction and an ongoing basis. We saw examples of these on wards we visited.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to staff who had started their role in the last year; they told us they had a full induction to be prepared for the role.
**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. From April 2018 to March 2019, 82.9% of required staff in medical care received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>Trust target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>113</td>
<td>98.3%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>154</td>
<td>90.6%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>31</td>
<td>88.6%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>48</td>
<td>87.3%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic and technical staff</td>
<td>39</td>
<td>86.7%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>355</td>
<td>79.6%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>295</td>
<td>78.2%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic and technical staff</td>
<td>13</td>
<td>61.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,048</strong></td>
<td><strong>82.9%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers could also identify any training needs, or specialist training, their staff required to provide opportunities to develop their skills and knowledge. Staff spoke positively to us about the appraisal process.

Both nursing staff and medical staff were supported to develop through regular, constructive clinical supervision of their work. Junior medical staff said they were well supported by the consultants, and arrangements were made for supervision, with protected teaching time and good quality training. There were practice development nurses to support nursing staff learning and development.

**Multidisciplinary working**

*Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.*

Patients had their care pathway reviewed by relevant consultants and specialist nurses and therapists. There was a holistic approach to assessing, planning and delivering care and treatment to patients. Therapy input was prominent on all wards with therapy staff embedded within teams within clinical pathways, this meant patients had the specialist input they required to support them with their recovery. We observed excellent multidisciplinary working on wards during our inspection. There was a real presence of the multidisciplinary team who were actively engaged.

The division had found innovative and effective ways to deliver more joined up care to patients. For example, the multidisciplinary team were involved with quality improvement areas to deliver
more effective care, and multi-professional opportunities were considered within roles. This included physiotherapists supporting the nursing workforce on respiratory wards.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Board rounds were attended by the multidisciplinary team and everyone engaged to ensure the care was co-ordinated.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patients could be referred to specialist services internally and externally to ensure a multidisciplinary approach to their care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff felt supported by the mental health liaison team and knew how to access this service for patients.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards. Patients were reviewed by consultants depending on the care pathway.

Staff could obtain/access support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Therapy services were provided on the week days, with arrangements for weekend cover or on call services where required. The physiotherapy weekend rota was voluntary, which did risk the ability to continue to staff this and provide the service during weekends.

The stroke service was providing a seven-day therapy service which included physiotherapy, occupational therapy and speech and language therapy. This helped with the ongoing rehabilitation of patients before they went home.

The trust participated in mandatory audit of performance against the seven day standards. Of the ten standards there are four key quality standards within the audit tool:

Standard 2: consultant review within 14 hours of decision to admin
Standard 5: access to diagnostics
Standard 6: consultant directed interventions available locally or within a defined care pathway
Standard 8: once or twice daily review where required

Trust wide audit results for April 2018, reported on 20 February 2019, showed full compliance with standard five and six. Compliance for standard two was 89% in week and 92% at weekends. Non-compliance was identified for standard eight daily review with average performance 69% in week and 51% at weeks. The trust was compliant with standard eight twice daily review.

The mental health liaison service is funded to provide a five day 9am to 5pm service for inpatient wards, however the emergency zone mental health liaison team will provide urgent advice over the weekend. The division was working closely with commissioners to provide mental health liaison team service across seven days and are awaiting decisions about funding. The team had previously trialled the seven-day service and recognised the benefit and is part of their proposed vision for the future.

**Health promotion**
Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and units. Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Specialist services were able to provide advice and support to patients relevant to their care and treatment needs, to help promote a healthier lifestyle and improve their outcomes. For example, raising awareness of healthy behaviours, and enabling people to have control and improve their health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty. However, there were some inconsistencies with the recording of mental capacity assessments when making resuscitation decisions.

Mental Capacity Act and Deprivation of Liberty training completion

All clinical staff completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The trust set a target of 85% for completion of MCA and DoLS training.

As at April 2019, the trust reported MCA and DoLS training was completed by 91.2% of all staff in medical care compared to the trust target of 85%. A breakdown of compliance for mental capacity and DoLS training as at April 2019 for registered nursing and midwifery and medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>183</td>
<td>200</td>
<td>91.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>418</td>
<td>464</td>
<td>90.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Both medical and registered nursing and midwifery staff in medical care met the trust target of 85% with completion rates of 91.5% and 90.1% respectively.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They made sure patients consented to treatment based on all the information available, and clearly recorded consent in the patients’ records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.
Our previous inspection found the understanding among staff of Deprivation of Liberty Safeguards was varied, and there was evidence of an inconsistent approach to the assessment of mental capacity. We told the trust they must update all staff on when to submit a Deprivation of Liberty Safeguard application in line with national guidance. All inpatients on medical care wards that cannot give informed consent to be admitted to hospital require a Deprivation of Liberty Safeguard authorisation, this authorises the trust to deprive the person for up to seven days. This must be in the patient’s best interest and follow strict criteria.

Since our last inspection we felt staff knowledge of Mental Capacity Act, Deprivation of Liberty Safeguards and Mental Health Act had improved. Staff told us the trust had revised the mental capacity form and it was now much simpler to use. Staff had been provided with additional training to support Deprivation of Liberty Safeguards, and patients were regularly discussed. Staff were able to talk through examples of decision specific assessments they had completed and were aware of fluctuating capacity and the need to make assessments at different points.

Information about how to submit a Deprivation of Liberty Safeguard was included in the mandatory safeguarding training to ensure greater staff understanding. Practice development nurses on some wards had also supported training in completing forms for capacity assessments and Mental Capacity Act training for staff.

Patients who were subject to a Deprivation of Liberty Safeguard were flagged on the electronic system and discussed as part of handover safety briefs, ward rounds and senior nursing leadership and flow meetings.

The learning disability team told us they supported clinicians on the wards to complete mental capacity assessments, encouraging best interest meetings and discussions, and any referrals to the Independent Mental Capacity Advocacy.

Improvements were needed to ensure consistent recording of capacity assessments to support resuscitation decisions. We reviewed the completion of Do Not Attempt Resuscitation documents and mental capacity assessments. There were three places to record capacity within the patient records, this included the front sheet, the proforma and the progress notes. These were not being completed consistently and therefore there were difficulties identifying if mental capacity had been assessed. However, on complex elderly care ward 9a the ward sister had introduced a new system, so at the beginning of each patient’s file with the resuscitation decision form there was also a capacity assessment form. This was not yet embedded in practice as had only been introduced two weeks before to our inspection.

Staff completed paperwork for patients under the Mental Health Act correctly. We reviewed the paperwork for a patient on a Section 2 under the Mental Health Act (to be detained in hospital under a legal framework for an assessment and treatment of their mental disorder). Documentation was fully completed for mental capacity assessment before the patient was sectioned, this was decision specific in relation to the patient’s stay as an inpatient. It included benefits and risks explained to the patient and ascertained the person did not have capacity. The section two was also completed in full, to include medical recommendation for assessment and interview with the patient, the reason for application and outcome. A best interest meeting had been held which was decision specific in relation to discharge.

Is the service caring?

Compassionate care
Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

There were examples where staff went above and beyond to care for patients:

- One nurse on the respiratory step-down ward (28b) purchased some lemonade from their own money because “it was just what the patient fancied.”
- Another example on the respiratory ward (27b) where a patient was celebrating a birthday and wanted a glass of wine, this was arranged by the specialist.
- On the renal ward (8b) discharge plans were arranged so a patient could attend an important family birthday celebration.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we observed positive interactions between staff and patients, providing kindness in care. We found the atmosphere in the complex elderly care wards was tranquil and calm, which was appropriate to meet the needs of the patient group on this ward.

Staff followed policy to keep patient care and treatment confidential. Staff spoke quietly or within private areas when discussing patient care and treatment.

Patients said staff treated them well and with kindness. However, recognised the pressures of staffing which compromised the time staff had available to give individual care.

We received positive feedback directly from patients. We observed on all the wards thank you cards from patients and/or their relatives all expressing their thanks for the care and treatment provided. On one of the wards a relative came in to thank the staff for looking after their relative who had died.

We received positive feedback directly from patients and saw thank you cards wards had received:

At our previous inspection we told the trust they must arrange additional beds, so they do not compromise patients’ privacy and dignity. During this inspection we found fewer instances where patient privacy and dignity was compromised during times of escalation. Flow was being better managed within the hospital, so people were only held in escalation areas for the smallest time possible. However, when patients were queueing in or out of the acute medical unit and bedded in the corridor, their privacy and dignity was less protected when compared to a patient bedded in dedicated bed space. Staff were conscious of this and screens were used to respect the patient’s privacy and dignity as much as possible. It was recognised by the trust this was not the ideal environment for patient privacy and dignity, but clinical priority and safety was paramount.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

**Emotional support**
Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

Staff demonstrated empathy when having difficult conversations and breaking bad news.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. There were arrangements for open visiting on Elgar and ward 32A as they felt this was best to support patients care and treatment.

The use of single rooms impacted on some patients’ psychological well-being. Consideration should be given to how the use of single rooms may impact on some individuals, particularly if they are in hospital for a longer period of times. Some patients described to us the psychological impact of being in a single room, which made them feel lonely or feeling trapped in a room, particularly when there was not enough light from windows.

The purple butterfly was used for personalised and compassionate end of life care. The purple butterfly could be placed on the door to ensure all staff were aware to provide additional sensitive and compassionate care. The palliative care team could support staff in caring for these patients. There was a purple butterfly menu, a menu for patients who were receiving end of life care, provided by the housekeepers.

**Understanding and involvement of patients and those close to them**

Some improvements were needed in how staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We saw staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. However, were told information was not always communicated in a timely manner to patients and relatives. Two relatives commented how they have been involved in the care, but staff were not always forthcoming with information. One patient also found the doctors did not always communicate what was happening, so it was difficult to find this information out.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw examples of ‘you said, we did’ boards on wards displaying the feedback and changes made.

Staff supported patients to make both advanced decisions and informed decisions about their care. We observed care and treatment being explained to patients and their families in detail for patients to provide consent.

**Friends and Family test performance**

The Friends and Family Test response rate for medical care at the trust was 20% which was worse than the England average of 24% from February 2018 to January 2019.

Southmead Hospital
1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.

2. Sorted by total response.

3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Is the service responsive?

Service delivery to meet the needs of local people

The service was restricted by the challenges faced with capacity and flow. However, planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were mostly appropriate for the services being delivered. Wards were designed to care for the most ill or at risk patients in the enhanced care four bedded bays, with other patients using the large number of side rooms. However, at times of escalation patients were required to be held for short periods of time in corridors, or additional bed spaces within the bays. These areas were not always suitable for patient experience, although safety was prioritised.

The environment in interventional radiology was still not suitable for inpatients, although there had been improvements. Interventional radiology is a day case unit designed for patients who have been pre-assessed as being unlikely to require an inpatient bed. There were 18 trolley spaces, with two separate areas for single sex accommodation. If used overnight trolleys were replaced with beds. The unit operated Monday to Friday from 8am to 8pm. Additionally, Sunday to Thursday there was escalation inpatient capacity and it was staffed between 7.30pm and 8am by two registered nurses, with Friday to Saturday staffing if required and authorised/approved. It was used as a second level of escalation capacity to admit inpatients who achieve the set criteria.

At our previous inspection we told the trust they must ensure the interventional radiology unit was suitable if patients were transferred for temporary care at times of high operational pressure. We visited interventional radiology during this inspection, which was being used for inpatients at the time of our inspection. The use of this area for inpatients was still not ideal, for example patients had to walk along the corridor to the shower room, and there was one shower room for both males and females. This meant patients needed to be helped to and from the room requiring staff time
and did not promote privacy and dignity. However, the patients who would be moved to interventional radiology tended to be discharged home the next day in line with the criteria, which was being better managed. We did find patients now had access to hot food, and arrangements were made with the catering team to ensure this.

The standard operating procedure for admitting inpatients to interventional radiology day case unit recognised the patient safety and patient experience issues within this environment. This was also included as a high risk on the Trust’s risk register. While the standard operating procedure stated only patients with a planned discharge would stay in the unit four one night, at the time of the inspection we found not all patients had been discharged in the morning.

Changes were made to the organisation of services to help improve the challenges with patient flow. The acute medical unit was formally reconfigured five years ago into an assessment side and other areas designated for enhanced care, ambulatory emergency care and short stay patients. The trust found evidence of continual improvements in how the flow of patients was managed in the unit. In the previous six months to the inspection there had been streamlining of the triage process, which we were told reduced the number of internal moves, helped quicker assessments and flow of patients through the unit, and was considered an overall benefit.

The trust was improving the way porters worked to improve flow. For example, there was a pilot on the acute medical unit using a transfer team to help flow between the acute medical unit and wards, by having porters available in the acute medical unit. Data showed the mean average wait for the sample group reduced to 14 minutes, which was a 62% improvement in process times. A business case was put forward to consider the additional staffing to provide focussed patient transfers. Porters were assigned to relevant areas to help move patients in a timely manner between wards. For example, there was a dedicated porter in the acute medical unit and in the discharge lounge.

The ambulatory emergency care unit (AEC) had extended hours to meet demand. The AEC was accessed through the acute medical unit via GP referral. The AEC was now open 8am to midnight, staffed from 7am to midnight by nursing staff and until 10pm by medical staff. This was extended in October 2018, where previously AEC wasn’t staffed from 7.30pm. Increased consultant cover and cover at weekends was in place to help admission avoidance.

The use of Elgar house had been changed and was now used as a care of the elderly delayed transfer of care process, and an area for reablement. This has improved flow for the care of the elderly wards with less ‘one ups and two ups’ (additional beds in bays).

Step down models of care were implemented so patients could be transferred quicker from high dependency beds.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The use of single rooms helped reduce mixed sex breaches as patients had their own private room and bathroom. The trust reported no mixed sex breaches.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff knew how to make referral to other services via trust systems, emails or phone calls. There was rapid access to specialties.

The service relieved pressure on other departments when they could to treat patients. Hot clinics were held for some specialties to avoid admissions and improve wait times. For example, Transient ischemic attack (TIA) clinics ran at the weekend from ward 7A. A TIA can mimic stroke-like symptoms. While TIAs generally do not cause permanent brain damage, they are a serious
warning sign that a stroke may happen in the future and should not be ignored. These hot clinics were for patients who did not require urgent hospital admission. Patients were referred by their GP and triaged by the medical and nursing team and those who were assessed were called into the ward. Two MRI scanner slots were available each weekend and patients could undergo other tests. These were reviewed, and decision made about their treatment. TIA clinics also ran during the week. Endoscopy was now running Saturday lists. The trust also introduced an endoscope ultrasound service in May 2019.

The service considered how to work within the healthcare system to provide care and advice. For example, the gastroenterology service had started a process where they could be contacted to provide advice and guidance for GPs. GPs could also refer directly to the ambulatory emergency care unit, and there was a referral system to manage this.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and a diagnosis of dementia, received the necessary care to meet all their needs. They supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff also had access to communication aids to help patients be involved in decisions about their care and treatment.

The trust had a learning disability team which patients could be referred to. The team helped review the best place for a patient to stay, for example; the privacy of a single room for a quiet space and less stimulation, or a shared space for more observation if patients cannot communicate their needs. They attended the multidisciplinary team best interest meeting, which also included the family. There were 50 learning disability champions across the trust, and the learning disability team were encouraging the champions in all areas.

Staff could access a mental health liaison team which included consultants and nurses. They operated an inpatient service between 8.45am and 5pm Monday to Friday. They helped to support both patients and the staff.

The trust had a dementia lead to support staff to care for patients with dementia. A forget me not symbol was used to identify patients living with dementia.

Not all environments were dementia friendly, however, the service was working to make some of the environments dementia friendly. Dementia care was considered within care of the elderly ward and the transitional and rehabilitation wards. There were some adaptations to the environment to be designed to meet the needs of patients living with dementia, for example in Elgar 2 there were colour coded doors for bathrooms and toilets with large symbols. Cupboards for storage were painted grey so to encourage patients not to use them. Elgar house had funding to make changes to the environment to make it more dementia friendly. For example, changes to the corridors to make them white and include paintings.

Weekly memory cafes were held jointly provided by the hospital dementia team, a dementia support charity and the carer’s liaison team. This provided an opportunity for patients, carers, family members and staff to drop in for information and advice about all aspects of dementia and cognitive impairment. They were held within the Brunel building (main hospital site) and in Elgar house.

Initiatives in Elgar House had helped promote patient engagement and creativity. They had creative champions, and activities were run on the ward. Visits from a therapy dog were also
arranged. Staff were being encouraged to offer activities daily. There were two shifts for activities only, but at times of high demands these did not always take place.

Stroke ward 7A had Behavioural Health Care Assistants to care for patients who needed enhanced care. These were members of staff who had a first degree in psychology, so they had additional knowledge and skills to help care for patients for example living with dementia.

Managers made sure staff, patients, and carers could get help from interpreters or signers when needed. Staff told us how they could access translators, there was also a multilingual work force which could be used to help with translation while a translator was being arranged.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed lunch time on one ward. All staff were helpful to bring patients their food. There were several choices available, and the housekeepers said they could order sandwiches if there was an admission after lunch or patients were hungry. Special diets were catered for. Hot drinks were offered at set times during the day, but staff told us they would make patients a hot drink if requested.

Access and flow

Flow continued to be a challenge for the trust, however, this was being better managed since our last inspection, with use of clear escalation processes and specific criteria for moving patients.

Our previous inspection identified the trust must make improvements for the management of patient flow in the medicine division, ensuring length of staff was reduced and bed occupancy rates were at safe levels. During this inspection we found there had been a clear focus on flow and the process for managing had greatly improved.

Staff also felt there had been definite improvement with flow across the hospital and could demonstrate this. They found there was more of a connection from the front door to the ward, and visibility of where people were. Staff spoke of more collaborative working for discharge and issues with leaving hospital being better challenged. Staff told us winter planning had been successful, asking staff for input, to help plan the bed space. Winter bed modelling for winter 2018/19 saw both the Neurological and Musculoskeletal Sciences, and the Anaesthesia, Surgery, Critical Care and Renal division each sharing a ward with medicine as part of the planned winter bed model. The trust reported this had a positive impact on the ability to provide the appropriate and necessary medical and nursing care. Staff consistently told us the one ups and two ups (beds in extra bays) were not frequent and were now used as pre-emptive transfers so patients would only be bedded on an additional bed within a bay for a short period of time.

There was a flow matron dedicated to improving safety, quality and flow. With the operational leads this ensured a seven day a week senior representation and guidance for management of patient flow within the hospital.

Ward sisters and matrons attended daily leadership and flow meetings to consider staffing and flow, for example any barriers to discharges. The bed manager presented the current position within the hospital and discussion of availability of beds.

The trust had a plan based on the national framework Operational Performance Escalation Level (OPEL) to respond to increased pressures in demand or surges. The OPEL level is set based on triggers and is updated every two hours, seven days a week on an electronic system.

Bed meetings were held three times a day and attended by leaders from across the divisions. An
internal critical incident was declared at 8am on Tuesday 25 June 2019 when the trust was in OPEL 4, the highest level of pressure escalation. The trust responded appropriately to this, discussions were held during meetings with actions proposed and followed up. Division representatives attended bed meetings to discuss beds available, identify outlying capacity, consider safe movement of patients to escalation areas and proposed discharges and how these could be supported. Any digression from standard operating procedures was also discussed and confirmed. Staffing was arranged to ensure discharge lounge, escalation areas and corridors could be managed. Calls were held externally within the healthcare system to maximise capacity within the community and help improve flow through the hospital to free up bed capacity.

Demand was outweighing capacity, and escalation areas were being used frequently. Patient areas were identified to be used temporarily to increase capacity, areas of bed escalation used were interventional radiology and medirooms. Updated standard operating procedures were developed for use of these areas at times of escalation. This included interventional radiology if in OPEL 3 or 4 and capacity capped at 10, medirooms capacity at 18 or 24 in winter used Monday to Friday, or pre-emptive transfer to be used in hours or with executive authorisation out of hours.

We requested data to show the use of escalation areas. From 14 January to 2nd June 2019, a total of 119 days, interventional radiology day case area was used for 77 days, ambulatory emergency care was used for 70 days, and medirooms for 20 days as part of the winter bed model. Interventional radiology recovery area was being used regularly for medical inpatient care. Patients who were to be moved to the interventional radiology recovery area for their inpatient care were required to meet specific criteria included within the standard operating procedure. An audit was being completed for any non-adherence to the standard operating procedures. In April 2019 there were four patients who were bedded in interventional radiology recovery area from emergency department with no definite discharge. At the time of our inspection for June 2019 there had been 15 patients who did not meet the criteria where discharge was not planned or confirmed for the following day. This covered all patients, not just those from medical care services.

The ambulatory emergency care area in the acute medical unit was also used as an escalation area for inpatients. There were eight spaces but three of these were protected to not be used for inpatients, so the ambulatory service could continue to run first thing in the morning.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards and worked to minimise the number of medical patients on non-medical wards. There was a management plan for medical outliers and staff were aware of where these patients were within the hospital bed base. The trust had standard operating procedure for the medicine division, medical winter bed base and outlier management. Each day at board rounds the multidisciplinary team identified patients who were suitable to step down to the winter bed base capacity or outlier beds. These patients were then discussed at the leadership and flow meeting, and further updates to the duty matron. A board round was held to discuss medical outlier patients, before ward rounds were completed. Interventional radiology was prioritised for ward rounds so patients could be seen by the medical team to allow for early discharge and to not impact on daily elective work.

Between 1 January 2019 and 25 June 2019, the number of outliers fluctuated from a couple of patients to just over 60 patients. Numbers were higher between January and mid-February where there was planned winter capacity to outlie patients.
The complex assessment and liaison service (CALS) team helped support the frailty pathway and the flow for the care of the elderly patients within the hospital. They supported complex geriatric assessments at the front door (emergency department and acute medical admissions) and patients once admitted to wards.

There had been an ongoing reduction in the length of stay on the complex assessment unit ward (32a) since becoming the frailty short stay ward in 2016, which was supported by data. Data also showed a reduction in average length of stay by 1.5 days for elderly patients on care of the elderly wards between 2017 and 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>Spells</th>
<th>Associated Bed Days</th>
<th>Average Length of Stay Care of the Elderly Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>April to February 2017</td>
<td>4191</td>
<td>58655</td>
<td>14</td>
</tr>
<tr>
<td>April to February 2018</td>
<td>4800</td>
<td>60007</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Intervention by the CALS team supported admission avoidance and early discharge across the emergency zone. A frailty ambulatory pilot in the emergency department had been completed between September 2018 and March 2019. This enabled time complex geriatric assessments and provision to begin making arrangements for the patient, for example social work assessments and placements, to support a timely discharge. Some patients could be discharged home rather than being admitted to hospital. Funding had been arranged for a room to be available for frailty care from August 2019. In the acute medical unit there was a seven-day presence of the CALS team, to help assess patients and arrange suitable admissions, or discharges. Helping to facilitate safe discharge. There was potential for a patient to be transferred directly from the acute medical unit to Elgar house if seen by the CALS team. They also helped identify high impact user groups such as frequent users to ensure care plans were appropriate for these people to prevent further admissions.

Managers and staff worked to make sure that they started discharge planning as early as possible. The patients expected discharge date was reviewed regularly through their admission and discussed amongst staff. Barriers to discharge were discussed and relevant teams involved to help expedite.

The management of discharges had improved since our last visit, an operational improvement methodology had suggested different ways of working for better patient outcomes.

The integrated discharge team helped supported complex discharges. They were responsible for co-ordinating available beds in the community or packages of care for patients to be discharged safely. Case managers were available to support staff and prompt them to plan for the patient’s discharge.

The integrated care bureau was responsible for improving planning to facilitate earlier discharge and thus patient outcomes. A single referral form had been introduced, to refer to the integrated discharge team to support complex discharges, and had helped reduce the length of stay. This pulled information from both nursing and social assessment to populate the referral form. Data showed the average days from single referral form to discharge, and the average length of stay for integrated care bureau patients was decreasing and therefore improving.

Delayed transfers of care were not meeting commissioner targets. Delayed transfers of care as a percentage of bed base between 28 March and 20 June 2019 fluctuated each week between 4.8% and 8.6%. This was continually not meeting the 3.5% target. However, discharge delays were reviewed regularly within the hospital and with stakeholders.
Discharges between 1 January and 26 June 2019 where patients were discharged beyond the date of being medically fit for discharge was 3124 patients, which was approximately 520 patients each month. Some of the barriers to discharge were waiting for packages of care or bed availability in the community.

The discharge lounge was open 7.30am to 7pm Monday to Friday, it had 20 chairs and two beds. Patients could wait in the discharge lounge for their relatives or for transport. When the trust was in escalation (declared internal critical incident) patients could go to the discharge lounge without their medications being ready, and the discharge lounge nursing staff would co-ordinate the medications prior to them being sent home. This helped to move patients who were medically fit from the wards, so beds could become available. Furthermore, at time of escalation volunteers were arranged to support the discharge lounge to collect medications, provide food and drink, and assist with moving patients.

Length of stay reviews were completed and information was presented on the medicine division dashboard, so leaders were able to review. The dashboard included a review of average length of stay, patients with length of stay between seven and 21 days, total discharges, morning discharges, and occupied beds.

**Average length of stay**

**Southmead Hospital**

From January to December 2018 the average length of stay for medical elective patients at Southmead Hospital was 4.5 days, which was lower than England average of 6.0 days.

For medical non-elective patients, the average length of stay was 7.3 days, which was higher than the England average of 6.2 days.

**Elective Average Length of Stay - Southmead Hospital**

![Graph showing average length of stay for different specialties]

*Note: Top three specialties for specific site based on count of activity.*

- Average lengths of stay for elective patients in neurology and nephrology were lower than the England averages.
- Average length of stay for elective patients in cardiology was similar to the England average.
Non-Elective Average Length of Stay - Southmead Hospital

Note: Top three specialties for specific site based on count of activity.

- Average lengths of stay for non-elective patients in general medicine and stroke medicine were higher than the England averages.

- Average length of stay for non-elective patients in nephrology are lower than the England average.

(Source: Hospital Episode Statistics)

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with national standards.

Referral to treatment (percentage within 18 weeks) - admitted performance

From February 2018 to January 2019 the trust's referral to treatment time (RTT) for admitted pathways for medical care was better than the England average.

In the most recent month, January 2019, 92.9% of patients were treated within 18 weeks compared to the England average of 86.9%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates by speciality for medical care is shown below:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>94.3%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>94.0%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>92.1%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

From February 2018 to January 2019 four specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>89.1%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>86.7%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>79.4%</td>
<td>90.4%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for admitted RTT (percentage within 18 weeks)

(Source: NHS England)

Patients moving wards per admission

The trust provided ward moves data at trust level. From March 2018 to February 2019, 52.3% of individuals trust wide did not move wards during their admission and 47.7% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patients moving wards at night

Patients were being moved between wards or beds at night. Talking to eight patients and three relatives we were told of three moves:

- One patient 12.10am move
- Relative patient moved at 4am
- One patient moved at midnight for a second time.

Patient moves between wards/services was monitored. The division was aware they were moving too many patients at night time. As part of the division’s urgent care improvement programme they were using ‘perform’ improvement methodology to reduce inpatient moves through the night. Data showed in March 2019 417 patient moves happened during 9pm and 8am, representing 31% of all ward moves. By working with individual wards to review activity and moves this would help understand the specific challenges and actions needed to improve this position.

From March 2018 to February 2019, there were 8,060 patients moving wards at night within medical care. The months with the highest number of ward moves at night were March 2018 and January 2019 with 826 each.

The two wards with the highest number of ward moves at night were the acute medical unit, this is an admission unit so has a high level of activity and thus we would expect higher number of moves:
Further ways of improving flow within the medicine division was being explored. Firstly, a criteria led discharge (identifying the clinical criteria for a patient to be discharged and discharging when this has been met) was being trialled by four wards – care of the elderly (32a and 28a), general medicine (34a) and respiratory (27b). Focussing on and introducing and embedding the criteria led discharge to help increase weekend discharges. Secondly, a hospital at home model for medicine was also being explored and scoped to reduce length of stay.

It was recognised the pulling of patients from the emergency department could be improved. An electronic dashboard could be reviewed to see the time patients had spent in the emergency department, and work was being done with the perform team to inform this.

**Learning from complaints and concerns**

*It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.*

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff were encouraged to resolve complaints on the wards.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, patient stories were used within board meetings, or as part of student or staff training.

Staff were keen to ensure patients received optimum care and were responsive to concerns patients raised. For example, patients on long term oxygen therapy which was being delivered by nasal cannulas had reported sore ears where the tubing was sat. This was being reviewed, trialling different ways for more comfort and contacting supply companies for alternate options.

**Summary of complaints**

**Trust level**

From March 2018 to February 2019 the trust received 97 complaints in relation to medical care (12.9% of total complaints received by the trust). The main subject of complaints was clinical care and treatment (54).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>54</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>14</td>
</tr>
<tr>
<td>Communication</td>
<td>13</td>
</tr>
</tbody>
</table>
For the 81 complaints that had been closed at the time of data submission, the trust took an average of 36.2 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be investigated and closed within 30 working days.

The 16 complaints that had not yet been closed had been open for an average of 106.7 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

The trust did not provide a breakdown by core service of compliments received. From February 2018 to January 2019, the trust received 8,435 compliments trust wide.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The divisions had a senior leadership team with the appropriate range of skills, knowledge and experience. The medical care core service we inspected fell within two trust divisions. The medicine division and the neurological and musculoskeletal sciences division. Each division had a clinical director, divisional manager and head of nursing, who provided the divisional leadership. Each specialty within the divisions had a specialty lead, service manager, lead nurse and ward manager.

The medicine division leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. The clinical director and head of nursing were able to tell us about the improvements they had made since their last inspection. This included reducing the length of stay and the need for additional beds on wards. They felt the trust had improved on how they managed with excess demands on their services.

Most staff told us they were well supported by their divisional leadership team, but felt they were stretched across all specialties which sat within the division, compromising the time they had to support. This was a recognised challenge by the leadership team. However, staff were optimistic...
about a movement to cluster working within the division, where each cluster would have their own
manager for leadership and support.

*(Please see the surgery core service report with leadership relevant to the neurological and
muscloskeletal sciences division)*

The leadership team felt they received support from the board. Staff also felt support was
provided, although this was dependent on board priorities. From a recruitment perspective we
were told the board had an appetite for trying new things, which had been reflected in the new
models for staffing.

There was a programme of board visits to services. This included executives and non-executives
that completed walk arounds on wards. However, not all staff were aware of this. In the endoscopy
department we were told about a board member attending the area and is now a board champion
for endoscopy.

Regular meetings were held by the leadership team with their staff. For example, the head of
nursing held monthly sisters meetings and weekly matrons meeting. The clinical director held
meetings with medical teams.

Leadership and development pathways were also available for staff to allow for progression within
the trust.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action,
developed with all relevant stakeholders. The vision and strategy were focused on
sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply them and monitor progress.

The medicine division had a clear vision and set of values with quality and sustainability as the top
priorities. Their vision was “to ensure delivery of the highest quality clinical care by services that
are responsive, capable, and innovative by capturing the knowledge, skills and experience of a
committed, engaged and empowered workforce acting in partnership with our patients.”

There was a robust and realistic strategy for achieving priorities and developing good quality,
sustainable care. The medicine division urgent care improvement programme set out the key work
streams for the emergency zone, frailty, perform and inpatients. Key performance indicators were
used to assess performance. There were three quality themes for the quality priorities for 2019/20
around person centred care, safe and effective care, and learning and improving.

Staff knew and understood the vision, values and strategy and how achievement of these applied
to the work of their team. The leadership team regularly monitored and reviewed progress on
delivering the strategy and local plans. There were divisional strategic aims, but a recognition of
the strategic challenges.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients
receiving care. The service promoted equality and diversity in daily work, and provided
opportunities for career development. The service had an open culture where patients, their
families and staff could raise concerns without fear.

There was an evident multi-professional and collaborative culture within the division. Appreciating
the joined up working and expertise individuals can bring to roles and services.
The divisional leaders told us the culture of the medicine division had positively changed, and staff had a better understanding of the emergency pathways and the impact across the division. The divisional leaders were keen to keep developing a culture of openness.

Staff felt respected, supported and valued. They felt positive and proud about working for the trust and their team. All staff we spoke with had a positive attitude about working together, were passionate about care and were proactive about and wanted to make change and improvements for the benefit of the patients. They felt supported in their roles by senior staff, and all grades and roles of staff felt they were an important part of the ward team.

The trust recognised staff success by staff awards and through feedback. Lots of staff talked to us about their positive incident management (PIMS) awards, where they voted for their colleagues and helped promote staff wellbeing and enable acts of kindness.

Each division had Freedom To Speak Up Guardians. Staff knew about Freedom to Speak Up Guardians and their role. Some staff told us they did not feel confident to raise concerns which related to leadership to the medicine division’s Freedom to Speak up Guardian, due to their level of seniority. However, the trust confirmed the Freedom to Speak Up Guardian within the medicine division had one of the highest number of trust wide concerns raised to them and they told us the number of concerns was broadly in line with national trends. The Freedom to Speak Up Guardian strategy included recruiting more guardians into all roles and an additional focus on communication, awareness raising and championing speaking up.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, systems and processes to support the delivery of quality care and treatment. Each specialty had arrangements for their governance and could explain how this reported to the divisional governance meetings. Divisional clinical governance fed in to the clinical divisional management boards and then to the trust management team who reported to the quality groups and trust board. We reviewed example minutes and saw actions were recorded and followed up.

There were improvements being introduced to the governance structure and processes, although this was not yet fully embedded everyone appeared to be engaged and enthusiastic for the changes. Specialty leads told us the trust were keen to facilitate audit and governance. There had been recruitment of five governance roles within the division due to start in July 2019; divisional quality governance lead and a divisional patient experience lead each with a deputy, and a divisional quality governance co-ordinator. The divisional structure was also being reconfigured so the 13 specialties would be placed in four clusters with a cluster manager to improve governance and leadership support. There will be a set cluster format which will feed into the overall governance for the medicine division.

Mortality and morbidity reviews were completed at specialty level and reported to divisions. Avoidable harm cases could then be discussed at the trust wide mortality and morbidity group for learning to be fed back to the trust board. The structure of mortality and morbidity meetings was being improved in line with the improvements in governance.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. Staff could confidently talk to us about their involvement in governance.
Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were systems to identify learning from incidents, complaints and safeguarding alerts and make improvements.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’. Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. We reviewed the divisional risk register and saw risks matched concerns. Leaders on the wards and within specialties had a good understanding of their risks and how to manage them.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. When talking through audits leads were clear on their performance, and where improvements were needed.

Since our last inspection there was a better oversight and co-ordination of patient flow within the hospital. Flow was reviewed regularly with relevant people, and there were clear actions and updates discussed within bed meetings. Following the declaring of an internal critical incident during our time of inspection teams were asked for feedback about what did or did not go well with the management of this, to allow for learning. Most staff we spoke with about flow told us this was being better managed, and they could see the benefits of changes.

Nursing leaders managed any risks or issues which may impact the division. Daily leadership and flow meetings were held by the nursing matrons and sisters from each medical ward, and senior staff. This was an opportunity to discuss pressures on the division, flow, each ward’s staffing and any safety concerns. Staff were deployed between wards to cover for any vacancies where able. Requests for bank and agency staff were discussed and actioned by senior staff.

An external company completed an internal audit in April 2019 to review the management of medical outliers. They assessed there was ‘significant assurance with minor improvement opportunities’.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. There were several electronic systems used, some staff explained frustrations and the time constraints with using lots of different systems which did not interface. For example, for one patient a consultant may need to use seven different systems and may need to scroll for archived information to find a relevant consultation letter. However, it was also recognised how there was always access to patient notes both from this admission and previous admissions or appointments.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Key
performance indicator dashboards and assessments were held for each division. This reviewed quality, workforce, finance and responsiveness.

Leaders used meeting agendas to address quality and sustainability sufficiently. We saw examples of agendas for meetings both at a divisional and local level.

**Engagement**

*Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.*

Patient engagement was gained via friends and family test, patient advices and liaison service, or any informal information received for example verbal to staff. The complex advice and liaison service team had used experience based design to gather patient feedback on the experience of the frailty service at the front door. They also piloted an app designed specifically for patient feedback.

Wards held team meetings to engage with their staff, although the regularity of these were variable and there were difficulties to hold and get good attendance. The acute medical unit matron was planning to trial skype calls to hold their team meetings.

The medicine division had started to hold confidential focus groups where registered nursing staff from all areas of the division come together to discuss their reasons for staying in the division or reason for considering leaving. This was a new initiative to help gain feedback from staff to support where improvements can be made for retention of the nursing workforce.

The trust had recruited overseas nurses who were due to join the organisation. Support was being sought for these nurses from people who have had similar experiences, to ensure they feel welcomed and act as buddies.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.*

The division compared themselves to other trusts, to allow for benchmarking. We were told they felt they were doing well comparatively. When introducing new processes or systems they would visit other trusts to learn and develop.

There were organisational systems to support improvement and innovation work. Perform methodology had been used to deliver a step change improvement in patient flow. The trust partnered with an external service to introduce and embed perform. Staff were supported to understand their roles within patient flow and the digital tools they had available, to help improve processes. A Health Service Journal partnership 2019 award was presented to North Bristol Trust and their partners for the ‘best clinical service and treatment pathway transformation project’.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. Staff keenly spoke to us about their involvement with perform projects or plans to use perform methodology for future projects.

Several quality improvement projects had been run relevant to medical care. For example, quality improvement for discharge, stroke services, end of life care, pharmacy services, capacity, cognition and communication, and specialist services. Further work was planned around quality improvement.
North Bristol NHS Trust provides emergency and planned (often referred to as ‘elective’) surgery from its core site at Southmead Hospital.

Emergency surgery is provided seven-days a week. There is a suite of six emergency operating theatres including two 24-hour theatres. Patients can be admitted through the emergency department or the surgical admission unit. An ambulatory care clinic runs every day where patients can have investigations and be reviewed by a senior surgeon. In addition a five-day emergency vascular and seven-day plastic trauma clinic is provided.

Planned surgery is provided using 23 operating theatres and with 395 beds at Southmead Hospital.

The operating theatres incorporate a mediroom model of care, which is used instead of traditional anaesthetic and recovery rooms. The medirooms are individual rooms adjoining each operating department. Patients are admitted, prepared for surgery and recovered after surgery in these rooms.

The trust covers the following surgical specialities:

- Burns, plastics
- Elective orthopaedics
- General surgery
- Gynaecology and obstetrics
- Neurosurgery
- Theatres, medirooms, acute pain team
- Trauma and orthopaedics
- Urology
- Vascular surgery

The surgical core service is spread across two of the divisions in the trust. These are anaesthesia, surgery, critical care and renal (ASCR) and neurosurgical and musculoskeletal sciences (NMSK). Each division has a separate governance system, but each follow the same structure.

For each division there is a senior management team consisting of a general manager, a clinical director and a head of nursing. Underneath each senior management team there are surgical specialities/clusters. The management of the specialities/clusters consists of a service manager/assistant general manager, lead nurse/matron and a specialty lead. For example, under the ASCR division, the surgical services/clusters were: breast services, burns/plastics services, colorectal, general surgery, renal and transplant services, urology, vascular, anaesthesia, and elective and emergency care. Under the NMSK division, the surgical services/clusters were: neurosurgery and orthopaedics and trauma.

The trust has 13 surgical wards, all located at Southmead Hospital:
The trust had 49,678 surgical admissions from January to December 2018. Emergency admissions accounted for 14,675, there were 26,721 day case admissions, and the remaining 8,300 admissions were for planned procedures.

(DSource: Hospital Episode Statistics)

During our inspection we visited the following wards, units and theatres:

- Gates 20 and 21 which included medirooms, and emergency and elective theatres.
- Gate 25a which cared for neurology and neurosurgery patients.
- Gate 25b which cared for trauma and orthopaedics patients.
- Gate 26a which cared for elective orthopaedics patients.
- Gate 26b which cared for trauma and orthopaedics, and general surgery patients.
- Gate 33a which cared for burns and plastics patients.
- Gate 33b which cared for vascular surgery patients.
- Gate 34a which cared for short stay patients.
- Gate 34b which cared for urology patients.
- Pre-assessment and surgical assessment units, and the discharge lounge.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Speciality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate 6b</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Gate 20</td>
<td>Theatres, medirooms, acute pain team</td>
</tr>
<tr>
<td>Gate 21</td>
<td>Theatres, medirooms</td>
</tr>
<tr>
<td>Gate 25a</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Gate 25b</td>
<td>Trauma and orthopaedics</td>
</tr>
<tr>
<td>Gate 26a</td>
<td>Elective orthopaedics</td>
</tr>
<tr>
<td>Gate 26b</td>
<td>Trauma and orthopaedics, surgical assessment unit, general surgery</td>
</tr>
<tr>
<td>Gate 32b</td>
<td>Surgical assessment unit - gastroenterology, infectious diseases, haematology</td>
</tr>
<tr>
<td>Gate 33a</td>
<td>Burns, plastics</td>
</tr>
<tr>
<td>Gate 33b</td>
<td>Vascular surgery</td>
</tr>
<tr>
<td>Gate 34a</td>
<td>Short stay unit, general surgery, general medical</td>
</tr>
<tr>
<td>Gate 34b</td>
<td>Urology</td>
</tr>
</tbody>
</table>
During our inspection, we spoke with over 60 members of staff including members of the divisional management teams, specialty leaders, matrons, porters, medical and nursing staff, and allied health professionals. We spoke with 12 patients and those close to them including their families. We observed the treatment and care provided to patients as well as attending safety briefings and bed meetings. We reviewed documentation including 10 patient records, minutes of meetings, reports, and policies and procedures.

### Is the service safe?

#### Mandatory training

The service provided mandatory training in key skills to all staff. However, there were some mandatory training courses where staff did not meet trust targets for updating these key skills. Not all staff in medirooms had immediate life support training in line with guidance.

#### Mandatory training completion rates

Nursing and medical staff received and mostly kept up-to-date with their mandatory training. The trust set a target of 85% for completion of mandatory training. Managers monitored compliance with mandatory training and alerted staff when they needed to update their training.

A breakdown of compliance for mandatory training courses as at April 2019 for registered nursing staff in surgery is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient handling</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>569</td>
<td>611</td>
<td>93.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management (clinical)</td>
<td>567</td>
<td>612</td>
<td>92.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - 2 year expiry</td>
<td>566</td>
<td>612</td>
<td>92.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety - 3 year expiry</td>
<td>115</td>
<td>125</td>
<td>92.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism (VTE)</td>
<td>542</td>
<td>590</td>
<td>91.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>556</td>
<td>606</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical blood transfusion training</td>
<td>456</td>
<td>501</td>
<td>91.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety - 2 year expiry</td>
<td>346</td>
<td>386</td>
<td>89.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>545</td>
<td>612</td>
<td>89.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood collection training</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - level 2</td>
<td>542</td>
<td>612</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire</td>
<td>532</td>
<td>607</td>
<td>87.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>518</td>
<td>612</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>505</td>
<td>610</td>
<td>82.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>499</td>
<td>612</td>
<td>81.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling</td>
<td>477</td>
<td>612</td>
<td>77.9%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Compliance with mandatory training for nursing staff had improved since our last inspection. In surgery, the trust had an overall mandatory training compliance rate of 88.2% for registered nursing staff. The 85% target was met for 13 of the 17 mandatory training modules for which
registered nursing staff were eligible. Of the four modules that did not meet the trust target, compliance was close to the target but still needed to improve.

A breakdown of compliance for mandatory training courses as at April 2019 for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As at April 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>418</td>
<td>446</td>
<td>93.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - level 2</td>
<td>408</td>
<td>446</td>
<td>91.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire</td>
<td>402</td>
<td>446</td>
<td>90.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - 2 year expiry</td>
<td>374</td>
<td>418</td>
<td>89.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>374</td>
<td>435</td>
<td>86.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - 3 year expiry</td>
<td>24</td>
<td>28</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>368</td>
<td>446</td>
<td>82.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>361</td>
<td>446</td>
<td>80.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Non-patient handling</td>
<td>259</td>
<td>321</td>
<td>80.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>359</td>
<td>446</td>
<td>80.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>353</td>
<td>446</td>
<td>79.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Waste management (clinical)</td>
<td>342</td>
<td>446</td>
<td>76.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Venous thromboembolism (VTE)</td>
<td>329</td>
<td>431</td>
<td>76.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling</td>
<td>125</td>
<td>184</td>
<td>67.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical blood transfusion training</td>
<td>207</td>
<td>418</td>
<td>49.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Compliance with mandatory training for medical staff had improved since our last inspection. In surgery, the trust had an overall mandatory training compliance rate of 81% for medical staff. The 85% trust target was met for six of the 15 mandatory training modules for which medical staff were eligible. Of the nine modules that did not meet the target, seven were close to the target compliance. However, two modules, patient handling and clinical blood infusion training, needed to improve significantly.

(Source: Routine Provider Information Request (RPIR) – Training tab)

At the last inspection, staff told us work pressures prevented them from attending some mandatory training. Staff we spoke to on this inspection told us this had improved.

Training was delivered across the trust to clinical staff on sepsis recognition. This training included the use of sepsis screening tools and the sepsis six care plans. Sepsis six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis. Leaders told us sepsis training for surgical staff was not mandatory, and therefore, the trust did not measure compliance against total numbers of staff. However, sepsis training had been delivered to over 600 registered nurses and over 100 medical staff in surgery. This training was continuing to be rolled out.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. At the last inspection there was no evidence staff had received this specific training. The mental health liaison team told us mental health
training was now provided as part of mandatory training on the Mental Capacity Act. Nursing and medical staff also received mandatory dementia training.

All staff had basic life support training. However, not all staff in medirooms had immediate life support (ILS) training. This was not in line with the Guidelines for the Provision of Anaesthesia Services from the Royal College of Anaesthetists (RCoA), which stated all clinical staff working within a recovery area should be certified to a standard equivalent to immediate life support providers, and training should be provided.

Leaders told us they wanted all staff in medirooms to have ILS training. They explained this had been a challenge to arrange because of the difficulties in releasing staff to undertake this training due to work pressures. Leaders told us there were plans to provide blocks of ILS training to staff in medirooms. They sought to assure us that in the meantime, patient safety was not compromised in medirooms. They explained staff had the tools to recognise deteriorating patients and were able to call for emergency support from a trained team if a patient went into cardiac arrest. Following our inspection, the trust provided us with a completed action plan on how the service planned to deliver ILS training to mediroom staff. The action plan stated the service had ensured at least one person on shift in medirooms would be ILS trained from May 2019. However, this did not meet the RCoA’s guidelines for the Provision of Anaesthesia Services which stated all clinical staff should be trained.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training modules as at April 2019 at trust level for registered nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As at April 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children - level 2</td>
<td>538</td>
<td>612</td>
<td>87.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 2</td>
<td>538</td>
<td>612</td>
<td>87.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery, the trust had an overall safeguarding training compliance rate of 87.9% for registered nursing staff. The 85% target was met for both safeguarding modules for which registered nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance for medical staff had improved since the last inspection. A breakdown of compliance for safeguarding training modules as at April 2019 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As at April 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children - level 2</td>
<td>411</td>
<td>446</td>
<td>92.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In surgery, the trust had an overall safeguarding training compliance rate of 92% for medical staff. The 85% target was met for both safeguarding training modules for which medical staff were eligible. *(Source: Routine Provider Information Request (RPIR) – Training tab)*

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. The trust provided information and guidance for staff on their responsibilities and how they can act to safeguard patients. Staff we spoke to understood how to recognise safeguarding concerns. For example, staff on ward 33A (burns and plastics) were mindful of the need to find out the cause of burns in case the burns were related to abuse, neglect or self-harm. Staff had access to relevant contact details of people within and outside the trust who they could approach for additional safeguarding advice.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff supported patients with mental health conditions well. Staff were aware of how to access the mental health liaison team for advice on how to best support patients.

**Cleanliness, infection control and hygiene**

There was an unacceptable standard of infection control in theatres. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises were not always visibly clean. Infection control principles were not always followed.

The surgical wards were visibly clean, and furniture was in good order. Infectious patients could be isolated effectively on wards to reduce the risk of cross infection. The service had enough single-rooms to isolate infectious patients as wards at the hospital had mostly single rooms. We saw rooms used to isolate infectious patients were clearly identified with signs to alert staff and visitors. Staff wore correct personal protective equipment such as aprons and gloves when entering isolation areas.

Posters were displayed reminding staff and others of hand hygiene and the importance of being bare below the elbow to enable effective handwashing.

Staff were expected to screen patients for MRSA in line with trust policy. The policy required all patients on the burns unit (ward 33A) to be screened on admission and weekly thereafter. Nurses in the pre-operative assessment unit screened other patients for MRSA and other infections as appropriate depending on risk factors. We requested compliance figures for MRSA screening in surgery. However, the trust provided us with MRSA screening compliance rates for elective orthopaedic (hips, knees and spines) patients only. The trust’s compliance rate was 95% between January and April 2019.

The risk of infection was assessed in line with national guidance. Patients who needed a vascular access device had their risk of infection assessed according to standards in the National Institute for Health and Care Excellence (NICE) QS61 (Statement 5). The trust required the completion and documentation of specified procedures, which were necessary for the safe insertion, maintenance and removal of the device when no longer needed. The visual infusion phlebitis score records we reviewed were fully completed. People who needed a urinary catheter had their risk of infection minimised in line with NICE QS61 (Statement 4). This was by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as
soon as no longer needed. Patients with urinary catheters had a urinary catheter care pathway which detailed twice-daily checks and actions required to maintain infection-free care. The catheter care plans we reviewed stated all actions had been completed.

Staff worked to prevent, identify and treat surgical site infections. Surgical site infections (SSI) were being monitored and investigated. The trust undertook mandatory SSI reporting for infection following hip and knee replacements, which was coordinated by the NMSK Division. During 2018/19, orthopaedic SSIs had been higher than the national benchmark. A quality improvement programme led by a consultant orthopaedic surgeon was in place to review all aspects of the patients’ pathway from referral to discharge with the aim of reducing SSIs. An elective orthopaedic infection control standard operating procedure had also been introduced to prevent cross infection and maintain safety.

In the theatre department, we found infection control principles were not always followed. For example, we found a lack of hand gel dispensers. We raised this with leaders who informed us they would arrange for additional hand gel dispensers to be installed.

There were clinical machines stored in corridors in the theatre department. A senior member of staff informed us this was to ensure equipment was accessible quickly if and when needed. We found that many of these pieces of equipment were dusty. We raised this with the matron on site who told us this would be looked into.

Changing areas in theatres were sometimes untidy and did not promote good infection control practice. Theatre shoes which appeared soiled with blood were scattered around one of the staff changing rooms, or unclean piled up in boxes. Staff told us it was the responsibility of individual wearers to clean shoes. However, we observed several staff in theatres with soiled shoes with what looked like blood stains on them. We also observed a member of staff walk into theatres wearing suede shoes instead of waterproof shoes. When this member of staff was challenged by another for their footwear, the member of staff dismissed their concern. We raised our observations with trust leaders who informed us a meeting would be arranged to discuss these findings and agree future actions as necessary.

We observed a surgeon who was about to undertake a surgical case wearing their watch in a clinical area. We also observed a member of staff carrying a food/water container out of a sterile scrub area.

Staff we spoke to in theatres were not always confident the theatre cleaning schedule was followed at the end of each list. There was also a lack of accountability among staff we spoke to about who was responsible for cleaning specific areas of the theatre complex.

Some theatre preparation areas were also cluttered and visibly unclean, causing a risk to infection control in areas where sterile surgical equipment was opened and laid out. In the preparation room by theatres three and four we found a computer which was visibly dirty with a thick layer of dust on it. Dust can contain microorganisms that can cause infection in immune compromised patients. A senior scrub nurse told us that operational pressures meant staff were not always able to clean this area as scheduled.

To prevent cross-contamination from their clothing, theatre staff were expected to change out of their scrubs when not in the surgical environment. During our inspection we observed hospital staff wearing scrubs outside of the operating theatres. We were unable to differentiate where these staff had been working as staff from different divisions of the hospital also wore scrubs. At our previous inspection, there were plans to provide scrubs of different colours allocated to different departments so that non-compliance could be identified. However, this had not yet been implemented.
Environment and equipment

The design use of facilities and premises and equipment kept people safe. However, there were gaps in some maintenance and checking of equipment, including in surgical safety procedures.

Clinical areas were secured for the protection of patients and staff and opened only using swipe cards provided to authorised people.

Staff were expected to carry out daily safety checks of specialist equipment. However, we identified some gaps in completion. Daily checks on anaesthetic machines in operating theatres were appropriately completed. Resuscitation equipment was available and fit for purpose in theatres and on wards. However, we found checks were not always completed daily in some wards in line with trust policy. We found it was unclear from the sealed tag on the resuscitation trolleys whether the trolley had been tampered with as replacement tags had no serial numbers. Trolleys were tagged but could be easily broken and replaced between monthly full checks with no auditable trail.

Temperatures were not recorded for warming cabinets in theatre preparation rooms and there was no accountability to maintain them. The preparation rooms in the theatre department contained a warming cabinet for each theatre. We did not find documentation to show daily temperature checks had been carried out as required by trust policy.

The service had enough suitable equipment to allow staff to safely care for patients.

Theatres were well laid out and equipped with essential and speciality-specific equipment. Appropriate difficult airway equipment was readily available in accordance with the Difficult Airway Society guidelines.

At the last inspection, we found only seven of 29 theatres had doors with vision panels fitted. This was a potential risk as inexperienced visitors into the department may accidentally walk into the theatre suite. This issue had not progressed since our last inspection and remained on the risk register. Staff highlighted this to us as a risk on this inspection, although we had no evidence of any impact on patient safety at the time. There was a maintenance programme for vision panels to be fitted in the theatre doors over the next 12 months.

Staff mostly managed and disposed of clinical waste safely. At our last inspection, we saw overfull bins used for disposal of sharp instruments (sharps bins) on surgical wards. During this inspection we found this had improved with one exception. Within an unlocked sluice on the surgical assessment unit we found a large unlidded sharps bin with used and exposed needles and syringes. The unlocked sluice room was accessible to patients and visitors. There were two other bins in the room which either had no label or a worn out and ineligible label to indicate what items were to be disposed in them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Patients with significant comorbidities were referred to a complex preoperative assessment clinic. High risk patients underwent a comprehensive assessment using a frailty scoring protocol to plan appropriate care after their surgery. Guidance from an orthogeriatrician was provided for patients admitted with a fractured neck of femur.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service had implemented the latest version of the National Early Warning Score.
(NEWS2) to improve recognition and response to patients at risk of deteriorating and recognition of sepsis. Instructions for staff on what to do if they suspected or knew a patient to be suffering from sepsis was set out in observational charts, and senior staff were confident staff in the service were aware of how to escalate patients suspected or known to have sepsis. The trust had an escalation policy for patients with presumed/confirmed sepsis who required immediate review. We reviewed audit data to show how compliant staff were with the escalation policy. NEWS2 audit results for December 2018 to July 2019 showed compliance varied. Most areas in surgery were compliant, achieving over 90% overall compliance in the audit. However, wards 6b (neurosurgery) and 7b (elective orthopaedics) were not compliant, achieving 68% and 77% compliance over this period, respectively. As part of its plan for the quality of clinical services, the trust had set the improvement of its response to deteriorating patients as one of its priorities for the financial year of 2019/20.

The arrangements for completing surgical swab counts were not in line with guidance from the Association for Perioperative Practice (AfPP). We observed a nurse perform the initial surgical swab count for two procedures that were going to take place one after another. The nurse in question was not sure when we asked them whether they would be part of the team for the second procedure. This was not in line with standards and guidance from AfPP which stated the initial surgical count must be performed immediately prior to the commencement of surgery. The standards and guidance also stated the surgical count should be carried out by two members of staff. Furthermore, the same members of staff should carry out the second (intraoperative) and third (postoperative) counts as well.

In theatres, we found instrument checklists had not been ticked to confirm there had been an instrument count. When we raised this with a member of staff, they explained they had checked the set of surgical instruments before the start of the procedure and the department did not tend to tick the instrument checklists. This was not in line with good practice as it did not provide evidence of essential safety checks.

Staff completed risk assessments for each patient on admission/arrival, updated them when necessary, and used recognised tools. Staff knew about and dealt with any specific risk issues. At the point of admission to the wards, patients were assessed for their risk of, for example, falls, developing pressure ulcers or venous thromboembolism (blood clots). The patient records we reviewed containing risks assessments were fully completed. Patients who were at risk of a blood clot were given treatment in advance of their procedure to reduce the risk. Staff responded to patient risk by placing patients at high risk of falls, or assessed as having other risks, in bays with other patients, rather than single rooms, so staff could monitor them more easily. Staff said they were also increasing observations across wards to reduce the incidence of falls.

There were safety procedures followed in operating theatres to reduce risk of errors. The National Patient Safety Agency’s ‘five steps to safer surgery’ was being followed as part of the WHO surgical safety checklist in theatres. We observed six theatre teams completing safety checks before, during and after surgery. Staff demonstrated a good understanding of the five steps to safer surgery procedures.

The service carried out a monthly audit of compliance with the WHO surgical safety checklist. The checklist was developed with the aim of reducing errors and adverse events and increasing teamwork and communication in surgery. The trust had consistently exceeded its target (95%) for compliance with the checklist in the 12 months from June 2018 to May 2019. Compliance with the checklist reached 97% in June 2019 according to the trust’s integrated performance report (July 2019). Audit results were published weekly to allow lessons to be learnt from mistakes or any gaps in the process, and to celebrate success. Non-compliance with the WHO checklist was reported to
the theatre matron daily. This was in turn reported to the theatre management group who monitored compliance with the WHO checklist.

Safety briefings were held before each theatre list and attended by the full theatre team. This was to ensure the theatre team were fully briefed on each patient on the list. We observed that every change to the theatre list resulted in an additional safety briefing led by the consultants and documentation completed detailing the new information.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Safety briefings were held daily on wards, and multidisciplinary board rounds were used to discuss each patient.

Staff told patients when the patient needed to seek further help and advised what to do if their condition deteriorated. For example, when patients were discharged from the burns’ unit, they had access to an advice line staffed by nurses on the ward.

The service had access to mental health liaison and specialist mental health support. Staff managed risks relating to patients’ mental health well. Staff were aware of how to manage violent behaviour and could describe techniques to keep themselves and patients safe. For example, staff would use de-escalation and distraction techniques, increase levels of supervision and call security staff if necessary. Electronic patient information screens in the wards we visited alerted staff to whether a patient had mental health issues including dementia or learning disabilities. The mental health liaison team were developing an e-learning programme for the whole trust which covered management of agitated patients.

**Nurse and non-medical staffing**

The service usually had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients. An electronic tool based on the needs and risks of patients (safe care live) was used to work out safe staffing levels. Staff told us matrons visited the wards daily and sought assurance that staffing levels were safe. Daily meetings were held to discuss staffing levels. Charge nurses in all the surgical wards we visited were also able to describe the steps they would take if they felt staffing on the wards were not safe. This involved escalating the matter to matrons and ward managers, and requesting extra support as required.

In the anaesthesia, surgery, critical care and renal division, a safe staffing review took place in March 2019. This review looked at a selection of wards including ward 34B (urology) and ward 33B (vascular surgery). The review provided for increased numbers of nursing staff in ward 34B (general surgery and urology) and 33A (burns and plastics).

Staff told us they had enough cover from the nursing team most of the time, although they were not always staffed to agreed levels. Staff we spoke with did not think this compromised patient safety.
There were additional staff available and used to provide enhanced care for patients. On ward 25A, the neurosurgery ward, specially trained special behavioural healthcare assistants were available. They would stay with patients to assist and support them with their psychological needs.

The service used highly qualified nurses (nurse practitioners) to assist with or carry out certain medical procedures on the wards. A nurse practitioner in neurosurgery had been piloted to support some medical procedures on ward 6B following feedback from junior doctors that they needed additional support. Staff we spoke with were positive about the impact the nurse practitioner role had. One improvement had been around working to ensure patients’ medicines to take home could be arranged quicker. This also meant patients did not have to wait unnecessarily in the hospital and a bed was released back to the ward.

Bank and agency nurses were used to fill most staffing gaps. The trust sought to use regular bank and agency staff as they would be trained and familiar with the environment and procedures. In the surgical assessment unit (ward 34B) where there were 11 registered nurse vacancies, staff explained they were mostly able to use their own staff to do regular bank shifts.

Annual agency use for nursing shifts stood at 5% between March 2018 and February 2019. Senior staff we spoke with said, where possible, they avoided using agency staff. Where agency staff were needed, staff were selective about who they used to ensure teams worked well and had the right skill mix. For example, senior staff told us some of their regular agency staff had been working for the service for several years.

Leaders told us some of the most challenging roles to recruit to were theatre practitioners in perioperatives, anaesthetics and recovery. The operating department practitioner was also a challenging role to staff. However, a recruitment campaign was ongoing at the time of the inspection to recruit for these roles.

The vacancy within the neurosurgery perioperative nurse role was on the risk register. Senior staff told us there was a lack of agency staff with the skills needed to undertake this role. The service managed this risk by using neurosurgery nurses on the wards to fill in gaps in the working schedules.

Staff turnover in nursing was reducing. The trust’s reported annual turnover rate for registered nursing staff in surgery between March 2018 to February 2019 was 15.3%. This was below (better than) the turnover rate for the trust compared to data at our last inspection, where turnover was 20.6% between August 2016 and July 2017.

There was a high turnover of healthcare staff. The trust reported a high turnover of healthcare assistants (21%) compared to other staffing groups. Senior staff we spoke with were aware of the issue. They explained theatres only employed healthcare assistants at band two with the ability to become band three. Senior staff explained they believed misunderstanding about the banding for healthcare assistants may be the reason for the higher staff turnover. There was a plan to increase retention among this staffing group. This included current healthcare assistants attending recruitment days to effectively communicate what their role involved. The service did not use agency staff for healthcare assistant roles between March 2018 to February 2019.

The service was actively seeking to recruit staff, including through recruitment days for nursing students and healthcare assistants as well as attending a nursing careers’ fair. There were also rolling adverts on the trust intranet (including ‘refer a friend’) as well as on NHS jobs. The anaesthesia, surgery, critical care and renal division had also recruited a recruitment, retention and wellbeing matron to support these efforts.
We spoke with staff in theatres about staffing levels. Most of those we spoke to said staffing was an issue. Staff sickness, turnover and vacancies were highlighted as reasons for staffing difficulties in theatres. Staff told us recruitment of mediroom staff was a challenge in particular. Senior staff in theatres told us vacancies and recruitment were a regular agenda item in the theatre management group meetings run by the division and the matron for the department. This meeting was also attended by senior nursing sisters. However, staff told us the department “pulled together well” and the “goodwill of staff to stay on and open a third theatre was a regular occurrence”.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

There were low vacancy and sickness rates. The trust reported an annual vacancy rate of 3.3% and an annual sickness rate of 1.1% for medical staff between March 2018 and February 2019. The sickness rate for medical staff had slightly improved (reduced) since our last inspection when the trust reported a sickness rate of 1.3%.

Staff we spoke with in theatres told us about staffing shortages among respiratory specialist registrars. The risk register also referred to a shortage of transplant surgeons. These risks were being managed and a business case had been made for increased resources.

The trust reported no use of locums in the surgery service between March 2018 and February 2019.

Medical staff we spoke with said there was adequate consultant presence with daily consultant-led ward rounds. In the urology specialty, a business case for more staff resources and the trust was in the process of recruiting at the time of our inspection. This expansion included more consultants and a second robot. Clinical leaders were assured this would ease the pressure on the current consultant workforce.

In trauma and orthopaedics, clinical leaders told us they were oversubscribed for trainees and had a full complement of junior doctors.

**Turnover rates**

Turnover rates for medical staff were high, although this may be influenced by slightly misleading data provided by the trust. The trust set a target of 15.6% for the staff turnover rate. From March 2018 to February 2019, the trust reported an overall turnover rate of 24.3% in surgery. This exceeded (was worse than) the trust’s target. Across surgery overall, turnover rates for medical staff were 46.2%. The high turnover rate for doctors may be partially explained by the movement within rotational and junior posts.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Staffing skill mix**

The trust had a relatively typical skill mix among the medical staff. In December 2018, the proportions of consultants, junior doctors and foundation year 1-2 doctors reported to be working at the trust were similar to the England averages.

**Staffing skill mix for the whole time equivalent staff working at North Bristol NHS Trust**
This Trust  England average

<table>
<thead>
<tr>
<th>Consultant</th>
<th>51%</th>
<th>49%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>32%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, and available to all staff providing care. However, we did find some records were not stored securely and some were not complete.

The service was increasingly recording information electronically and reducing its reliance on paper records. This included the use of electronic patient records, emergency surgery booking, preassessment processes and the coordination of elective (planned) theatre activity. Information stored electronically was secure. We observed computer screens being locked when not in use, and access was password protected to prevent unauthorised access. Wards had electronic patient information screens positioned by the main reception area of the ward. These contained live and current information about patients on the ward. Staff had to log into the system to access detailed information about patients, and to edit information. These screens played a vital part of the daily board rounds.

However, security for confidential patient records and information was not always adequate. At our previous inspection we told the trust they must provide security for all confidential patient records and information. During this inspection we found records were mostly being stored securely. However, we found paper notes were not always stored in locked trolleys in the pre-operative assessment unit. We were told by the nurse in charge that new trolleys were on order.

Patient observational notes were kept in folders outside single rooms. In June 2019, the trust had issued a new standard operating procedure permitting the practice of leaving these folders outside patients’ rooms.

Patients’ notes were not always comprehensive, and all staff could not access them easily. We reviewed 12 patient records. Not all pages in the records we reviewed were labelled with patients’ names. Where patients’ records were stored electronically, this meant there were no delays with information being available when the patient was moved or transferred to a new team. However,
pre-operative assessments were not recorded electronically, and a patient we met had their procedure delayed as the report was not available on time.

**Medicines**

*The service used systems and processes to safely prescribe and administer medicines. However, medicines were not always recorded and stored safely.*

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, we did find some medicines which had expired or not safely monitored. Opening dates were not being recorded on medicines to ensure they were discarded within an appropriate timeframe. Furthermore, there was no procedure to date-check the medicines stored in the trolleys and some out of date medicines were found.

Medicines on the wards were accessible to all staff. However, all medicines had been locked in cupboards with access restricted to clinical staff. Medicines being stored in the fridge were locked away using a digital lock. However, the code for the lock was written on the side of the fridge so access was not being restricted. This was an area which was not accessible to patients and visitors, but this was not good practice.

In theatres, medicine fridge temperatures were recorded daily to ensure medicines remained safe to use, though we did find some gaps in recording. However, in one of the theatres we found a tray holding multiple vials of the muscle relaxant drugs rocuronium and suxamethonium. These vials appeared to be left behind from the previous session. These muscle relaxants were controlled drugs and were susceptible to temperature, and so should have been stored and locked in a refrigerator. We alerted the staff nurse to this and handed the tray to one of the coordinators.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. For example, we observed a pharmacist based in the pre-operative assessment unit advising patients on medicines during their hospital stay. The pharmacist was also responsible for medicines reconciliation, writing scripts for MRSA decolonisation, as well as writing up drug charts.

We spoke to staff about the systems and processes for effective antimicrobial medicine use. We were told this involved the antimicrobial pharmacist and microbiologist carrying out ward rounds and reviewing the prescribing of antibiotics. A twice-yearly study on prescribing practices of antibiotics was also carried out across the trust. We reviewed the latest audit results of these studies, which showed a general improvement in the prescribing of antibiotics across the trust.

In some of the records we reviewed where the patient had been prescribed antibiotics, the records did not mention why antibiotics had been prescribed or the duration for which antibiotics had been prescribed.

Staff stored and managed all medicines and prescribing documents in line with the trust’s policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Bimonthly medicines governance group meetings were held attended by leaders from both surgical divisions. These meetings included discussions about alerts from the Medicines and Healthcare products Regulatory Agency, as well as discussion of medicines related incidents and audits.

Staff followed current national practice to check patients had the correct medicines. The prescription charts we reviewed all had medication reconciliation completed in a timely manner. Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking. These reconciliations were completed by the pharmacist and were
Decision making processes ensured patients’ behaviour was not controlled by excessive and inappropriate use of medicines. Staff explained how they would support patients who lacked capacity to make a decision on their medicines. Staff knew when it was appropriate to administer medicines which were prescribed to be taken when required.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew how to report incidents through the electronic reporting system. All staff we asked were able to tell us how the system worked and how they would report an incident.

Staff we spoke with on wards said the electronic reporting system worked well. Staff could specify whether they wanted feedback when reporting incidents. Those who had requested this told us they had received meaningful feedback. However, staff we spoke with in theatres said they did not always receive feedback after reporting an incident through the electronic reporting system.

Where a reported incident caused moderate or greater harm, these incidents were reviewed by the heads and deputy heads of nursing. A decision was then made as to the appropriate response, including whether to carry out a full investigation. Leaders told us if it was a serious incident, an immediate meeting would be held, and a 72-hour report produced to ensure any identified concerns that might still be ongoing were addressed.

Staff were aware of learning from recent incidents. For example, all surgical wards we visited were able to provide consistent examples of learning from incidents across the service and the divisions more generally. Staff were able to describe the lessons learnt from the incident and the steps taken to ensure something similar did not happen again.

Senior nurses shared learning from incidents with staff. Staff told us learning from incidents was shared on wards through various channels including safety briefs, team meetings, governance meetings, board and ward rounds, huddles and LASER (Learning After Significant Event Recommendations) posters across the hospital. Staff told us feedback and sharing from incidents had improved since our last inspection.

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the NHS Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2018 to April 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>2</td>
<td>13.3%</td>
</tr>
</tbody>
</table>
Sub-optimal care of the deteriorating patient & 2 & 13.3% \\
Pressure ulcer & 2 & 13.3% \\
Diagnostic incident including delay (including failure to act on test results) & 1 & 6.7% \\
Incidence of venous thromboembolism & 1 & 6.7% \\
Medical equipment/devices/disposables incident & 1 & 6.7% \\
Slips/trips/falls & 1 & 6.7% \\
Infection control incident & 1 & 6.7% \\
**Total** & **15** & **100%**

(Source: Strategic Executive Information System (STEIS))

The service had not reported a never event in the last year. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2018 to April 2019, the trust reported no never event in theatres or surgical wards.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff were open and transparent and gave patients and, where appropriate, their families a full explanation when things went wrong. We reviewed a sample of reports of completed investigations (root cause analyses) into recent serious incidents in the surgery department. The duty of candour was documented and applied in these cases.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors. There was a slight downward trend in patient harms (improvement), and the trust was now using other measures to record this information.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the patient safety thermometer showed the trust reported 57 new pressure ulcers, eight falls with harm and 17 new catheter urinary tract infections from February 2018 to February 2019 for surgery.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at North Bristol NHS Trust

1 Total Pressure ulcers (57)

2 Total Falls (8)

3 Total CUTIs (17)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

The service displayed safety information on all surgical wards we visited. However, staff told us the safety thermometer data collection had recently been replaced across the service. They explained this was because the trust was already collecting similar information as part of internal audits. As well as falls, pressure ulcers and catheter acquired urinary tract infection, these included audits of national early warning scores (NEWS2), and compliance with procedures for hand hygiene, cannula, airflow, catheterisation and central lines. This information was collected daily by the charge nurse on the ward and reported on monthly.

The trust provided us with results of this audit data in the anaesthesia, surgery, critical care and renal division for the period December 2018 to July 2019. During this period, the division had achieved an average compliance rate of 98.8% for hand hygiene, 97.1% for NEWS2, 93.4% for IV insertion and 96.3% for IV ongoing care.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance.

There were processes to ensure staff were kept up to date with latest guidance and good practice from the National Institute for Health and Care Excellence (NICE). Clinical leaders would receive alerts from the medical director’s office or directorate general managers about the latest guidance and good practice relevant to their specialty. Clinical leaders also told us they were stakeholders with NICE and often directly contributed to new guidance. For example, we saw evidence of consideration of draft NICE guidelines in vascular surgery department meetings.

The surgical divisions had processes to ensure care and treatment was aligned with current evidence-based practice. Staff used enhanced recovery programmes to help improve patient outcomes. These were programmes designed to get patients up and about following orthopaedic surgery. This had been seen to significantly improve outcomes for recovery for these patients. On ward 34B, a general surgical ward, enhanced recovery checklists were displayed on patient’s doors to support their progress. Healthcare assistants we met were clear about their role in helping patients to be as independent as possible to encourage recovery.

The trust, which provided the major trauma centre for the region at Southmead Hospital, reported data externally to the ‘major trauma dashboard’. This was a way of benchmarking outcomes, results or quality of care between major trauma centres in England in relation to specific measures. These were based on objective evidence, such as NICE guidance but also reflected experience from senior clinicians in the trauma networks. Measures included the quality of data submitted to the network but also of process measures such as time to scan or use of consultant-led trauma teams. The trust provided us with results for 2018/19, which showed it consistently performed above the national average for nine out of 13 measures. For the other 4 measures the trust was slightly below the national average in some quarters.

Staff used ‘care bundles’ in line with the Institute for Healthcare Improvement guidance. These were approved pathways of care for different procedures or conditions. We saw evidence in patient records of staff recording they were following ‘care bundles’ effectively.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients we spoke with told us they had enough to eat and drink. We saw housekeepers regularly offering patients hot drinks on the wards.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Fluid balance charts we reviewed were completed and calculated appropriately.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nurses used the malnutrition universal screening tool (MUST) for all patients on admission. Within the records we reviewed, MUST assessments were completed and recorded on the electronic system.
Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Nurses were aware of how to refer to dietitians through the electronic referral system. We saw evidence in patients’ notes that dietitians were involved in patient care. For example, to review use of a naso-gastric feeding tube.

Patients waiting to have surgery were not left ‘nil by mouth’ for long periods. Staff labelled patient’s rooms with their dietary requirements including whether they were fasting prior to surgery. Patients we spoke with told us staff had explained fasting times to them and they were offered food and drink as soon as possible after surgery.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used the abbey pain scale to record pain observations for patients who had communication difficulties, generally as a result of cognitive impairment. Staff asked patients about their pain as part of regular intentional rounding (a routine used by nurses on wards to check each patient regularly for certain aspects of care). Staff could get support from the multidisciplinary acute pain team to support patients with pain review and management if required.

Patients received pain relief soon after requesting it. Patients we spoke with were positive about the way their pain was managed and told us they could ask for more pain relief if needed.

Staff prescribed, administered and recorded all pain relief accurately. We saw evidence of this when reviewing prescription records.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in national clinical audits. The service performed well in most national clinical outcome audits and managers used the results to improve services further. Most audits were similar to national averages, and some were better. However, the trust was seeing more patients readmitted following certain surgical procedures, which was an indicator of the outcome for these patients being suboptimal.

**Relative risk of readmission**

**Trust level**

The trust had a high risk of readmissions for some patients. From December 2017 to November 2018, all patients at the trust had a higher than expected risk of readmission for elective and non-elective admissions when compared to the England average.

The chart below shows the risk of readmission for the top three specialities, based on count of activity for elective admissions:
Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in urology and general surgery at the trust had a higher than expected risk of readmission for elective admissions.
- Patients in plastic surgery at the trust had a similar to expected risk of readmission for elective admissions.

The chart below shows the risk of readmission for the top three specialities, based on count of activity for non-elective admissions:

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in general surgery and urology at the trust had a higher than expected risk of readmission for non-elective admissions.
- Patients in trauma and orthopaedics at the trust had a lower than expected risk of readmission for non-elective admissions.

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

National Hip Fracture Database

Southmead Hospital

The trust was performing similar to other trusts in the national hip fracture audit.

The table below summarises Southmead Hospital’s performance in the 2018 national hip fracture database. For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means the trust’s performance fell within the middle 50% of results nationally.
<table>
<thead>
<tr>
<th>Metrics (Audit indicators)</th>
<th>Hospital performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>102.7%</td>
<td>Similar</td>
<td></td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients having surgery on the day or day after admission</td>
<td>79.5%</td>
<td>Similar</td>
<td>x</td>
</tr>
<tr>
<td>(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude peri-operative medical assessment rate</td>
<td>93.2%</td>
<td>Similar</td>
<td>x</td>
</tr>
<tr>
<td>(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients documented as not developing a pressure ulcer</td>
<td>98.1%</td>
<td>Similar</td>
<td>x</td>
</tr>
<tr>
<td>(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude overall hospital length of stay</td>
<td>19.9 days</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 30-day mortality rate</td>
<td>8.6%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Monthly meetings were held to discuss all hip fracture patients who had died. Clinical leaders explained these meetings were an opportunity to raise concerns and any suggestions for service improvement. These were multidisciplinary meetings with medical presence and the matron in charge of the hip fracture unit in attendance.

**Bowel Cancer Audit**

The trust was performing better or within the expected range for all indicators in the national bowel cancer audit. The table below summarises North Bristol NHS Trust’s performance in the 2018 national bowel cancer audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>123.2%</td>
<td>Good</td>
<td>Good is over 80%</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted post-operative length of stay &gt;5 days after major resection</td>
<td>41.8%</td>
<td>Better than national aggregate</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A prolonged length of stay can pose risks to patients)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 90-day post-operative mortality rate</td>
<td>2.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 2-year post-operative mortality rate</td>
<td>18.2%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 30-day unplanned readmission rate</td>
<td>17.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A potential risk for early/inappropriate discharge is the need for unplanned readmission)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection</td>
<td>45.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)

(Source: National Bowel Cancer Audit)

**National Vascular Registry**

The trust was performing within the expected range for all indicators in the national vascular registry. The table below summarises North Bristol NHS Trust’s performance in the 2018 national vascular registry.

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal Aortic Aneurysm Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Surgical procedure performed on an enlarged major blood vessel in the abdomen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment</td>
<td>97.0%</td>
<td>Not applicable</td>
<td>✓</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted post-operative in-hospital mortality rate</td>
<td>2.2%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of patients who die in hospital after having had an operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Carotid endarterectomy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment</td>
<td>94.0%</td>
<td>Not applicable</td>
<td>✓</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude median time from symptom to surgery</td>
<td>13 days</td>
<td>Not applicable</td>
<td>✓</td>
</tr>
<tr>
<td>(Average amount of time patients wait to have surgery after the onset of their symptoms)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk adjusted 30 day mortality and stroke rate</td>
<td>2.0%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of patients who die or have a stroke within 30 days of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Vascular Registry)
National Joint Registry (Audit of hip, knee, ankle, elbow and shoulder joint replacements)

Most indicators for the national joint registry audit were within the expected range. One indicator out of five indicators was a negative outlier: Risk-adjusted 5 year revision ratio (for knees excluding tumours) (Proportion of patients who need their knee replacement ‘re-doing’). The table below summarises Southmead Hospital’s performance in the 2018 national joint registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) (Patient details help ‘track and trace’ prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</td>
<td>91.7%</td>
<td>Similar</td>
<td>×</td>
</tr>
<tr>
<td>Hospital level: Hips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who need their hip replacement ‘re-doing’)</td>
<td>1.29</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.00</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
<tr>
<td>Hospital level: Knees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 5 year revision ratio (for knees excluding tumours) (Proportion of patients who need their knee replacement ‘re-doing’)</td>
<td>1.72</td>
<td>Negative outlier</td>
<td>×</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) (Proportion of patients who die within 90 days of their operation)</td>
<td>0.80</td>
<td>Within expected range</td>
<td>×</td>
</tr>
</tbody>
</table>

(Source: National Joint Registry)

National Prostate Cancer Audit

Indicators for the national prostate cancer audit were within the expected range. The table below summarises North Bristol NHS Trust’s performance in the 2017 national prostate cancer audit.
## Metrics

**Hospital performance**

**Comparison to other trusts**

**Meets national standard?**

### Men with complete information to determine disease status

(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)

<table>
<thead>
<tr>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>89.6%</td>
<td>N/A</td>
<td>✗</td>
</tr>
</tbody>
</table>

### Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy

(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)

<table>
<thead>
<tr>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.93%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy

(Complications following surgery may reflect the quality of surgical care)

<table>
<thead>
<tr>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.3%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

### Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy

(External beam radiotherapy uses high-energy beams to destroy cancer cells)

<table>
<thead>
<tr>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data available</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Prostate Cancer Audit)

### National Emergency Laparotomy Audit

#### Southmead Hospital

The national emergency laparotomy audit had variable performance.

The table below summarises Southmead Hospital’s performance in the 2017 national emergency laparotomy audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).
<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ascertainment</strong> (Proportion of eligible cases included in the audit)</td>
<td>88.3%</td>
<td>Green</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Crude proportion of cases with pre-operative documentation of risk of death</strong></td>
<td>91.8%</td>
<td>Green</td>
<td>✓</td>
</tr>
<tr>
<td>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude proportion of cases with access to theatres within clinically appropriate time frames</strong> (Proportion of patients who were operated on within recommended times)</td>
<td>84.8%</td>
<td>Amber</td>
<td>✗</td>
</tr>
<tr>
<td><strong>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre</strong> (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</td>
<td>82.3%</td>
<td>Amber</td>
<td>✗</td>
</tr>
<tr>
<td><strong>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively</strong> (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</td>
<td>94.0%</td>
<td>Green</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Risk-adjusted 30-day mortality rate</strong> (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</td>
<td>10.9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Emergency Laparotomy Audit)

The audit results showed the hospital had achieved ‘green’ for most indicators. The service had achieved ‘amber’ compliance for two standards: access to theatres within clinically appropriate time frames and high-risk cases (greater than or equal to 5% predicted mortality) with consultant
surgeon and anaesthetist present in theatre.

We spoke with clinical leaders to find out why these two indicators were amber rated and what actions were being taken to improve performance in the audit. Clinical leaders explained the hospital’s amber rating for access to theatres within clinically appropriate timeframes was not due to emergency theatre capacity. They explained in some cases there had been a clinical conversation about the appropriateness to come to theatre which resulted in a delay. Clinical leaders said their performance against this indicator was also affected by a small number of cases where patients had been transferred to them from a neighbouring hospital. They explained the transfer of these patients from one hospital to another extended their access to theatres in those cases.

With regard to the hospital’s amber rating for high-risk cases with a consultant surgeon and anaesthetist present in the theatre, clinical leaders told us in all such cases a consultant surgeon had been present. However, in some of the cases audited, the anaesthetist had been a senior fellow or trainee instead of a consultant. Clinical leaders told us they had recently appointed a further six consultant anaesthetists and they were assured this would improve the hospital’s performance against this indicator. Data provided by the trust showed the service had improved its performance against this indicator during the fourth quarter of 2018/19 (January to 31 March 2019)

Clinical leaders had an action plan to improve the service’s performance against this audit.

**Patient Reported Outcome Measures**

Patients reported outcomes which were mostly the same or slightly better than the England averages in certain procedures. In the patient reported outcomes measures (PROMS) survey, patients were asked whether they felt better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

**Visual analogue scale (EQ-VAS)**

Visual analogue scale (EQ VAS) is asking the patient to mark their health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to “the worst health you can imagine”, and the highest rate (100) corresponds to “the best health you can imagine”.

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues, namely mobility, self-care, usual activities, pain, or discomfort anxiety or depression. The EQ-5D-5L uses five levels of responsiveness to measure problems. The range is: no problem, to disabling/extreme problems.

The oxford hip score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.
In 2016/17, for groin hernias, the trust’s performance was better than the England average.

For varicose veins, the trust’s performance was about the same as the England average.

For hip replacements, the trust’s performance was about the same as the England average.

For knee replacements, the trust’s performance was about the same as the England average.

(Source: NHS Digital)

Managers carried out a comprehensive audit programme. Managers used information from the audits to improve care and treatment. Action plans were required to be developed in response to the results for clinical audits. These action plans were monitored within the relevant clinical specialty. The central clinical audit team had oversight of all clinical audit actions and advised clinicians on how to develop action plans to best address areas of concern.

Managers shared and made sure staff understood information from the audits. All actions were available for review on the trust intranet by any member of staff. Improvement was checked and monitored.

Competent staff

The service sought to ensure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development. However, the trust’s appraisal target rate was not met by all staffing groups in the service.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. In theatres, every area had its own skills matrix from novice to expert.

Managers gave all new staff a full induction tailored to their role before they started work. New staff we spoke with were supported well. Staff we spoke with who had recently joined the trust were positive about the support they received. New starters completed a trust-wide mandatory training programmed and a local induction to the ward. There was a preceptorship programme for staff.
Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. From April 2018 to March 2019, 83% of required staff in surgery received an appraisal compared to a trust target of 90%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Medical staff</td>
<td>227</td>
</tr>
<tr>
<td>Registered nursing staff</td>
<td>459</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>372</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>61</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic and technical staff</td>
<td>40</td>
</tr>
<tr>
<td>Support to scientific, therapeutic and technical staff</td>
<td>10</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>5</td>
</tr>
<tr>
<td>Qualified allied healthcare professionals</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,186</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The trust’s target for appraisal completion was 90%. This target was only achieved by medical staff in the period of February 2018 to March 2019, 95% of whom had an appraisal within this time frame. As a result, we could not be assured managers were able to always identify training requirements for staff as staff did not always receive annual appraisals in line with trust policy.

Staff said the appraisal period was between June and November, and many had recently had their appraisal. The numbers above ending March 2019 could therefore now be higher. Staff said they were working towards ensuring all new starters had regular performance reviews.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Those staff we spoke with said they received an appraisal every year where they had the opportunity to identify appropriate training. Staff were positive about the support and training opportunities available. This was supported by the fact that the trust had been the highest ranked trust in the deanery’s junior doctors’ survey.

Consultants were reminded centrally by the trust when their appraisals and revalidation were due.
There were enough clinical educators to support staff learning and development. For example, theatres had a peri-operative development team of two dedicated staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff completed competency frameworks relevant to their roles. For example, the competency framework for nurses included cannulation. There was a competency framework for medirem staff which included airway management training.

Managers made sure staff received any specialist training for their role. For example, staff on ward 33A (burns and plastics) completed competencies in caring for patients with burns and attended an ‘emergency management of burns’ course. Staff told us these were funded by the trust, and there were lots of opportunities for development.

Staff were provided with training through simulation exercises which included sepsis recognition and surgical emergencies. In November 2018, the trust launched its clinical simulation space (Sim Space) as part of its ‘improving patient safety by healthcare simulation’ initiative. The Sim Space recreated real-life medical and surgical situations to train clinical staff. A debrief and reflection workshop followed the sessions. Leaders told us several hundred staff had been trained through these simulation courses and more training was planned to be delivered throughout this financial year (2019/20). Staff we spoke with were positive about the quality of the simulation training.

Managers identified poor staff performance promptly and supported staff to improve. Managers monitored poor performance through the appraisal process or through support from the human resources team. Ward managers we spoke with were positive about the support from human resources for managing poor performance. Managers had one to one workforce meetings every three months with human resources and finance where these matters could be raised.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, ward 33A (burns and plastics) had a weekly multidisciplinary team meeting to discuss patients. Similarly, on ward 34B, the discharge coordinator was involved in multidisciplinary board rounds, meetings and liaison with families. Doctors, nurses and healthcare assistants were positive about team-working on the wards.

Daily safety briefings took place on wards to discuss patient risk. These were attended by a multidisciplinary team to include nurses, healthcare assistants, and house keepers.

At our last inspection, staff said access to medical consultants and timely reviews for patients who were accommodated on surgical wards was difficult. This had improved since our last inspection. Staff we spoke with said they had lists of doctors they could contact as well as their contact details, and doctors were responsive when they were contacted. On ward 6B and 25A (neurosurgery), at least one junior doctor was assigned to the ward at all times.

We observed safety huddles and board rounds on ward 25A attended by a multidisciplinary team including physiotherapists. We were told these were well attended.

A multidisciplinary team training programme had also been rolled out to train operating department practitioners, healthcare assistants and nurses on human factors and behaviours. This was in recognition that all members of the operating team were essential in ensuring the running of safe and effective operating theatres.
Seven-day services

Key services were available seven days a week to support timely patient care.

The surgical division provided services seven days a week. Staff could call for support from doctors and other disciplines, including pharmacists, mental health services and diagnostic tests, 24 hours a day, seven days a week. There was access to all key diagnostic services 24 hours a day, seven days a week, to support clinical decision-making. This included critical imaging and reporting.

Physiotherapy and occupational therapy services were available Monday to Friday, 8am to 5pm, with an on-call physiotherapy service over the weekend. There was limited occupational therapist cover on weekends if patients required specific treatment related to mobility aids.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had relevant information promoting healthy lifestyles available.

Nurses and anaesthetists working in the pre-operative assessment clinic used appointments to encourage patients to adopt healthier habits. For example staff could refer patients to smoking cessation services. Pharmacists could discuss nicotine replacement options with patients at their pre-operative assessment. The pre-operative assessment clinic also had an intravenous iron clinic to support patients they identified as anaemic.

The service had an enhanced recovery programme for patients undergoing certain types of surgery including colorectal surgery. As part of this programme, patients were invited to a group information session run by a specialist enhanced recovery nurse at the pre-operative assessment centre. These sessions were used to give patients information on the steps they can take before and after their operation to speed their recovery after surgery. This included information on nutrition and exercise, reducing smoking and alcohol consumption. The programmes ethos was on prevention being better than cure.

Staff could refer patients to alcohol liaison if there were alcohol dependency issues.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. However, not all decisions were well documented. Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The trust had recently revised its consent policy to emphasis to staff the importance of explaining to patients the process and purpose of any examination, care or treatment and gaining their agreement.

Staff we observed acted within the legal framework to obtain patient consent for treatment. Written and signed consent forms were completed pre-operatively in the outpatient clinic and verbally checked again on admission. In procedures not requiring written consent, we observed how staff explained what they were planning to do. They then obtained verbal or implied patient consent for the care and treatment they provided.
Staff told us their starting point with all patients was to assume the patient had mental capacity to make their own decisions. Where patients were assessed as lacking mental capacity, staff would carry out a capacity assessment.

However, we found documentation of consent in patient records was not always comprehensive. The benefits and risks of procedures were not always recorded in consent forms.

Since our last inspection, the trust had introduced a simplified mental capacity assessment form to meet legal requirements and ensure staff had a good understanding of how to use it. Staff we spoke with told us the new paperwork had been helpful as it had streamlined the process for mental capacity assessments. We reviewed two mental capacity assessment forms as well as paperwork for deprivation of liberty safeguards. These were completed and signed by an authorised member of staff.

Most but not all of the paperwork for resuscitation discussions and decisions was fully completed. We reviewed four resuscitation forms on the burns and plastics ward (ward 33a), the neurosurgery ward (ward 25a) and the trauma and orthopaedics ward (ward 25b). Two of these forms were completed correctly. On one of the forms we reviewed, the box to indicate whether the patient had mental capacity was not ticked. However, on the form it stated resuscitation had been discussed with the patient who was involved in the decision. There was no information in the form otherwise to suggest the patient lacked mental capacity. Another form we reviewed was not co-signed to indicate it had been reviewed and endorsed by the most senior health professional.

**Mental Capacity Act and Deprivation of Liberty training completion**

Demonstrating a stronger clinical understanding and application of the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLS) was one of the priorities for improvement the trust set itself for the financial year of 2018/19.

The trust set a target of 85% for completion of MCA and DoLS training.

As at April 2019, the trust reported training was completed by 90.7% of all staff in surgery compared to the trust target of 85%.

Both medical staff and registered nursing staff in surgery met the trust target. A breakdown of compliance for mental capacity and DoLS training as at April 2019 for registered nursing and medical staff is shown below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>407</td>
<td>440</td>
<td>92.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Registered nursing staff</td>
<td>525</td>
<td>587</td>
<td>89.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)
Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff showed a patient-centred approach.

Patients said staff treated them well and with kindness. We saw staff showed an encouraging approach to patients and supported them to recover. We observed compassionate and respectful behaviour towards patients. We saw staff introduce and identify themselves to patients to lessen any anxiety. Staff took the time to clearly explain to patients every step of the process, so they knew what to expect. This helped put patients visibly at ease.

Staff followed policy to keep patient care and treatment confidential. We saw staff knocked on patient doors before entering. Patients could use the blinds on doors for more privacy. Staff also maintained patients’ dignity by making sure patients were covered when transferring them to and from a bed. We observed staff taking part in daily safety huddles where staff were mindful their discussions could not be overheard by patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress. Patients we spoke with told us staff responded promptly when they used the patient call bells and staff regularly asked them about whether they were experiencing any pain or discomfort. The patients we spoke with during our inspection were positive about the care they had received in the service including one patient who said, “I can’t fault the care I have received.”

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with felt staff supported their emotional wellbeing. Patients were grateful for the time and reassurance staff gave them before, and after surgery.

Staff understood the emotional and social impact a person’s care, treatment or condition had on their wellbeing and on those close to them. Patients had access to counselling, for example when they had surgery following a traumatic accident. On ward 33a (burns and plastics) staff could access the psychology team who visited the ward three times a week to support patients with the emotional impact of burns injuries.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

On ward 25a (neurosurgery), there was a carers bed on the ward to accommodate carers to stay with patients. The ward also had recliner chairs for carers, relatives and others close to patients to make their stay as comfortable as possible.

Cancer information and support clinics were run by the cancer support team for patients who were living with cancer. Clinics discussed issues such as impact of a cancer diagnosis, what to expect, physical activity and diet, work and finance, and information on local services. These meetings
were also an opportunity for people living with cancer to meet other people with similar experiences, thereby providing assurance, reducing anxiety and any sense of isolation.

Patients in the service living with cancer were also able to take part in the trust’s ‘Living Well Programme’. This programme involved patients receiving a holistic assessment of their physical, emotional and social needs. A care plan was developed as part of this process. The programme also included education and information events and courses run by cancer clinical nurse specialists and psychologists, covering topics such as mindfulness and relaxation, dealing with emotions and feelings, and improving physical capabilities.

The chaplaincy service was also available for patients and those close to them from all spiritual and religious backgrounds who wanted support to help them cope with their situation.

**Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were also able to rely on the support of a specialist team of nurses to communicate with patients with learning disabilities.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care. The bariatric surgery team had put together a video to be shown to patients before their pre-surgery appointments with their consultant. The video introduced the team and delivered information typically given by the consultant at the pre-surgery session. By presenting patients with this information earlier, the video aimed to enable patients to consider the information and have a better informed and more engaged meeting with their consultant.

Staff supported patients to make informed decisions about their care. One of the patients we spoke with told us they “had all the confidence in the world because staff kept me informed throughout my stay at the hospital. I always felt in charge of the care and treatment I received.”

During times of operational pressure, surgical patients were moved to the interventional radiology unit due to a lack of surgical beds. Staff told us family and friends of patients who were moved to the interventional radiology unit from surgical wards had not always been informed the patient had been moved, which caused anxiety and stress for patients and their family and friends.

**Friends and Family test performance**

A high proportion of patients gave positive feedback about the service in the friends and family test (FFT) survey, although response rates were below the England average. The highest portion of positive feedback from patients was on ward 6b (neurosurgery) and the lowest portion of positive feedback (86%) was on ward 43a (general surgery, general medical).

The FFT response rate for surgery from February 2018 to January 2019 at North Bristol NHS Trust was 22% which was worse than the England average of 28%. The highest response rate (61%) was on gate 21 (theatres, medirooms) and the lowest response rate (14%) was on day surgery.

Staff we spoke with explained FFT responses from patients were collected electronically and paper forms were not available for people to complete during their time at the hospital. Staff said they expected this may result in fewer people providing feedback through the FFT. Staff we
spoke with said they were seeking to improve returns including by providing friends and family with an electronic tablet computer to complete the test.

FFT results were displayed in parts of the service for patients and staff to view.

Southmead Hospital

4. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.

5. Sorted by total response.

6. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the needs of the local population. As a district general hospital the service aimed to provide excellent care to the local population. Senior leaders told us they had good dialogue with local primary care providers as well as the regional commissioners to ensure the care they provided was informed by the needs of the local population. The planning of services was also informed by engagement with the regional trauma centre, vascular network and burns network.

The service had engaged well with the NHS England and NHS Improvement Getting It Right First Time (GIRFT) programme, with all surgical specialities having undergone review at the time of our inspection. Senior leaders said this programme provided the surgical specialities with information...
to compare their services from a safety, quality and value for money perspective. Service leaders said all the surgical specialities knew their top three GIRFT successes as well as their top three GIRFT priorities, and these tended to be about local provision of services.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. On surgical wards most patients were in single-rooms. Where patients were in bays staff designated these as male or female only bays.

Staff sought to make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Where a patient had dementia, learning disabilities and/or was subject to deprivation of liberty safeguards licence, this was highlighted on daily board meetings and twice daily safety briefings. This ensured staff on every shift were aware and could meet the needs of these patients.

At the time of our inspection, a best interest and discharge planning meeting was taking place to discuss where a patient with advanced dementia was going to be housed after being discharged. There was an interim plan to accommodate the patient in the community. We saw evidence of communication between the hospital social worker and the community social worker.

Staff supported patients living with dementia and learning disabilities. Staff used ‘this is me’ documents and patient passports. Nurses in the pre-operative clinic identified patients living with dementia before the operation and organised appropriate support. Carers were encouraged to complete ‘this is me’ documents with the personal preferences of the patient so this was ready for the patient’s stay in hospital. Staff on wards supported patients living with dementia by using ‘this is me’ to find out about patient’s preferences. Staff could get support from the trust-wide specialist dementia nurses from Monday to Friday 8am to 4pm.

Meeting the needs of patients with learning disabilities was one of the priorities for improvement set by the trust for the financial year of 2019/20. As part of this plan, the trust committed to improving care delivery. This included training staff on caring and treatment for patients with learning disabilities to deliver measurable improvements in care quality.

Staff recognised and supported patients with communication difficulties. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The learning disabilities team supported staff to communicate with patients with learning disabilities.

The trust had made arrangements for additional support for patients with mental health needs, such as working with the local psychiatric liaison team, dementia nurses and nurses for patients with learning disabilities.

The service had systems to help care for patients in need of additional support or specialist intervention. The mental health liaison team worked with the community crisis team when a patient at risk of self-harm required discharge or if they required an inpatient psychiatric bed.

The service had information leaflets available in languages spoken by the patients and the local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or people proficient in sign language when needed. Staff told us they had access to a translation service if and when required for patients whose first language was not English.
Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients were given a choice of food and drink to meet their cultural and religious preferences. If patients ate a particular diet because of their religion or culture, they were encouraged to inform staff of this, so the service could cater to their needs.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

**Average length of stay**

For most patients, the length of stay at the hospital was around the same as the England average. However, for trauma and orthopaedic patients, this was longer, which can be an indication of recovery or discharge not being as effective or efficient as in other hospitals. It can also be an indication, as the trust reported, of a failure of the local system to discharge patients into ongoing care outside of the hospital.

From January to December 2018, the average length of stay for surgical elective patients at the trust was 4 days, which is similar to the England average of 3.9 days. For surgical non-elective patients, the average length of stay was 5.1 days, which is similar to the England average of 4.7 days.

The chart below shows the average length of stay for the top three specialties, based on count of activity for elective admissions:

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>4.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Urology</td>
<td>2.8</td>
<td>2.5</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>4.2</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for patients having elective trauma and orthopaedics surgery at the trust was 4.7 days, which is higher than the England average of 3.7 days.
- The average length of stay for patients having elective urology surgery at the trust was 2.8 days, which is similar to the England average of 2.5 days.
- The average length of stay for patients having elective neurosurgery surgery at the trust was 4.2 days, which is lower than the England average of 4.9 days.
Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for patients having non-elective general surgery at the trust was 2.9 days, which is lower than the England average of 3.7 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at the trust was 12.4 days, which is higher than the England average of 8.5 days.
- The average length of stay for patients having non-elective urology surgery at the trust was 2.5 days, which is similar to the England average of 2.7 days.

(Source: Hospital Episode Statistics)

Managers and staff worked to make sure most patients did not stay longer than they needed to in hospital. For example, discussions about delayed discharges and length of stay could be seen in notes from a surgical cluster meeting. Audits of patients with a length of stay between seven to 14 days across all divisions had also taken place and each division had identified their actions to reduce lengths of stay. Fortnightly checkpoint meetings were led by the executive team, which reviewed progress against the divisions’ actions.

The weekly whole system operational group meeting, with representatives from community providers and social services, focused on reviewing discharge plans for patients who have had a long length of stay in hospital. The anaesthesia, surgery, critical care and renal division identified ‘stranded patients’ as those whose length of stay had passed seven days and could not be discharged home due to various reasons – sometimes clinical, but often due to their ongoing needs not able to be met at home.

The trust had invested in a quality improvement programme called Perform to equip staff with tools and techniques to manage patient admission and discharge. As a result of this work, staff told us that the last winter (2018/19) was one of the most successful in terms of patients being efficiently discharged. Staff explained this initiative included improving ward rounds, and ensuring tests were done in a timely manner. There were processes to follow when this had not happened, and a single referral form for discharge completed at the point of a patient’s admission. Staff told us the objective of the work was to help all staff to proactively consider why patients remained in in hospital when they were medically fit for discharge.

Enhanced Recovery

The service had an enhanced recovery programme for patients undergoing certain surgical procedures. This programme was designed to give the patient a shorter length of stay and improve their time to discharge home. Patients on the programme were invited to an information
session run by a specialist nurse. These sessions were used to give patients information on the steps they can take before and after their operation to speed their recovery following surgery. As part of the programme, enhanced recovery nurses visited patients during their time in hospital to remind them of the need to follow the advice on being active following their procedure. Nurses also called patients for four to five days following their discharge from hospital to identify any potential complications at the earliest opportunity as well as to remind patients of nutritional and physical exercise guidance. This helped to avoid readmission to hospital.

**Discharge Home**

There were innovative initiatives to support patients to return home as soon as possible after surgery. For example the hospital at home service was launched in February 2018. Hospital at home provided specially trained nurses to provide care and treatment to patients in their own home. While receiving treatment as part of the hospital at home service, patients remained under the care of their hospital consultant, and were only discharged once their treatment plan had been completed. The surgery division reported that the hospital at home service had resulted in a reduced length of stay in hospital and was a factor in reducing the number of cancelled operations.

We visited the hospital's discharge lounge which was operational between 7.30 am to 7.30 pm, Monday to Friday (excluding public holidays). Staff we spoke with said they mostly had good engagement from surgical wards and the medirooms to move patients ready to be discharged to the discharge lounge. Staff told us the orthopaedic ward staff in particular used the discharge lounge well to support better patient flow and discharge through the hospital. Staff spoke highly of the work the hospital's ‘perform team’ had undertaken with the discharge lounge which allowed them to be part of the improvements for the service.

We spoke with a member of the discharge team who was also the homelessness champion. They supported homeless patients to be discharged safely by organising housing appointments, for example. At the time of our inspection, the discharge coordinator was supporting five homeless patients.

The burns ward ran follow up outpatient clinics for surgery patients between Monday to Friday. These clinics sought to decrease the chance of readmissions and improve bed capacity and flow in the service.

The service relieved pressure on other departments when they could treat patients in a day. There were services to support patients to have surgery without the need stay in hospital. The surgical day assessment unit was open seven days a week and had three treatment rooms. Patients could be referred from their GP to the unit for scans, tests, or diagnosis without needing to be admitted. Patients could have surgery on the day or return the next day for surgery.

The acute burns clinic and 24/7 hotline supported patients to avoid admissions to hospital.

One area of concern for a number of staff were in delays to arranging medicines for patients to take home. Staff told us this was a factor in delayed discharge of patients who were waiting for the busy medical team to prescribe medicines.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The referral to treatment times at the trust varied, with some above (better than) the England average, and others below (worse than). The average overall was better than the England average, but did not meet the target of 92% of patients seen within 18 weeks.

From February 2018 to January 2019, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was better than the England average. It ranged from 71.2% to 77.3%,
compared to the England average of 64.3% to 68.3%.

In the latest period, January 2019, 74% of this group of patients were treated within 18 weeks compared to an England average of 65%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties (cardiothoracic surgery, general surgery and plastic surgery) were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery. Note, cardiothoracic surgery was the smallest of the trust specialties. This and general surgery also met the 92% target.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>100.0%</td>
<td>78.6%</td>
</tr>
<tr>
<td>General surgery</td>
<td>95.5%</td>
<td>71.9%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>85.8%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

However, three specialties (urology, neurosurgery, and trauma and orthopaedics) were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery. Urology and trauma and orthopaedics were among the larger specialties at the trust. Neurosurgery was a small speciality.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.1%</td>
<td>76.1%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>64.3%</td>
<td>69.0%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>42.2%</td>
<td>58.8%</td>
</tr>
</tbody>
</table>

The trust monitored referral to treatment times through the monthly board report.

Senior leaders told us urology performance was improving every month following actions to increase capacity in theatres by working 12 hour shifts in theatres.

Cancelled operations

The trust was better than the England average for cancelled operations not being re-booked within 28 days. However, it was higher (worse than) than the England average for cancellation of planned operations, although this was improving. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or
on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, this is recorded as a breach of the standard. Subsequently, the patient should be offered treatment at the time and hospital of their choice. The service completed investigations (root cause analyses) for all patients breaching the 28-day rebooking standard.

The chart below shows how the percentage of patients not rebooked rose up until the fourth quarter of 2017/18 before dropping to just 3% by the end of 2018. However, at all times, the trust was below (better than) the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - North Bristol NHS Trust**

![Graph showing percentage of patients not rebooked](image)

**Cancelled Operations as a percentage of elective admissions - North Bristol NHS Trust**

![Graph showing cancelled operations as a percentage of elective admissions](image)

Cancelled operations as a percentage of elective admissions only included short notice cancellations. The service completed mini investigations (root cause analysis) for planned operations that were cancelled on the day.

Over the two year period, the percentage of cancelled operations at the trust was consistently worse than the England average. However, this was an improving picture. The trust’s performance followed a similar trend to the England average.

*(Source: NHS England)*

The trust monitored cancelled operations as part of the monthly integrated performance report. The trust target for cancelled operations was 0.8%. Performance in February 2019 was 1.3%. In February there were three breaches of the 28-day re-booking target for cancelled operations.

Cancelled operation by reason in the March 2019 board report showed the most common reason was staffing (41%) followed by lack of beds (28%) and lack of theatre time (14%).

The site team told us cancellations of elective operations were uncommon and the number of operations cancelled in 2019 so far was low. The site team prioritised urgent, cancer and critical care cases. However, the service was working to reduce on-the-day cancellations. For example, patients were called two days before the operation to clarify preparations for surgery and reassure patients that if they were unwell on the day they would be re-booked for another date quickly.

**Theatre Utilisation**
The service monitored theatre utilisation key performance indicators at speciality level including: sessions, cancelled sessions, utilisation, delays to start times, over-runs, cancellations on the day. Managers were open with staff about the data and frequently shared the data with them to discuss efficiency and how to improve.

Data provided by the trust showed that theatre utilisation varied between 73.5% to 78.7% between July 2018 to June 2019.

There was a clear separation between emergency and planned theatres to reduce the risk of planned surgery being cancelled due to emergency demand. Managers had plans to manage peaks in demand, especially for time-sensitive operations such as emergency transplants. As a result, there were plans to have a dedicated emergency transplant theatre to meet demand.

**Bed Capacity**

Facilities and premises were mostly appropriate for the services being delivered, except when areas were used at times of hospital escalation. All wards were spacious with en-suite single rooms and two four-bed bays. However, medirooms, which were designed for short stays of up to 24 hours, were used during times of bed pressures to care for patients for up to 48 hours. This was not ideal because the medirooms had limited bathroom and shower facilities (only one toilet for every six rooms and one shower for every 12 rooms), as well as restrictions on visitors. Senior staff acknowledged medirooms were not designed to be an inpatient area and it was not ideal for patients to be there for more than 24 hours. They explained staff across the service, including the site team, worked together to ensure instances of patients staying in medirooms for over 24 hours were minimised. Senior staff also told us they had increased catering provision in the medirooms. There was a capital plan to increase toilet and shower facilities in this area.

During times of operational pressure, surgical patients were moved to the interventional radiology unit due to a lack of surgical beds. The interventional radiology unit was a purpose-built unit with 18 beds for patients who attended the hospital for interventional radiology and day case procedures. These patients were therefore unlikely to require admission beyond day care. The trust had a standard operating procedure (SOP) to manage the use of the unit to accommodate surgical patients during times of operational pressures. This SOP identified the number of patients that may be admitted to the unit, how long patients could stay in the unit, and whether a patient was safe to be accommodated on this unit. The SOP stated that surgical patients should not be in the unit for longer than a day. However, staff told us this was not always possible, and patients were often kept in the unit for periods in breach of the SOP. Staff told us staffing levels were not always increased to support the nurses with the additional requirements for extra patients in the interventional radiology unit.

During the time of our inspection, two surgical patients were admitted to the interventional radiology unit due to a lack of surgical beds. At our previous inspection we told the trust they must ensure the interventional radiology unit was suitable if patients were transferred for temporary care due to operational pressures. On this inspection, we found that although improvements had been made, the interventional radiology unit was still not suitable for inpatients. There were female and male toilet facilities but only one shower room, which also had a toilet. The shower room was along a corridor, which meant if staff accompanied a patient, they would be temporarily away from the unit. However, arrangements were made to ensure patients accommodated in interventional radiology had access to hot food.

At the time of our inspection, we found an extra bed had been placed in a four-bedded bay on ward 34a. Staff acknowledged this was not ideal, and it was not a regular occurrence. Staff
explained to us any patient who was accommodated on an extra bed in a four-bedded bay would be prioritised in decisions about transfers.

The service was taking action to effectively plan and manage its bed capacity. This included a flow meeting every morning. These meetings were to discuss staffing and flow, for example any barriers to discharges. Bed meetings were also held three times a day and attended by leaders from across the divisions.

The trust had a plan based on the NHS performance tool ‘operational performance escalation level (OPEL) to respond to increased pressures in demand or surges. The OPEL level is set based on triggers and is updated every two hours, seven days a week on an electronic system. An internal critical incident was declared at 8am on Tuesday 25 June 2019 when the trust was in OPEL four, the NHS’s highest level of pressure escalation. The trust responded appropriately to this with discussions held during meetings with actions proposed and followed up. Divisional representatives attended bed meetings to discuss beds available, identify outlying capacity, consider safe movement of patients to escalation areas and proposed discharges and how these could be supported. Any digression from standard operating procedures was also discussed and confirmed. Staffing was arranged to ensure the discharge lounge, escalation areas and corridors could be safely managed. Calls were held externally with partners in the healthcare system to free-up capacity where possible within the community and help improve flow through the hospital and release beds.

At times of operational pressures, the medirooms were an overflow area for patient care for the hospital, which meant planned and emergency work might be affected. This was part of the consideration for the trust when it was facing serious bed pressures. Elective operations were cancelled where possible to ensure priority was given to emergency patients.

Patients moving wards per admission

The trust provided ward moves data at trust level. From March 2018 to February 2019, 52.3% of individuals trust wide did not move wards during their admission and 47.7% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patients moving wards at night

From March 2018 to March 2019, there were 3,333 patients moving wards at night within surgery. The months with the highest number of ward moves at night were November 2018 and January 2019 with 355 and 324 respectively.

The two wards with the highest number of ward moves at night were as follows:

- Gate 32b (Surgical Assessment Unit - Gastroenterology, Infectious Diseases, Haematology): 1,343 ward moves
- Gate 21 (Theatres and medirooms): 819 ward moves

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Moves at night were high on the above wards as most of the surgery patients in these areas were emergency cases.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, the service was not responding to complaints in good time.
Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with knew how to complain if they needed to.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to make a complaint was displayed at the entrance to wards.

The service encouraged feedback from patients. We saw 'you said, we did' actions displayed on ward communication boards. For example, on ward 34b patients had requested ice was provided for drinks, and staff now had access to ice for patients.

Staff understood the policy on complaints and knew how to handle them. Staff did their best to address patients' concerns before they became complaints.

Managers investigated complaints and identified themes. Matrons we spoke with were knowledgeable about recent complaints.

Matrons were supporting the division with a backlog of complaints. Senior nursing staff and the governance team were meeting on a weekly basis to discuss outstanding complaints to ensure there was ongoing oversight of their handling and to identify any themes and patterns that may be emerging from the complaints.

**Summary of complaints**

**Trust level**

From March 2018 to February 2019, the trust received 153 complaints in relation to surgery (20.3% of total complaints received by the trust). The main subject of complaints was clinical care and treatment (84).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>84</td>
</tr>
<tr>
<td>Access to services – clinical</td>
<td>24</td>
</tr>
<tr>
<td>Communication</td>
<td>18</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>17</td>
</tr>
<tr>
<td>Discharge arrangements</td>
<td>4</td>
</tr>
<tr>
<td>Patient's property</td>
<td>1</td>
</tr>
<tr>
<td>Quality of facilities</td>
<td>1</td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
</tr>
<tr>
<td>Domestic services</td>
<td>1</td>
</tr>
<tr>
<td>Admission arrangements</td>
<td>1</td>
</tr>
<tr>
<td>Information provision</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>153</strong></td>
</tr>
</tbody>
</table>
For the 134 complaints that had been closed at the time of data submission, the trust took an average of 40.3 working days to investigate and close these. This was not in line with its complaints policy, which stated complaints should be closed within 30 working days.

The 19 complaints that had not yet been closed had been open for an average of 57.8 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Senior leaders we spoke with were aware the service did not always respond to patient complaints within the timeframes set out in the trust’s complaints policy. They explained the service’s approach to responding to complaints had historically not been the most effective. Leaders told us past restructures to save costs had resulted in administrative staff being reduced in numbers, which had a detrimental impact to the timeliness of responses to complaints. Leaders told us they were in the final stages of recruiting administrators to support the service in dealing with complaints in a timely manner in line with the trust’s policy.

Senior leaders told us there was an action plan with timeframes to clear the backlog of complaints and ensure new complaints were dealt with in accordance with the trust’s policy. They explained their action plan also aimed to ensure the service was learning from complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We were told by senior staff that the trust’s Patient Advice and Liaison Service (PALS) team attended a senior nurses’ meeting earlier this year to provide practical advice to staff on more effectively dealing with complaints. This included giving staff the confidence to have conversations with complainants at the earliest opportunity to identify the root cause of their complaint. Senior staff told us managers had also offered to sit with staff when they called complainants to help build confidence among staff.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff were made aware of feedback from complaints at team meetings and safety briefings. Staff were aware of recent complaints. For example, in pre-operative assessment there had been a communication failure where theatres were not made aware a patient had a learning disability even though this was identified at their pre-operative appointment.

Leaders told us of actions they had taken in response to feedback from patients. For example, the surgical day assessment unit was moved out of the surgical assessment unit following complaints from patients who reported the co-location of these units caused them confusion and distress.

Number of compliments made to the trust

From February 2018 to January 2019, the trust received 8,435 compliments trust wide. The trust did not provide a breakdown by core service of compliments received.

Staff we spoke with across many of the specialties, including renal and transplant, told us they were proud of the positive feedback from patients.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in
the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

At the time of our inspection, the anaesthesia, surgery, critical care and renal divisional management team were undergoing changes in personnel. The former head of nursing and divisional managers had both recently stepped down. Leaders told us both vacancies had recently been filled and the new divisional management team would regroup in July 2019. The neurological and musculoskeletal sciences division had also appointed a new clinical director in April 2019.

These recent changes aside, the two divisions enjoyed stable leadership at all levels of the clinical structures, including long-standing and experienced specialty leaders and assistant general managers.

The leadership team had the appropriate range of skills, knowledge and experience to perform its role. However, recent changes to the management team required time to embed.

In 2018/19, the trust embedded the principles of ‘service line management’ (SLM). SLM involved identifying the different business units, or ‘service lines’, of an NHS foundation trust. This was to understand how they contributed to the trust’s performance as a whole, encouraging clinicians and managers to deliver improvements in quality and productivity at the specialty level. Service leaders told us they endorsed trust leaders’ passion for what they described as ‘bottom-up leadership’. As part of this SLM initiative, surgical leaders explained they, along with other service leaders in the trust, had undergone a senior leadership programme. Consequently, divisions were semi-autonomous and able to make a lot of their own decisions, with effective deputy arrangements and succession planning.

Leaders across both divisions spoke positively about the support and level of engagement they had from their respective divisional managers as well as the trust executive team.

Staff were generally supportive about the leadership up through the structure. Staff we spoke with were positive about the support from matrons. Nurses told us matrons were easy to contact, with a single bleep for all, and visited wards regularly. Matrons were positive about the support from other matrons. Matrons and general managers were positive about support from the divisional head of nursing and divisional director.

Leadership development opportunities were available to staff. For example, a development programme was available for nurses at band seven. This focused on identifying and nurturing leaders for the future. The service was working to develop nurses at band six to support with succession planning and staff retention.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was an effective and realistic strategy for achieving trust priorities and developing good quality, sustainable care. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. Senior leaders told us a new strategy for the service had recently been devised in conjunction with the trust’s wider five-year forward view for the organisation. Service leaders told us this new strategy comprised of three broad themes: staff, digital strategy and partnerships.
Senior leaders explained the new strategy sought to emphasise staff wellbeing, recruitment as well as better retention of existing staff. This included objectives like providing low-cost local housing for staff and explaining the service’s use of non-traditional roles including surgical care practitioners. Senior leaders said the digital strategy sought to further enhance the use of technology by building on the service’s reputation as a robotics centre. Senior leaders were confident this new strategy would deliver an enhancement in patient safety or experience.

Senior leaders said they were going to regular staff engagement events to promote this new strategy to ensure as many staff across all roles and bands understood the new strategy and were able to ask questions. Senior leaders also told us their ambition was to engage with patients in the realisation of the service’s new strategy.

Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. The values of the trust were to work well together, putting patients first, recognising the person and striving for excellence.

**Culture**

*Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.*

Staff felt positive and proud about working for the trust and their team. Staff felt respected, supported and valued. All staff we spoke with said they were valued for the work they did. Staff felt positive and proud about working for the service and their team which were described as close-knit and supportive. All staff we spoke with were committed to giving the best patient care.

Leaders in the anaesthesia, surgery, critical care and renal (ASCR) division told us they had introduced a staff engagement computer application (app) to seek feedback from staff across the service including from staff in theatres. This could be accessed through an icon on the desktop of trust computers. Between July 2018 to June 2019, over a thousand responses were recorded through this app with staff raising a range of issues.

Staff felt able to raise concerns without fear of retribution. All staff we asked in surgical wards said they felt able to speak up about any issues or make suggestions for improvements without fear of any reprisals; confident they would be listened to and their issues acted upon. Staff we asked were able to describe the different ways they could speak up about an issue including concerns about a colleague’s practice.

Senior leaders told us about work undertaken to improve cultures within theatres, so staff felt empowered to speak up and challenge colleagues. This included the introduction of a second edition of a theatre etiquette policy setting out the behaviours expected from staff. Simulation training was also taking place which encouraged team cohesiveness and communication skills, in addition to clinical skills. Leaders told us the service used ‘swarm’ meetings, which were a form of safety incident huddle which took place as close as possible in time and place to the incident. This was used to remind staff it was acceptable and necessary to speak up and challenge colleagues when they witnessed poor practice.

Not all staff we asked knew how to use the freedom to speak-up process and about the role of the freedom to speak-up guardian (FTSUG). The trust’s FTSUGs provided independent and impartial support to workers to speak up. This was to ensure those with responsibility for responding to the matters they raised did so following the policies and procedures of the organisation, as well as with good practice. We saw just one poster across the service promoting the trust's FTSUGs. This
was in the interventional radiology unit. This poster contained the pictures, names, roles, divisions as well as contact details for the trust’s FTSUGs.

The service applied duty of candour appropriately. Staff we asked understood the duty of candour and provided examples of its application.

The service supported staff wellbeing. Staff had access to support for their own physical and emotional health needs through occupational health. Staff we asked were aware of the trust’s wellbeing programme for staff. This included physical and psychological support such as access to a free helpline for psychological support. Staff also had access to a 24/7 free, confidential helpline offering counselling about financial and legal matters, personal issues and more.

Staff in the burns and plastics ward told us that in response to a challenging incident last year, a group event was organised to help staff with the emotional and psychological impact this had on them. Staff said although there were delays in organising this event, they found it helpful. Staff were confident lessons had been learnt and such events would be organised more quickly in the future.

There were several initiatives to support staff wellbeing. For example, the service held regular, well attended ‘Schwartz rounds’ which were group reflective practice forums which provided all staff the opportunity to reflect on the emotional aspects of their work.

The recruitment, retention and wellbeing matron kept in touch with new starters in the ASCR division with ‘keeping warm’ phone calls. They sent letters to check in on how they were getting along in their new role. The matron also arranged lunchtime walks for staff. A senior leader who had joined one of these walks told us about the positive impact it had on their day.

The service recognised staff success by staff awards and through feedback. We observed managers praise colleagues for their work. The service also promoted the use of a tool to recognise staff excellence. This included positive incident management (PIMS) awards where staff voted for their colleagues and helped promote staff wellbeing and enable acts of kindness.

Teams had positive relationships, worked well together. We observed individuals and teams communicating well and working cooperatively.

**Governance**

**Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

There were effective structures, systems and processes to support the delivery of quality care and treatment. The surgical specialties each had their own arrangements for governance and could explain how this reported to the divisional governance meetings. Divisional clinical governance reported to the clinical divisional management boards. They in turn reported to the trust management team who reported to the board assurance committees and trust board. We reviewed example minutes from cluster meetings and specialty level governance reports. These minutes indicated discussions had taken place regarding issues including staffing, performance, sustainability, patient feedback and serious incidents. We saw actions were recorded and followed up.

Mortality and morbidity reviews were completed at specialty level and reported to divisions. Avoidable harm cases could then be discussed at the trust wide mortality and morbidity group for learning to be fed back to the trust board. Information about mortality and morbidity reviews were
shared with the divisional management team through regular governance reports submitted by the specialties.

Staff at all levels of the organisation understood their roles and responsibilities and what to raise with a more senior person. The service sought to make governance everyone’s business by offering all staff the opportunity to get involved in governance meetings. Staff in the anaesthesia, surgery, critical care and renal division had ten half days protected time to attend governance meetings. Senior staff explained these ten half days were used as an opportunity, for example, to bring staff in theatres and anaesthesia together with staff in orthopaedics to discuss common themes. These multidisciplinary meetings were an opportunity to have open and thorough discussions about incidents and other issues. Senior staff told us the use of these meetings have contributed to the fact the surgical services had not had any recent never events.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

There were effective arrangements for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’. Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. We reviewed the divisional risk register and saw risks matched concerns. Leaders on the wards and within specialties had a good understanding of their risks and how to manage them. Surgical cluster meetings and governance reports included discussion of specialty risks, as well as discussion of mortality and morbidity reviews.

Divisional leaders also demonstrated awareness of the risks facing surgical services across both divisions. For example, senior leaders identified the relatively higher surgical infection rates in orthopaedic procedures as well as emergency theatre capacity more generally as risks facing surgical services. Senior leaders told us there were action plans to address these risks and steps had already been taken to manage them. This included the introduction of an elective orthopaedic infection control standard operating procedure to prevent cross infection and maintain safety.

In addition, leaders said the aesthetics, critical care, surgery and renal division was not producing clinical letters for patients in line with a contractual standard with the clinical commissioning groups. This required letters to be sent within ten working days. This issue was also highlighted in our last inspection. However, divisional leaders told us since our last inspection performance had improved. They explained that in some of the surgical specialities, the ‘turnaround’ time for clinical letters had reduced from 12-14 weeks to between three and four weeks. Nevertheless, divisional leaders said they were not satisfied with this progress and their aim was achieve a seven-day turnaround time. As a result, division leaders said this remained recognised as a risk for surgical services because of the potential impact it could have on patients receiving care.

Senior leaders also identified the lack of vision panels on the majority of theatres doors as one of the risks facing the surgical services. The issue was on the risk register. Senior leaders acknowledged the issue was a cause of concern among staff and it posed potential infection concerns as well. The process was complicated by the building contract. However, leaders explained a programme to install windows in the remaining windowless theatre doors would roll out over the following 12 months.
Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. When talking through audits, leaders were clear on their performance and where improvements were needed.

Minutes of bimonthly medicines governance group meetings, which leaders from both surgical divisions attended, included discussion of medicines’ issues on the risk register.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff. These included local audit programmes to monitor patient harm.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. There were also electronic flow whiteboards in all surgical wards. However, theatres and medilrooms were not on the same electronic flow system as the wards.

Managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Key performance indicator dashboards and assessments were held for each specialty. This reviewed quality, workforce, finance and responsiveness.

The service submitted data and notifications to external bodies as required. This included data for national audits and notifications of serious incidents. Leaders described the processes to ensure the integrity of data submitted to external bodies. For example, leaders explained that monthly meetings took place to discuss all instances of mortality following hip fracture procedures. Research staff attended these meetings, and they were an opportunity to discuss any potential issues regarding the quality of the data submitted to the national hip fracture database. The burns unit also contributed to the international burns injury database – measured key performance indicators such as length of stay and consultant review in first 12 hours.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders were aware of the challenges of effective information gathering and sharing in such large divisions. Leaders told us feedback from staff about mass communications across whole divisions, through newsletters and weekly emails, for example, was that they were not an effective means of communication. Leaders said they now encouraged teams to have their own internal communication channels. This included the theatre teams and operating department practitioners who had their own newsletters.

Leaders explained the two divisions were large and covered a wide range of specialities. Service leaders told us that to improve communication, they divided their divisions into ‘clusters’ by grouping together specialities which worked effectively together. Divisional leaders held monthly meetings with the leaders. These clusters serve as effective information sharing and gathering.
events. The cluster leaders were then able to share information from these meetings with their teams.

The divisions had various groups which they termed as ‘boards’. These included divisional boards, a theatre board, and governance boards. Leaders explained these boards met regularly and were opportunities to communicate with staff and to gather and share information.

Divisional leaders in the neurological and musculoskeletal sciences division explained that at divisional meetings teams were asked to deliver short presentations about their services. These presentations would cover what was and was not working well about a service as well as any help the team needed going forward. Assistant general managers would be in those meetings and took this information away to decide on appropriate action. Leaders explained this ensured these meetings were an effective platform for two-way communication.

Staff in theatres told us regular meetings were held where staff could express their views and suggestions, and they thought these meetings were effective.

Staff were involved in decision making about changes to the trust services. Senior leaders actively sought and listened to the views of frontline staff in the planning and delivery of services and in shaping the culture. For example, senior leaders explained two new skin cancer theatres were going to be opening in October 2019. This was in response to listening to dermatological staff about the year-on-year increase in the instances of skin cancer and therefore growing demand for theatre time and space.

The service engaged with patients through patient user groups. Senior leaders explained some of these groups, including user groups for urology, bariatric and cancer patients, were actively providing feedback through social media. Senior leaders told us they were using different platforms including social media to engage with their patient user groups. In response to feedback from patients, the neurological & musculoskeletal sciences division prepared patient information videos to encourage physiotherapy rehabilitation for patients who had undergone hip or knee replacement. These videos sought to make the information conveyed more informative and interesting. This was in line with the trust’s priorities for improvement in the financial year of 2018/19 to enhance the way patient involvement and feedback was used to influence care and service development.

The team running the enhanced recovery programme for colorectal surgery sought and acted on feedback from patients by changing their template letters to patients.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service actively sought to participate in improvement and innovation projects. This included projects to test methods to improve the uptake of oral iron in anaemic patients as well as the uptake of smoking cessation in pre-operative assessment clinics. The bariatric surgery team were also working with international partners to improve surgical outcomes by optimizing perioperative care.

There were organisational systems to support improvement and innovation work. Leaders gave examples of how they were using technology to improve the delivery of services, including signing a partnership with a local university to introduce novel technologies. The service had recently opened its second robot in theatres meaning the hospital was a double robotic hospital at the time of our inspection. Leaders’ ambition was for the service to become a national robotics centre with
general surgery, upper gastrointestinal surgery, and bariatric surgery introducing robotic
techniques into their practice. There was an action plan spanning several years to develop the use
of robotics further.

A detailed external review was carried out looking into the governance arrangements to oversee
the introduction of novel techniques. The recommendations from this review were implemented in
2017. Leaders told us the new arrangements encouraged innovation through more effective
oversight of novel techniques.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which
had been implemented. External organisations had recognised the improvement work undertaken
by the service. For example, staff in the service spoke positively about the trust's investment in
Perform, a quality improvement programme, to serve patients as efficiently as possible as they
moved through stages of care. Staff were supported to understand their role in achieving
efficiencies and given the tools to help improve processes. Huddles were taking place across the
service to help teams to manage their work better and prioritise actions. The trust was awarded by
an external body for its implementation of this quality improvement programme.
Maternity

Facts and data about this service

North Bristol NHS Trust has 76 maternity beds, and maternity services provide a full range of antenatal, intrapartum and postnatal maternity care, both in the community and in hospital settings.

The hospital setting offers both inpatient and outpatient care. Inpatient services at Southmead hospital include a consultant led central delivery suite, a midwife led unit (Mendip Ward) and two wards providing antenatal and postnatal inpatient care (Quantock Ward and Percy Philips Ward).

There is a maternity assessment unit open 24 hours a day, seven days a week.

Women may also attend clinics as outpatients to be seen by a range of specialist practitioners in the antenatal assessment clinic.

Midwives and GPs can refer women in the early stages of pregnancy to the Early Pregnancy Assessment Clinic. This clinic provides advice, guidance and treatment for women with pain and/or bleeding in the early stages of pregnancy (up to 16 weeks) and pregnant women with a high risk of an ectopic (outside the womb) pregnancy.

The maternity facilities offer en-suite rooms, birth pools, overnight partner stays if labour is induced and following the birth, plus a family room. They also provide a full range of complementary therapies and pain management.

Cossham Hospital is a free-standing midwife-led birth centre which is currently closed for births until October 2019, with women in labour being diverted to the midwife-led unit at Southmead Hospital.

(Source: Routine Provider Information Request (RPIR) Universal – Sites tab / RPIR – Acute context tab)
From January to December 2018, there were 5,882 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at North Bristol NHS Trust – Comparison with other trusts in England.

(Source: Hospital Episodes Statistics (HES))

A profile of all deliveries and gestation periods from January to December 2018 can be seen in the tables below. This excludes any deliveries where the delivery method is ‘other’ or ‘unrecorded’.

<table>
<thead>
<tr>
<th></th>
<th>NORTH BRISTOL NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,769</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>89</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>105</td>
<td>1.8%</td>
</tr>
<tr>
<td>20-34</td>
<td>4,243</td>
<td>72.4%</td>
</tr>
<tr>
<td>35-39</td>
<td>1,238</td>
<td>21.1%</td>
</tr>
<tr>
<td>40+</td>
<td>272</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td>5,858</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
The trust has a similar profile of deliveries in terms of single or multiple births when compared to the England average.

At North Bristol NHS Trust, gestation periods were being recorded locally but an internal mapping error meant the submissions were not being accurately made to national datasets. Local records showed an unrecorded rate of 0.2% but national recorded showed an unrecorded rate for 78.7% of deliveries from January to December 2018.

(Source: Hospital Episode Statistics, January 2018 to December 2018)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

**Number of deliveries at North Bristol NHS Trust by quarter**

![Graph showing number of deliveries at North Bristol NHS Trust by quarter from 2016 to 2019](image)

The number of deliveries at the trust fluctuated between 1,439 and 1,522 per quarter during the reporting period. (Source: Hospital Episode Statistics - HES Deliveries (January 2018 - December 2018))

We inspected the maternity services on 25, 26 and 27 June 2019. This inspection was unannounced. We visited the early pregnancy assessment Unit (EPAC), the antenatal clinic, the maternity assessment unit, the antenatal ward (Quantock ward), the central delivery suite, the midwife led birth unit (Mendip ward) and the postnatal ward (Percy Philips ward).

We returned for an unannounced visit to the maternity unit during the night shift on 11 July 2019.

During our inspection, we spoke with 52 members of staff including managers, midwifery staff, doctors, cleaners, administration staff, security staff and sonographers. We spoke with 11 patients and their partners. We observed treatment, reviewed records and minutes of meetings, and attended handover meetings and safety briefings.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff had completed it.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed some training on recognising and responding to the needs of women with mental health needs. Staff were trained to look for signs of post-puerperal psychosis, for example, delusions, acting out if character and erratic behaviour.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received email alerts from the central training team to highlight when members of their team were due to complete training. For example, the clinic manager had received information that some staff were due to complete blood transfusion training. While staff at the clinic did not carry out blood transfusion, the training included elements of care and treatment relating to obtaining, holding and sending blood samples that were pertinent to clinic staff. Additional dates had been arranged for staff to attend this training.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory training courses as at April 2019 at trust level for registered nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at April 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Waste management (non clinical)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Non-patient handling</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Waste management (non clinical)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Food safety - 3 year expiry</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Infection prevention and control - 3 year expiry</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>244</td>
<td>260</td>
<td>93.8%</td>
<td>85%</td>
</tr>
<tr>
<td>Health and safety</td>
<td>239</td>
<td>262</td>
<td>91.2%</td>
<td>85%</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>235</td>
<td>262</td>
<td>89.7%</td>
<td>85%</td>
</tr>
<tr>
<td>Infection prevention and control - 2 year expiry</td>
<td>230</td>
<td>260</td>
<td>88.5%</td>
<td>85%</td>
</tr>
<tr>
<td>Dementia - level 1</td>
<td>228</td>
<td>258</td>
<td>88.4%</td>
<td>85%</td>
</tr>
<tr>
<td>Waste management (clinical)</td>
<td>225</td>
<td>259</td>
<td>86.9%</td>
<td>85%</td>
</tr>
<tr>
<td>Food safety - 2 year expiry</td>
<td>147</td>
<td>171</td>
<td>86.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>225</td>
<td>262</td>
<td>85.9%</td>
<td>85%</td>
</tr>
<tr>
<td>Venous thromboembolism (VTE)</td>
<td>221</td>
<td>258</td>
<td>85.7%</td>
<td>85%</td>
</tr>
<tr>
<td>Fire</td>
<td>223</td>
<td>262</td>
<td>85.1%</td>
<td>85%</td>
</tr>
<tr>
<td>Information governance</td>
<td>216</td>
<td>262</td>
<td>82.4%</td>
<td>85%</td>
</tr>
<tr>
<td>Patient handling</td>
<td>191</td>
<td>253</td>
<td>75.5%</td>
<td>85%</td>
</tr>
<tr>
<td>Clinical blood transfusion training</td>
<td>182</td>
<td>243</td>
<td>74.9%</td>
<td>85%</td>
</tr>
</tbody>
</table>
In maternity the 85% target was met for 15 of the 18 mandatory training modules for which registered nursing and midwifery staff were eligible.

At the time of our inspection, the trust did not provide any training data for medical staff within maternity. However, we were informed that completion of all mandatory training was necessary for medical staff to pass their appraisal, and data submitted in September 2019 indicated full compliance.

Some staff were trained to meet the needs of women with additional needs such as mental health conditions, autism and learning disability. However, these numbers were few and trained staff were not representative of different disciplines, grades or clinical areas. Only two staff had training regarding learning disability, these were both based on the central delivery suite and were both healthcare assistants. Only two staff were trained regarding autism, these were a midwife and a technician, both based on the central delivery suite. There were 19 staff who had participated in training regarding mental health, the majority of these were healthcare assistants with only three midwives and two nurses. No doctors had completed this training.

**Safeguarding**

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

All staff received training specific to their role in how to recognise and report abuse. The trust provided information and guidance for staff on the action to take to safeguard women. The policy and procedure included information on domestic violence, female genital mutilation, child sexual exploitation and a separate policy detailed action to take in the event of a baby abduction. The staff were required to complete annual safeguarding training with additional ad hoc training provided by the safeguarding team when required. Additional training material was being developed regarding risks to women from trafficking, refugees and asylum seekers and adverse childhood experiences.

The trust set a target of 85% for completion of safeguarding training. In maternity, the 85% target was met for all three safeguarding training modules for which registered nursing and midwifery staff were eligible. A breakdown of compliance for safeguarding training courses as at April 2019 at trust level for registered nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at April 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults - level 1</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 3</td>
<td>249</td>
<td>262</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 2</td>
<td>244</td>
<td>260</td>
<td>93.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Staff knew how to identify adults and children at risk of, or suffering from, significant harm and worked with other agencies to protect them. Staff we spoke with consistently said they would always try to speak with women on their own to assess for safeguarding risks. Staff had a good understanding of identifying women who could be at risk from ‘trafficking’ and child sexual exploitation and worked closely with charities to support women in these situations. Staff gave us examples of when they had identified concerns and arranged for these to be investigated.
The service had strong links with a local domestic violence support group. The safeguarding leads shared promotional material with women at risk from domestic violence, so they could contact the organisation if needed at home. Staff gave us examples of when they had acted to help women who were fearful for their safety at home. When safeguarding concerns arose, staff developed individual safety plans in conjunction with the woman and with advice from independent domestic violence advisors based in the emergency department. Staff shared these plans with the maternity security team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding champions worked on the wards. These champions supported staff to recognise and report safeguarding concerns and shared updates regarding the safeguarding procedures.

Staff followed the baby abduction policy. Staff had recently participated in a baby abduction drill on the post-natal ward. This had been planned with the help of parents on the ward. This drill identified gaps in the central delivery suite reception security. Afterwards, staff attended a debrief to recognise and share learning from the drill.

**Cleanliness, infection control and hygiene**

*The service did not control infection risk well. Staff did not always use equipment and control measures to protect women, themselves and others from infection. They did not always keep equipment and the premises visibly clean.*

Not all areas of the ward had suitable furnishings which were clean and well maintained. We saw three armchairs on the central delivery suite with ripped fabric seats. The worktop at the nurse’s station was stained and roughened through wear in places.

Not all wards used a system to regularly change curtains around beds. On Quantock ward, the antenatal assessment unit and the antenatal clinics, staff were unclear of when the fabric curtains around beds were last changed, and there were no dates to show when they had been changed. We saw curtains in the assessment unit which were soiled with blood and with pen marks. Staff did not know the system for cleaning or replacing curtains around birthing pools. There were vertical fabric blinds used in some patient areas which could not be easily cleaned. There were no dates to show when these blinds were last changed. We saw one of these blinds was soiled with blood and staff told us this had been stained for some time.

Cleaning schedules and checklists were not used effectively. Staff did not consistently complete records to show when cleaning tasks were completed. There was confusion regarding who was responsible for some cleaning tasks. For example, none of the staff we spoke with knew who was responsible for cleaning the children’s toys in the family room. Staff stated there were occasions when not all areas of the wards were cleaned thoroughly. During our inspection, we saw that one ward was visibly dusty in places, mainly in the corridor which served as a thoroughfare to other areas. In the family room, the floor, chairs and tables were visibly dirty, and children’s toys were dirty. The toys included items that were not easily decontaminated, for example, toys made of fabric and worn-down wood. There were also light pulls in the toilets that were discoloured from use.

Managers completed environmental cleaning audits of the central delivery suite, Mendip ward, Percy Philips ward and Quantock ward. Audits highlighted various concerns, many of which were still evident during our inspection. These included: stained curtains, body fluids on walls, flaking plaster, rusty appliances, unclean toilets, debris on floors, dust. The action plan was written following our inspection. The action plan was brief and focussed on individual issues and lacked a joined up, proactive approach to ensuring cleanliness across the maternity unit.
Staff followed infection control principles including the use of personal protective equipment (PPE). PPE such as gloves and aprons were stored throughout all clinical areas. We saw staff using PPE when providing care and treatment to women. Handwashing facilities were available, and hand gel was located throughout wards and departments for the use of staff and visitors to the ward. We observed staff washing their hands before contact with women. This was in line with NICE QS61 Statement 3.

There was a midwife who took the lead for infection control. This member of staff completed hand hygiene audits every month and staff discussed the results of these in the safety briefings at the end of every month. During the three months prior to our inspection, the results of these audits showed 100% compliance for all wards except the antenatal clinic.

Staff cleaned equipment after patient contact. We observed sonographers take appropriate action to thoroughly clean the ultrasound probes and the ultrasound machine following every use. However, staff did not always follow trust guidelines for cleaning equipment. For example, staff we spoke with did not know the correct procedure for cleaning birthing pools. One of the birthing pools was visibly discoloured.

Staff and women using the service could not be assured that equipment was cleaned after every patient contact. Staff did not consistently label equipment to show when it was last cleaned. For example, birthing balls on the central delivery suite were not labelled as clean and staff did not record when they had been cleaned.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well.

The use of the premises did not always keep people safe. The procedures to allow entrance to the maternity unit did not assure the safety of women and children inside. The main entrance to the central delivery suite lobby was via one set of external doors. A receptionist or a midwifery care assistant controlled access to these doors. Once inside the doors, the visitor could access all wards. The entrance lobby inner doors to the central delivery suite did not have access control. The magnetic locks were removed when the doors were replaced in 2017 and were not refitted on completion.

Staff told us they sometimes felt unsafe when manning this entrance. This was because women or their partners and visitors sometimes became aggressive. These staff members did not have training to deal with challenging behaviour. The protocol to summon help when they felt threatened was not always effective. This was because the alarm rang through to the central delivery suite where staff were often too busy to answer.

Improvements had been made to increase security. The trust had changed procedures to reduce the footfall to the maternity services via the CDS door. The trust planned to add an access controlled lobby area to the CDS reception and access control to the inner doors leading from CDS to the rest of the unit.

At the other entrance to the maternity unit, the outer and inner doors to the lobby were fitted with access control. Security staff operated these locks and issued patients and visitors with lanyards that were colour coded to indicate a designated ward area and labelled with bed space and ward area. According to the trust protocol, only two people accessed the lobby at any one time, to allow for safe processing. However, we observed that this protocol was not consistently followed, and on occasion, members of the public ‘tail-gated’ through the doors.
Members of the public waited for the day assessment unit in an unobserved room less than two metres from unmanned doors that led directly into the central delivery suite. We noticed these doors were propped open on six occasions during our inspection, and we saw a woman and her partner use this door to access the central delivery suite.

Access to the maternity theatre area was via swipe-card controlled double doors. However, during our inspection, we saw on three occasions that these doors were propped open.

The service was located in an old building with limited space. Some areas of the maternity unit did not have suitable facilities to meet the needs of women and their families. The main corridor to the maternity assessment unit and the central delivery suite ran through the centre of Quantock ward, with women’s bedrooms on one side and their toilets and bathrooms on the other side. Members of the public and staff accessed this corridor unaccompanied, at any time of day or night.

Members of the public waited for the day assessment unit in an unobserved room where women staying on the ward were eating breakfast. On Quantock ward, the bathroom opposite the waiting area for the maternity assessment unit doubled up as a room for staff to test urine samples. Women were required to leave their samples in this public area.

The maintenance of equipment did not always keep people safe. The air handling units in the maternity theatre were at risk of failure due to being in use beyond their recommended lifespan. This was on the divisional risk register and rated as an extreme risk. There was a plan to repair these units during this financial year (2019/20).

Routine portable appliance testing (PAT) was not fully up to date at the time of inspection. Compliance was variable across the wards. On Mendip ward, two of the 27 appliances were overdue for this testing. On Percy Philips ward, seven of the eight appliances were overdue for this testing. On Quantock ward, two of the five appliances were overdue and on the central delivery suite, 20 of the 97 appliances were overdue for testing.

The service did not always have enough suitable equipment to help them to care for patients safely. For example, the fridge used to store breast milk on the post-natal ward could not be locked and was recorded as not registering optimum temperatures. Staff were waiting for this to be replaced. At the time of our inspection, the temperatures in the rooms on Mendip ward were very hot. New air conditioning units were on order awaiting delivery.

Some staff told us there was not always a ready supply of equipment such as drip stands, pumps used to speed up labour, and arm cuffs to monitor women’s blood pressure. Leaders had taken action to address risks associated with shortfalls in equipment availability. For example, the divisional business included a plan to replace four ultrasound scanners and purchase an additional three resuscitation equipment for infants, five cardiotocography machines and an unspecified number of saturation machines. A programme of servicing, maintenance and repair of ultrasound machines was in place and three new machines had recently been purchased.

Consumable equipment on all maternity wards was available, in date and well-stocked. Staff could order suitable equipment such as chairs, beds, mattresses and commodes from a central trust-wide store to meet the needs of women with a raised body mass index. Women could reach call bells beside their beds and staff responded quickly when called. However, not all call bells in bathrooms were not within easy reach. On the central delivery suite, women in the birthing pool could not reach the call bell on the other side of the delivery room.

Staff carried out some daily safety checks of specialist equipment. On all wards, resuscitation equipment for babies was checked every day, including the contents of the trolley, as per the trust policy. On Mendip ward, emergency equipment for adults was checked thoroughly and regularly.
However, on other wards, staff did not consistently carry out daily safety checks of specialist equipment. The protocol for checking emergency equipment for adults required staff to check if the defibrillator and suction machine were working, the oxygen cylinder was at least three-quarters full and the trolley was clean and tagged. Staff were required to open the resuscitation trollies to check the contents once per month. Following the check, staff attached a new tag to the resuscitation equipment trolley to indicate it was ready for use. On the central delivery suite, the timing of these checks was inconsistent. On one of the trollies, the face mask and bag had expired in December 2017 and the packaging was ripped. On Quantock ward, we noted from the check sheets that during June 2019, there were five days when the check sheet was not signed.

Boxes of equipment for responding to emergencies such as post-partum haemorrhage, sepsis, eclampsia and diabetes were available in each clinical area. These were checked once per month and tagged. However, the procedure for tagging did not enable managers to trace who had opened and closed these trollies and boxes at any given time. During our inspection at night-time, we noted that emergency equipment trollies and boxes were left unattended in unlocked rooms, with replacement tags readily available. On Percy Philips ward, one of the emergency boxes was not tagged.

Staff did not always dispose of clinical waste safely. Staff we spoke with were aware of safe procedures and used appropriate bins to separate waste accordingly. However, during our inspection, we saw that staff stored used urine funnels in an open sharps box in a patient bathroom on Quantock ward. Not all sharps boxes were closed, and one was overfilled. Staff on the central delivery suite were not disposing of controlled medicines in accordance with the medicines policy.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and acted to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating women and escalated them appropriately. Staff completed the Modified Early Warning Score for Obstetrics to monitor patients and recognise the deteriorating patient, including those at risk of developing sepsis. Compliance with this process was not audited because there had been no incidents relating to this process and no changes to national guidelines to indicate a new risk. We checked patient records during our inspection and saw these charts were completed correctly.

The triage midwife alerted medical staff when a referral was made for a woman with no fetal movement so that they were available to see them on arrival. A midwife or doctor saw women attending the antenatal assessment unit with reduced fetal movement within one hour of arrival. If a woman presented with no fetal movement, they were seen immediately. This was in accordance with the Royal College of Obstetricians and Gynaecologist Guidelines.

Staff monitored fetal heartbeat and uterine contractions using individual cardiotocograph machines. There was also centralised monitoring system which was used to provide additional oversight of the women being monitored. However, women being monitored in the maternity assessment unit, the maternity theatre and Quantock ward did not benefit from this additional assurance because the system was not functional in these areas of the unit. This was on the divisional risk register and options for replacement were being considered.

Staff completed risk assessments for each woman on arrival and updated them when necessary and used recognised tools. The triage nurse in the antenatal assessment unit completed an initial
assessment form for each woman expected in the unit. This information was handed over to midwives working in the unit, so they were able to prioritise care and treatment.

Staff knew about and dealt with any specific risk issues such as venous thromboembolism, sepsis, falls and pressure ulcers. Sepsis training was provided to all staff within the trust and local maternity induction and during specific annual midwifery training. Audits of compliance with sepsis protocols indicated there were some delays in initiating the protocol and gaps in the management of suspected sepsis. Recommendations from the audit included a need to instigate the protocol if the woman presented with two temperatures between 37.5 and 37.9 degrees or one temperature of more than 38 degrees. For patients at risk of pressure area damage, staff monitored their skin and arranged use of appropriate equipment, for example, pressure-relieving mattress.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman’s mental health. Staff completed or arranged psychological assessments and risk assessments for women thought to be at risk of self-harm or suicide. There were strong links with the safeguarding team who supported staff to meet the needs of these women.

Staff shared key information to keep women safe when handing over their care to others. The service completed World Health Organisation surgical safety checklists in maternity surgery. Compliance with this process was not audited because there had been no recent incidents or changes to national guidelines to identify a risk. We observed this process during our inspection and saw the checklist was completed to an exemplary standard.

Shift changes and handovers included all necessary key information to keep women safe. There were safety briefing noticeboards in the ward staff offices. These boards displayed relevant information and updates relating to the ward or unit. Staff were expected to read these when on duty. However, there was no system to identify if staff had done this.

Midwifery and nurse staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Staff of all grades told us that midwifery staffing had previously been a concern for the service. However, managers had partially mitigated this risk. The maternity service had recently recruited 24 (whole time equivalent) newly qualified midwives, and there was a vacancy rate of -1.1% for midwives and 2.7% for midwifery assistants.

This mitigation had resulted in a safe service level. This was evident in the midwife to birth ratio of one midwife to every 25.2 births from January to December 2018. This was similar to the England average of one midwife to every 24.6 births and was indicative of a safe staffing level.

The number of midwives and midwifery assistants on all shifts on each ward usually matched the planned numbers. Data from staffing metrics showed there was overstaffing for midwives and 2% unfilled shifts for midwife assistants.

Leaders mitigated staffing risks on an ongoing, shift by shift basis. The service had low rates of bank and agency midwives used on the wards. Managers limited their use of bank staff and requested staff familiar with the service. They did not use agency staff except when one to one care was needed for women with mental health needs. Managers made sure all bank and agency staff had a full induction and understood the service. From March 2018 to February 2019, the trust reported 13,466.2 of the 299,344.0 available hours for registered nursing and midwifery staff were
filled by bank staff (4.5%) and 22.8 hours were filled by agency staff (less than 0.1%) in maternity. Over the same time, the trust reported 8,364.2 of the 125,916.4 available hours for nursing assistants were filled by bank staff (6.6%). None of the nursing assistant hours were filled by agency staff.

The ‘flow midwife’ maintained a real-time overview of the whole service and prioritised staffing resources accordingly. This included moving staff, authorising additional shifts, arranging bank cover and on rare occasions, sanctioning use of agency staff.

Managers accurately calculated the number and grade of midwives and midwifery assistants needed for each shift, in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of women.

However, the staffing acuity tool was not used on all wards because it did not reflect the complexities of antenatal care. For example, telephone calls, triaging, waiting time breaches and managing women attending for induction of labour. Staff told us the current staffing arrangement for the maternity assessment unit did not match the pattern of demand at night time, which was consistently busy until 0200 each day.

There were 51 incidents related to short staffing in midwifery reported during the three months preceding our inspection. Staff told us that staff sickness continued to be a factor in staffing pressures. Sickness rates for midwives and midwife assistants was higher than (worse than) the trust target of 4.2%. From March 2018 to February 2019, the trust reported an overall sickness rate of 5.7% in maternity, for midwives this was 5%, and for midwife assistants, the rate was 7.6%. This did not meet the trust’s target.

Twenty-seven of the 51 staffing incidents reported during the three months preceding our inspection were related to night time cover. During our inspection, we saw that staff sickness affected the availability of staff, and this impacted on women’s care. For example, during the night shift, a woman could not start her induction because the midwife in charge knew the early day time shift was short-staffed.

Flow midwives were not employed during the evenings or at weekends. However, in the maternity assessment unit, there was a plan to trial an additional midwife working from 1000 to 2230pm at weekends and bank holidays to help with the workflow.

Medical staffing

The service had some gaps in medical staffing. Medical staff had the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the
right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women safe. As part of an operational productivity programme led by NHS Improvement, the trust had participated in a ‘Getting It Right First Time’ (GIRFT) report in maternity. This report highlighted concerns regarding the lack of consultant presence on the antenatal and postnatal wards. To address this, the service was given funding to increase the number of consultants employed in maternity.

At the time of our inspection, the obstetric medical workforce was fully staffed. The service was using locum staff on six-month contracts whilst a substantive recruitment process was underway.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In December 2018, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were about the same as the England averages. We spoke to junior and senior doctors, and they confirmed there was always suitably skilled and experienced medical staff to meet the needs of patients. At the time of our inspection, eight consultants were covering the on-call rota. Consultants were on-site between 0800 and 2030 from Monday to Friday. At weekends, consultants were on-site between 0800 and 1400. The service always had a consultant on-call during evenings and weekends.

The maternity service had sickness rates below the trust target for medical staff. Across maternity, overall sickness rates for medical staff were 0%.

However, for medical staff, the maternity service had turnover higher than (worse than) the trust target. The trust set a target of 15.6% for turnover rate. From March 2018 to February 2019, the trust reported an overall turnover rate of 38.3% for medical staff. This may be partly explained by the transient nature of rotational and junior posts.

During times of holiday, there was not always enough permanent members of consultant staff to cover. Staff escalated this to the assistant general manager of women’s and children’s division who had the authorisation to arrange locum cover.

At the time of our inspection, locums were covering this additional capacity until permanent members of staff were recruited. These locums were on long term contracts. This aided continuity of care and reduced the risk to patient safety. Managers made sure locums had a full induction to the service before they started work.

Records

Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. When women transferred to a new team, there were no delays in staff accessing their records.

We checked eight sets of women’s records. All contained accurate recordings and interpretation of early warning escalation scores. Appropriate risk assessments were completed, for example, assessment for risk of venous thromboembolism.

Not all records were stored securely. Staff did not always protect the confidentiality of women’s personal information. During our visit to the unit at night time, we saw that staff left patient records unattended on shelves and in unlocked cabinets in unlocked rooms on Mendip ward, Percy Philips ward and Quantock ward. On the day assessment unit, three days’ worth of discharge summaries containing confidential patient information were stored in an unobserved tray beside the entrance.
to the unit where patients waited to be checked in. During the day time, on the central delivery suite, patient records were stored in notes trollies, but these were not consistently locked.

There was a risk that archived cardiotocograph records may become unreadable over time because they were not stored on an electronic system. Print outs were filed on the patient record during their admission and then after discharging these records were archived into special paper envelopes designed to slow down deterioration. This was rated as an extreme risk on the division risk register.

**Medicines**

**The systems and processes to safely prescribe, administer, record and store medicines were not always followed.**

Staff followed systems and processes when safely prescribing and administering medicines. Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

However, staff did not store and manage medicines and prescribing documents in line with the provider’s policy. We saw the fridge temperatures were recorded as out of the recommended range on the central delivery suite since 10 June 2019 and on Percy Philips ward since 24 December 2018. Staff had taken no action to ensure medicines were still safe to use.

Controlled drugs were not being disposed of in line with trust policy. Part used small amounts could be put into disposal bins with denaturing granules, however we saw large amounts being placed in the blue bins in the treatment room for disposal before being denatured. As the treatment door was unlocked, the controlled drugs could have been accessible to patients and visitors.

Medicines were not being stored securely. On the central delivery suite, the treatment room door was broken. Staff locked most medicines in cupboards, however, the medicines in the fridge and medicines for disposal were not secure. In the maternity theatre area, the anaesthetic office door was broken. Inside this room, staff left the medicines cupboards and fridge unlocked.

**Incidents**

**The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

All staff knew what incidents to report and how to report them. We saw that the antenatal ward had reported incidents relating to staffing shortages and when they had no capacity to admit women who required induction of labour.

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2018 to April 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage</th>
</tr>
</thead>
</table>
Maternity/Obstetric incident meeting SI criteria: 
- mother and baby (this include foetus, neonate and infant) 4 57.1%
- mother only 3 42.9%
Total 7 100.0%

(Source: Strategic Executive Information System (STEIS))

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong.

Staff received feedback from the investigation of incidents, both internal and external to the service. For every serious incident investigation, the team produced a poster showing the learning recommendations. For example, there was a poster emphasising the requirement for all women under obstetric-led care to have an obstetric review on admission and an individual plan of care. These posters were displayed in a folder in each clinical area, and staff knew how to refer to this resource.

Staff met to discuss the feedback from investigations and look at improvements to patient care. All learning from incidents was shared at the weekly safety meeting attended by the divisional lead for quality and patient safety, matrons, midwives, and consultants. For example, this meeting incorporated consideration of avoidable causes of harm that can lead to infants born at term being admitted to a neonatal unit. This was a safety project initiated as part of the national maternity transformation programme.

There was evidence that changes had been made because of feedback. For example, there was an incident involving a baby who was taken seriously ill immediately post-discharge from the unit. The investigation concluded that communication regarding the signs and symptoms of serious illness after birth needed to be clearer for parents. As a result, the ward now discussed this with families on day one and reminded them on the day of discharge, and parents signed to say they had been given this important information.

From March 2018 to April 2019, the trust reported no incidents which were classified as never events for maternity. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff using the maternity dashboard. Safety thermometer data was shared with patients and visitors.
Safety thermometer data was displayed on wards for staff and women to see. The trust was unable to provide safety thermometer data for the 12 months preceding our inspection.

Leaders continually monitored the safety and effectiveness of the service using data collected via the maternity dashboard and incident reports. This information was shared with staff in the monthly governance reports.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

There were up to date policies to plan and deliver high quality care according to best practice and national guidance. Leads wrote protocols for treatment of conditions, based upon credible evidence that was vetted through the trust guidelines committee. When new guidelines were published, the team amended treatment protocols accordingly. For example, the team had reviewed the Royal College of Obstetricians and Gynaecologists Prevention of Early Onset Neonatal Group B Streptococcal Disease and amended the trust guidelines to conform. All guidelines were stored in a folder in every delivery room. However, on the central delivery suite, these folders were not kept up to date and some contained obsolete guidance. Some guidance, such as an algorithm for treatment of post-partum haemorrhage, was not dated and was included without the supporting policy.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Midwives asked about women’s emotional well-being as part of the daily postnatal checks, and staff highlighted to the team any issues identified.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. At meal times, staff offered the menu choices presented by the hospital catering department, these included low potassium options. Outside of meal times, staff provided light snacks when required, for example, toast, crackers and biscuits. On the postnatal and antenatal ward, women could prepare their own breakfast and make hot drinks and toast.

Staff fully and accurately completed women’s’ fluid and nutrition charts where needed.

Specialist support from staff such as dietitians was available for women who needed it.

Women waiting to have surgery were not left nil by mouth for long periods.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
Staff assessed women’s pain in accordance with the Royal College of Midwives ‘Midwifery Care in labour guidance for all women in all settings’ November 2018. Staff gave pain relief in line with individual needs and best practice. Women told us they received pain relief soon after requesting it.

Staff prescribed, administered and recorded all pain relief accurately. We checked medicine administration charts, and these were completed in according to best practice.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved variable outcomes for women.**

The service participated in all relevant national clinical audits. The service performed variably in national clinical outcome audits and managers used the results to improve services further.

In the National Neonatal Audit Programme, the service scored within expected range or similar to other trusts for both metrics: mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids, and mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery.

In the National Maternity and Perinatal Audit Programme, the service scored better than expected for one measure: case-mix adjusted proportion of single, term infants with a five-minute Apgar score of less than seven. The service scored within expected range or within the middle 50% for three of the seven measures. These included: case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date and case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery, proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit.

However, three measures on the National Maternity and Perinatal Audit Programme scored worse than expected when compared to other hospitals. These included case-mix adjusted overall caesarean section rate for single, term babies, case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear, case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml.

In the MBRRACE-UK Perinatal Mortality Surveillance Report, mortality rates were up to 10% lower (better) than the average for the comparator group.

**National Neonatal Audit Programme**

The table below summarises Southmead Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? (Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and)</td>
<td>87.4%</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Hospital performance</td>
<td>Comparison to other hospitals</td>
<td>Meets national standard?</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------</td>
<td>------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Trust-level case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>88.8%</td>
<td>N/A</td>
<td>×</td>
</tr>
<tr>
<td>Antenatal measures (before birth, during or relating to pregnancy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date (Babies who are small for their age at birth are at increased risk of problems before, during and after birth)</td>
<td>54.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Intra-partum measures (during labour and birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)</td>
<td>28.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted overall caesarean section rate for single, term babies (The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)</td>
<td>29.8%</td>
<td>Higher than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of single, term infants with a 5-minute</td>
<td>0.6%</td>
<td>Lower than expected</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)

National Maternity and Perinatal Audit Programme

The table below summarises Southmead Hospital’s performance in the 2018 National Maternity and Perinatal Audit Programme against measures related to maternity care.
<table>
<thead>
<tr>
<th><strong>Metrics (Audit measures)</strong></th>
<th><strong>Hospital performance</strong></th>
<th><strong>Comparison to other hospitals</strong></th>
<th><strong>Meets national standard?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Apgar score of less than 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5-minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (Third- or fourth-degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)</td>
<td>6.1%</td>
<td>Higher than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml (Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)</td>
<td>5.5%</td>
<td>Higher than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Post-partum measures (following birth)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit (Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)</td>
<td>80.8%</td>
<td>Middle 50%</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Maternity and Perinatal Audit Programme)
Standardised Caesarean section rates and modes of delivery

Between January and December 2018, the total number of caesarean sections was similar to expected. The standardised caesarean section rates for both elective and emergency sections were similar to expected.

### Standardised caesarean section rate (January 2018 to December 2018)

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>NORTH BRISTOL NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.8%</td>
<td>769</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>16.5%</td>
<td>1,033</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>29.3%</td>
<td>1,802</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from January to December 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average. The trust had a similar proportion of instrumental deliveries and caesarean sections and a lower proportion of non-interventional deliveries when compared to the England averages.

### Proportions of deliveries by recorded delivery method (January 2018 to December 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>NORTH BRISTOL NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,802</td>
<td>30.8%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>796</td>
<td>13.6%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,260</td>
<td>55.7%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,858</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
1Includes elective and emergency caesareans
2Includes forceps and ventouse (vacuum) deliveries
3Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episode Statistics, January 2018 to December 2018)

Maternity active outlier alerts

As at 29 April 2019, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

MBRRACE-UK Perinatal Mortality Surveillance Report

The table below summarises Southmead Hospital’s performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016
### Metrics (Audit measures)

<table>
<thead>
<tr>
<th>Stabilised and risk-adjusted perinatal mortality rate</th>
<th>Trust performance</th>
<th>Comparison to other trusts with similar service provision</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK’s death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)</em></td>
<td>5.96 (5.18 to 7.52)</td>
<td>Up to 10% lower than the average for the comparator group</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: MBRRACE-UK)

The patient outcomes for the fetal medicine team were good. From April 2018 to March 2019, 50 women had had an amniocentesis and none of these had lost their baby during the two weeks following amniocentesis.

Managers used information from audits to improve care and treatment. The team initiated several measures as part of a quality improvement project to reduce incidences of post-partum haemorrhage greater than 1500 millilitres from 4.9% to 3.4% by May 2020. These included the implementation of a staged assessment tool used routinely for all women in labour to identify women at risk of post-partum haemorrhage. Other measures included having two healthcare professionals present at the time of delivery to administer prophylactic medicine quickly, changing the site of the intra-muscular medicines and weighing blood loss more regularly and at an earlier stage. All incidences of post-partum haemorrhage of more than 2000 millilitres were investigated and discussed at a monthly safety meeting. Staff attending this forum identified learning to take forward, for example, ensuring assessments were adequately documented.

Wellness outcomes for women had not been affected by the increase in identified incidences of post-partum haemorrhage. There had been no increase in the number of women who were diagnosed with anaemia, unplanned hysterectomies, blood transfusions or transfers to the critical care unit. However, the team recognised the impact upon the patient experience and used extracts from patient stories to educate staff.

Managers carried out a comprehensive audit programme. Internal audits were focussed on topics relevant to the safety and quality of service. This included auditing practice when new protocols were introduced. For example, in November 2018, managers audited how staff completed fetal monitoring in labour. This resulted in changes to the trust guidelines. Managers then audited again in January 2019 to check that staff were implementing the new guidance.

Managers used information from the audits to improve care and treatment. For example, the team was trialling a new technique for delivery for women at risk of a vaginal tear. Women who had experienced a vaginal tear were invited to a post-natal perineal clinic where staff provided useful information for their next birth.

Managers shared and made sure staff understood information from audits. Results of the National Neonatal Audit Programme and the internal maternity dashboard were reviewed at the monthly maternity clinical team meeting and the monthly women’s health and neonatal medicine clinical governance meeting.
Competent staff

The service made sure staff were competent for their roles. However, managers did not complete regular appraisals of staff’s work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers gave all new staff a full induction tailored to their role before they started work. For new band five midwives, this included two weeks of trust induction, two weeks of local induction and two weeks working on the unit in a supernumerary capacity.

Midwives attended training annually for specific maternity related subjects. Midwives completed an essential skills day based upon a recognised teaching method to embed the latest evidence-based practice into labour ward teams’ clinical care. This included hands-on skills stations and simulation scenarios in the clinical area. Midwives also completed a key skills training day specifically designed to meet their essential training needs. The last training day was held in November 2018 and included training regarding cord prolapse, post-partum haemorrhage, pre-eclampsia and breech births. The team used an evidence-based training package that teaches healthcare professionals how to respond to obstetric emergencies. However, the service was no longer allocating resources to train midwives to be scrub practitioners for the maternity theatres. At weekends and during the night, the surgical team relied upon the maternity service to provide midwives to ‘scrub in’ for emergency caesarean section operations. These experienced midwives were pulled from clinical non-theatre areas to cover these duties, often at short notice. The resource of staff who had the right skills and knowledge to do this was diminishing as staff left the service. The maternity leads had submitted a business case for a separate theatre scrub team to be trained and managed by the surgical directorate.

The practice educator midwives monitored the competencies of maternity staff. This was done primarily through attendance at the maternity specific training. In April 2019, 96% of midwives and 77% of midwifery care assistants had completed this training. Medical staff were also required to attend the maternity specific training. However, compliance was low. In April 2019, 83% of registrars, 50% of senior house officers, 56% of anaesthetic consultants and 46% of anaesthetic doctors had attended the required training.

The practice educator team were working in collaboration with a nearby trust and a local university to develop a competency framework for monitoring fetal well-being. When skills deficits were identified, bespoke training was tailored to meet the need. For example, the infection control lead had identified a gap in skills around aseptic technique and had implemented training in catheterisation and cannulation techniques and started a programme of observation of competencies. Managers supported staff to develop. For example, the service had not been able to recruit sonographers. To mitigate this risk, there was a rolling training programme for midwives to train as sonographers. Three midwives were undertaking this training at the time of our inspection. Some midwives and doctors also attended training led by anaesthetists in high dependency care for women who had additional medical care and treatment needs.

However, not all staff had the opportunity to discuss training needs with their line manager in a formal appraisal setting. From April 2018 to March 2019, 63.3% of required staff in maternity received an appraisal compared to a trust target of 90%.

The breakdown by staff group can be seen in the table below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional clinical services</td>
<td>80</td>
<td>119</td>
<td>67.2%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>149</td>
<td>231</td>
<td>64.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>8</td>
<td>12.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>0</td>
<td>3</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
<td>365</td>
<td>63.3%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The matron recognised that this needed effort to improve compliance, but no plan was being actioned at the time of our inspection.

There were six professional midwifery advocates for the midwifery service. These midwives offered one to one support and/or drop in sessions for the midwifery staff. However, the role of the professional midwifery advocate was still being developed within the service and these sessions were not frequently utilised.

Managers recruited, trained and supported volunteers to support women in the service. Volunteers hosted tours of the maternity unit for women and their partners and assisted with making hot drinks on the ward. Four of these volunteers had recently progressed to study midwifery.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

All staff we spoke with told us staff of different disciplines worked well together. During maternity theatre we saw that all staff worked harmoniously to deliver safe care to the patient.

Staff had regular and effective multidisciplinary meetings to discuss women and improve their care. Staff worked across health care disciplines and with other agencies when required to care for women.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Community midwives screened patients for mental health concerns using two standardised measurements. These measures included questions about suicidal intention and self-harm. If indicated, the community midwife referred women to the antenatal clinic and to the perinatal mental health team. These referrals were jointly triaged, and women were given a risk score which was included in the maternity electronic record. Women were seen by the most
appropriate clinician which may be an obstetrician, a mental health nurse or midwife, or the specialist mental health team.

Staff always had access to up-to-date, accurate and comprehensive information on women’s care and treatment. All staff had access to an electronic records system that they could update.

Women attending the service carried their pregnancy and midwifery records with them. The antenatal clinic experienced difficulties if the women did not bring their records as they were not able to see a full record of the previous history and care and treatment. In these circumstances they would complete paper templates for the women to insert. A scanned copy was also added to the electronic records system. The booking form was available electronically, so staff could see the reason for referral and any information shared by the referring clinician.

Sonographers reported immediately on the ultrasounds they carried out. A printed copy was placed in the patient’s hand-held notes and uploaded to the patient’s electronic record.

**Seven-day services**

_Not all key services were available seven days a week to support timely patient care._

At the time of our inspection, the structure for medical staffing did not provide an equitable seven-day service. Consultants were present on the unit for 12.5 hours per day Monday to Friday. However, on Saturdays and Sundays, consultants were present for six hours daily.

Consultants led daily ward rounds on the central delivery suite Monday to Friday and were physically present in the maternity unit between 0800 and 2030 hours from Monday to Friday. At evenings and weekends, one senior house officer and two registrars provided all medical care for the maternity service with additional responsibilities for gynaecology and neonatal wards. Consultants were available on call during these times.

Consultants did not lead daily ward rounds on the antenatal or postnatal wards. Women on these wards were reviewed by consultants depending on the care pathway.

Women could attend the maternity assessment unit 24 hours a day, seven days a week. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

There was a gap in service provision for women experiencing pain and/or bleeding between six and 18 weeks of their pregnancy. The Early Pregnancy Assessment Clinic only accepted referrals on weekday mornings. Women could not attend without a referral.

Sonographers worked within the antenatal clinic providing dating and sizing scans on a Monday to Friday. There were waiting lists for the scans. However, a trust initiative was in operation which provided additional clinics on Saturday mornings twice a month to enable women quicker access to their required scan.

**Health promotion**

_Staff gave women practical support and advice to lead healthier lives._

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Staff provided women with information regarding health promotion in pregnancy. There were posters and leaflets on the wards regarding the use of electronic cigarettes and smoking in pregnancy, healthy eating and monitoring their babies’ movements.

Staff assessed each woman’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Learning from a recent serious incident had prompted teams to be more
vigilant around their assessment of women’s vaping to clearly identify any tobacco smoking
element of their habit.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff supported women to make informed decisions about their care and treatment. They
followed national guidance to gain women’s consent. They knew how to support women
who lacked capacity to make their own decisions or were experiencing mental ill health.
They used to agree personalised measures that limit women’s liberty.

Staff understood the relevant consent and decision-making requirements of legislation and
guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989
and 2004 and they knew who to contact for advice.

Staff gained consent from women for their care and treatment in line with legislation and guidance.
Verbal consent was sought from women prior to any care, treatment or diagnostic tests taking
place. Staff made sure women consented to treatment based on all the information available. Staff
clearly recorded consent in the women’s records Staff sought written consent for invasive
procedures. For example, we saw written consent was obtained from women prior to their babies
receiving a procedure to address tongue tie.

Staff understood how and when to assess whether a woman had the capacity to make decisions
about their care. When women could not give consent, staff made decisions in their best interest,
considering women’s wishes, culture and traditions. The mental health specialist nurse or the
safeguarding lead midwife attended best interest meetings.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity
Act and Deprivation of Liberty Safeguards and staff understood Gillick Competence and Fraser
Guidelines.

All staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards,
achieving the trust target. The trust set a target of 85% for completion of Mental Capacity Act
(MCA) and deprivation of liberty safeguards (DoLS) training.

As at April 2019, the trust reported that mental capacity and DoLS training was completed by
98.5% of all staff in maternity compared to the trust target of 85%. A breakdown of compliance for
mental capacity and DoLS training as at April 2019 for registered nursing and midwifery staff in
maternity is shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery registered</td>
<td>256</td>
<td>260</td>
<td>98.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust did not report any training data for medical staff within maternity.

(Source: Routine Provider Information Request (RPIR) – Training tab)

There had been no Deprivation of Liberty Safeguards in maternity during the 12 months preceding
our inspection. If a patient required any kind of restraint the team contacted the specialist mental
health nurse who arranged suitably trained staff to assist.
Is the service caring?

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were responsive when caring for women. The maternity theatre team made a series of changes to the way they carried out elective caesarean sections in theatre to respond to women’s individual ‘birth plan’ requests and emulate as far as possible the concept of a ‘normal’ delivery. These changes included introducing all staff by first name and role, ensuring mothers are warm using heated mattress, warm fluids and blankets, explaining as much or as little as the patient wishes, timely cord clamping and birth partner trimming of the cord, dropping the screen once the cord is cut to allow for photos and for the partner to announce the gender of the baby, skin to skin contact in theatre as soon as possible after birth, explanation of the placenta to mother and birth partner, family leave the theatre as a unit reducing separation anxiety.

Staff took time to interact with women and those close to them in a respectful and considerate way. For example, the antenatal assessment unit staff were kind, compassionate and calm when communicating with women who were either telephoning or arriving at the unit. We observed several telephone calls made to the unit and noted that the triage midwife consistently and calmly obtained information and provided reassurance to women who had concerns with their pregnancy. Women who were assessed as not needing to attend the unit were clearly advised to ring at any time if they had any further concerns or noticed any other changes.

Women said staff treated them well and with kindness. The trust participated in the National Maternity Survey 2018. This showed the trust had made significant improvements for 10 indicators of care. For example, 83% of women said they were not left alone when worried compared to a national average of 77% for similar units and a previous score of 73% for this service. Results indicated that 98% of women reported being treated with dignity & respect, 99% of women had confidence in the staff and 97% of women were involved enough in decisions about their care.

Staff usually followed policy to keep women’s care and treatment confidential. In most of the maternity wards, staff took care to talk to women in private spaces, closing doors to protect their privacy. However, in the antenatal clinic, staff did not fully respect women’s’ privacy and dignity. We observed women being booked into the clinic by midwives and health care assistants in the corridor. We observed that other patients and their partners accessed this area during the clinic. The booking in procedure included taking physical observations such as blood pressure and asking potentially difficult questions about their home circumstances. One member of staff told us that if women arrived wearing a thick top layer of clothing they would be asked to remove this so that an accurate blood pressure reading could be obtained. They said that to promote the woman’s privacy and dignity a sheet would be held up if their underwear was exposed.

We observed a conversation that took place in the main corridor between a woman and a midwife relating to swabs which the woman needed to take and how to take them. There were other women and their partners in this area who also could have heard this conversation. This did not protect the woman’s confidentiality or promote their privacy and dignity.

Staff working in the recovery area of maternity theatres told us they had difficulty maintaining the confidentiality and dignity of patients due to the cramped environment of this clinical area.

Staff understood and respected individual needs of each woman and showed understanding and a non-judgemental attitude when caring for or discussing women. For example, a midwife had purchased small soft toys to give to mothers and their babies who were going to be separated.
after birth. This included women who returned to prison after the birth of their child or women whose babies were cared for by social services. The mother and her child swopped their toys when they were separated. This thoughtful gesture offered comfort to mother and baby at this difficult time.

**Emotional support**

Staff provided emotional support to women, families and carers to minimise their distress. They understood women’ personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff from the antenatal assessment unit supported women who presented with reduced fetal movement. We observed one woman who was provided with emotional support which allayed their anxieties when they had been referred to the unit following concerns raised to their community midwife. Staff provided reassurances and allayed women’s anxieties. Staff took time to explain the findings from ultrasound scans.

Staff worked with local charities to provide bereaved parents with memories of their child including footprint casts and memory boxes.

Staff demonstrated empathy when having difficult conversations. Staff on the antenatal ward and antenatal assessment unit accessed a private room to convey potentially distressing information to women and their partners. This would enable them to absorb the information and ask any questions in private.

Staff understood the emotional and social impact that a woman’s care, treatment or condition had on their wellbeing and on those close to them. A midwife explained how she had cared for a mother during a time of distress. When the woman identified that her baby had stopped showing signs of movement, an ultrasound scan showed that her baby had sadly died before labour had commenced. The woman had wanted a minimal intervention and a pool birth at home. The midwife helped her to give birth in the pool on the delivery suite where she was able to have immediate skin to skin contact with her child.

On Mendip ward, staff helped women to manage their anxieties. They maintained a quiet and relaxing environment. Staff assisted women to stay calm, for example, using aromatherapy, calm music, hypnobirthing.

The staff on Percy Philips ward prepared women and their partners for the emotional disturbance that is normal for women following childbirth. ‘Baby blues’ is an overwhelming emotional experience when women can feel very emotional, exhausted and at times, elated. Staff talked to relatives about signs to look out for to ascertain if this transient experience was becoming more serious, as if it lasted longer than a couple of days it might be a precursor to postnatal depression.

**Understanding and involvement of women and those close to them**

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment. We were given an example of how a team helped a new father who had autism. They included his needs in the well-being plan and discussed with him his own communication needs. This included frequent repetition about what was expected from him once his partner went home.

Staff made sure women and those close to them understood their care and treatment. Staff supported women to make informed decisions about their care. The team on the post-natal ward had developed a video explaining all information needed prior to discharge from the ward. Patients
and their partners viewed this in the family room. The service was planning to make a film to show prospective parents what to expect from an elective caesarean section.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. Patients we spoke with said they were provided with good information to enable them to understand their care and treatment. One patient said they completely trusted the staff and had faith in their judgements. Another patient told us they and their partner had daily updates from the medical and midwifery staff and were encouraged to ask any questions to aid their understanding. They commented they had been welcomed to the unit and the midwives had been helpful and explained the process.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. However, response rates for the friends and families test survey were low. Of those who participated in the survey, a high proportion of women gave positive feedback. The trust performed similarly to or better than other trusts for all 19 questions in the CQC maternity survey.

**Friends and Family test performance**

Please note, antenatal data for September 2018 and January 2019 was suppressed for this trust due to low response figures.

**Friends and family test performance (antenatal), North Bristol NHS Trust**

![Graph showing Friends and Family test performance (antenatal)](image)

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was better than the England average in five months, worse in two and the same in three.

In July, October and December 2018 and February 2019, the trust’s performance was 100% compared to the England averages of 95%.

In May 2018, the trust’s performance dropped to 85% compared to the England average of 95%.

**Friends and family test performance (birth), North Bristol NHS Trust**

![Graph showing Friends and Family test performance (birth)](image)
From March 2018 to February 2019 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally worse than or similar to the England average. The trust’s performance was worse than the England average in nine months, better in one and similar in two.

In July 2018, the trust’s performance was 98% compared the England average of 97%.

The latest figures for February 2019 show the trust performance to be 97% compared to the England average of 97%.

**Friends and family test performance (postnatal ward), North Bristol NHS Trust**

From March 2018 to February 2019 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally worse than the England average.

**CQC Survey of women’s experiences of maternity services 2018**

The trust performed better than other trusts for one of the 19 questions in the CQC maternity survey 2018 and about the same as other trusts for the remaining 18.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.9</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Question</td>
<td>Rating</td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved</td>
<td>9.0</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>you enough in decisions about your care?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated</td>
<td>9.4</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>with respect and dignity?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during</td>
<td>9.3</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>your labour and birth?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital</td>
<td>6.9</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>after the birth was appropriate?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>5.3</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Thinking about response time, if attention was needed after the birth,</td>
<td>7.4</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>did a member of staff help within a reasonable amount of time?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of</td>
<td>7.2</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>your baby, were you given the information or explanations you needed?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of</td>
<td>8.5</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>your baby, were you treated with kindness and understanding?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who was</td>
<td>6.8</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>involved in your care able to stay with you as much as you wanted?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room</td>
<td>8.7</td>
<td>About the</td>
<td></td>
</tr>
<tr>
<td>or ward you were in?</td>
<td></td>
<td>same</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised the service, so they met the changing needs of the local population. Specialist antenatal clinics were held each week for women with specialist maternal needs. This included, for example, substance misuse, multiple pregnancies, maternal medicine, endocrine and women with a high body mass index. A dietician attended a weekly clinic to support women attending the gestational diabetes clinic. This ensured women were seen by appropriate clinicians such as consultants or specialist midwife.

The trust was the first NHS funded milk bank in the UK. This had been developed as part of the south west neonatal network and was managed by the breast-feeding lead midwife. The milk was provided for babies whose mother was not able to provide their own milk across the south west.

The service minimised the number of times women needed to attend the hospital by ensuring that women had access to the required staff and tests on one occasion. For example, two band 5 nurses were recruited to staff a vaccination clinic in the antenatal clinic. The clinics provided influenza and whooping cough vaccinations to pregnant women which meant they did not have to make separate appointments with their GP practice for this care and treatment. Sonographers provided routine scans within antenatal clinics. These occurred at 12 and 20 weeks of pregnancy. Additional scans were provided when required or requested by the consultant such as babies that were small for the gestational age or reported reduced movement.
Facilities and premises were not always appropriate for the services being delivered. The restricted space of the recovery area of the maternity theatre impacted upon the experience of care for the women attending for elective caesarean section delivery. These women were told not to bring any personal belongings with them (except for a nappy and a hat for their new baby). The division planned to commission a feasibility study to explore options to extend the available space in this area.

However, facilities for bereaved parents were adequate. A bereavement suite was available to women who delivered a stillborn baby. The facilities included a delivery room with en-suite bathroom and a separate homely room with a double bed and comfortable seating. The women and their partner could remain in this room with their baby for as long as they needed. There were facilities for tea and coffee making and a separate entrance which meant they did not need to access or leave the area through the delivery ward.

Staff could access emergency mental health support 24 hours a day, seven days a week for women with mental health problems, learning disabilities and dementia. There was a mental health nurse and a mental health midwife available on-site. The team liaised with them if they had any concerns about a woman’s mental health. Some of these women were known to the nurse and midwife through antenatal referral and there was a well-being plan in place.

The service had systems to help care for women in need of additional support or specialist intervention. For example, a breastfeeding lead midwife was employed by the trust. They supported women with breast feeding issues and held daily clinics for women to attend at their convenience. Information relating to breast feeding was available on the wards.

The fetal medicine team offered clinics and telephone support service for women under their specialist care. This service operated during office hours Monday to Friday.

Managers monitored and took action to minimise missed appointments. Managers ensured that women who did not attend appointments were contacted. The antenatal clinic experienced a consistent did not attend rate of between five and six percent. The manager stated they did not benchmark this against other similar services.

Meeting people’s individual needs

The service was inclusive and took account of women’ individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. The electronic patient record system alerted staff to those patients with additional specialised needs, for example, women living with a learning disability or mental health illness.

Staff on the antenatal ward received support and guidance from the perinatal mental health team when providing care and treatment to women with mental health needs on the ward. This team consisted of a mental health midwife and a mental health nurse. This team worked in collaboration with the woman and the obstetric teams to develop a mental health wellbeing plan when the woman reached 32 to 34 weeks of her pregnancy. This plan was shared with relevant teams within and outside of the maternity service including GP, health visitor and community midwife. It was also copied into the electronic record system and flagged to raise staff awareness. We were provided with one example where information had been shared between community and ward staff to ensure the woman received the most appropriate care and treatment. Additional one to one care was arranged to support the woman and ensure her safety whilst on the ward.
Staff supported women with learning disabilities. Information about care and treatment was offered to these women in an accessible format. This was a printed document that explained the patient journey in easy read language and pictures. Staff described strategies they had used to help these women to have successful outcomes. These included limiting the number of staff working with them to provide continuity of care, arranging a longer inpatient stay and using repetition to help women to learn essential tasks such as feeding.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. However, the wards did not have access to assistive equipment such as audio induction loop systems to support women with hearing loss.

The service could translate information leaflets into languages spoken by women and the local community using a translation service. Patient information was also made accessible to women via an internet application or 'app'. This app was specifically designed by the trust to provide all necessary information resources for women during their pregnancy.

Managers made sure staff and women and loved ones and carers could get help from interpreters or signers when needed. The policy permitted staff to use interpretation and translation services for women who did not speak English as their first language. Staff in the early pregnancy assessment unit provided an example of when they used the telephone translation service for a woman whose first language was not English. Staff also told us they used an online translation tool on their mobile telephones to assist with the understanding of information provided to women.

However, staff did not always follow the trust policy, and this meant there was a risk of miscommunication. Staff on three wards told us they used family members or friends to help translate. We observed a partner translating for a woman in the maternity assessment unit. Some staff told us they would check that the woman was happy for her partner to act as interpreter by using an internet translation application initially.

Women were given a choice of food and drink to meet their cultural and religious preferences. There was a good choice of hot and cold meals, including halal, low potassium, gluten free, lactose free and vegan options.

**Access and flow**

Data showed that women could access the service when they needed it and received the right care promptly. However, staff told us women experienced delays for outpatient appointments and for procedures such as inductions.

From July 2017 to December 2018 the bed occupancy levels for maternity were higher than the England average. The trust had 85.3% occupancy in Quarter 3 2018/19 compared to the England average of 58.2%.

The chart below shows the occupancy levels compared to the England average over the period.
Managers and staff worked to make sure women did not stay longer than they needed to as outpatients of the service. The early pregnancy assessment clinic monitored waiting times through the electronic system used to enter patients into the system on arrival at the clinic. The reception staff recorded the time the patient arrived, and the clinician recorded the time the woman was seen. Women were provided with twenty-minute appointments at the early pregnancy assessment clinic and staff told us they did not have delays in waiting times. Appointments were often available on the same day as the woman was referred to the clinic. We saw the clinic were responsive when an urgent scan was requested for a woman from the gynaecology/miscarriage clinic with the woman being able to have a scan the same day. Women were able to ring the clinic for advice and guidance following their consultation and were provided with contact details. Further appointments for the clinic, for example for additional scans, were made prior to the woman leaving the clinic. When women had their appointments cancelled at the last minute, staff tried wherever possible to make sure they were rearranged as soon as possible.

The trust informed us that all outpatients were seen in the clinic by 12 weeks plus 6 days of their pregnancy, or within two weeks of receiving the referral if this was later. However, staff in the antenatal clinic reported there was not always enough capacity to provide appointments in a timely way to all women. For example, on the week of our inspection, three urgent appointments were requested which meant three women with routine appointments were postponed by up to a month. Staff said this was a frequent occurrence and managers followed a risk-based approach to determine priority of appointments.

Women could not always access mental health assessments in a timely way. Access to these appointments was variable. In June and July 2019, women waited an average of two to three weeks. However, in February and March 2019, women waited four to eight weeks and in April women waited five weeks. These delays were due to staff sickness.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned women’s discharge carefully, particularly for those with complex mental health and social care needs. On all the wards in the maternity service, staff participated in a ‘huddle’ twice daily to discuss the immediate needs of women in their care, including their discharge planning. The focus of these meetings was on information sharing. A single point of contact, namely a matron or a senior midwife then attended a trust-wide bed meeting with representatives from other
divisions in the rest of the hospital to gain oversight and contribute to flow across the trust. There was a ‘flow midwife’ whose role was to ensure that discharges and transfers of care were safely and expeditiously organised. This midwife also completed new born health checks, so this did not slow down discharge.

Teams worked to keep the number of cancellations of planned admissions to a minimum. For example, to meet additional demand, the booking system was changed in January 2018. This was now managed by ward staff who spent time planning appointments for women to have inductions. A referral form was sent to a generic email address and reviewed by the ward manager or deputy ward manager who triaged the referral and allocated a date to the woman. Women were informed of the admission date by text and phone and or email. Ward managers allocated midwives to be available for these women arriving for their induction appointments at pre-planned times.

However, staff told us that women who were due an induction or who had been induced were often experienced a delayed admission to central delivery suite because there were often insufficient beds available to accommodate all the referrals for induction, and there were no ring-fenced beds allocated for this purpose. Leaders told us that the number and complexity of women requiring induction of labour had increased as a result of the requirement to adhere to new guidelines published by the Royal College of Obstetricians and Gynaecologists. During the six months preceding our inspection, 17% of women booked for an induction waited more than 12 hours for the artificial rupture of their membranes (an essential element of labour being induced). On the week of our inspection there were two women who required an induction the following week who had not been allocated a bed or a time. During the three weeks prior to our inspection, a woman had delivered her baby on the antenatal ward because there was no bed available on the central delivery suite. Since January 2019, there was one occasion per month when the central delivery suite was unable to accept new admissions.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service did not clearly display information about how to raise a concern in patient areas. The antenatal clinic managers told us they had not had many complaints. There were no complaints leaflets evident in the department, but staff said they would direct patients to put any complaint in an email and would provide the relevant email address. We did not see evidence of feedback from patient concerns on display in patient areas. For example, there was no ‘you said, we did’ feedback.

Women, relatives and carers knew how to complain or raise concerns. Three of the ...women we spoke with did not know how to make a complaint. However, the women we spoke with said they would be able to talk to the midwives should they have a complaint as they were approachable and helpful.

Managers investigated complaints and identified themes. However, investigations took longer than expected. For the 38 complaints that had been closed at the time of data submission, the trust took an average of 49.5 working days to investigate and close these. This was not in line with their complaints policy, which stated complaints should be closed within 30 working days. The five complaints that had not yet been closed had been open for an average of 87.2 working days at the time of data submission.
Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback was shared at the weekly patient safety meeting. For example, partners of women had complained there was nowhere for them to sleep on the wards. In response, the service had placed an order for additional reclining chairs and a patient bathroom was designated for partners use.

**Summary of complaints**

From March 2018 to February 2019 the trust received 43 complaints in relation to maternity (5.7% of total complaints received by the trust). The main subject of complaints was clinical care and treatment (26).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care and treatment</td>
<td>26</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>11</td>
</tr>
<tr>
<td>Communication</td>
<td>2</td>
</tr>
<tr>
<td>Quality of facilities</td>
<td>1</td>
</tr>
<tr>
<td>Medical records</td>
<td>1</td>
</tr>
<tr>
<td>Access to services - clinical</td>
<td>1</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.

The leadership team had the appropriate range of skills, knowledge and experience to perform its role. The maternity service was part of the Women’s and Children’s division. At the time of our inspection, the senior leadership team for this division included an experienced clinical director and a divisional operations director. The current head of midwifery and a matron were on sick leave, which had led to senior staff picking up additional roles and responsibilities. At the time of our inspection, the newly appointed deputy director of midwifery had been in post for two weeks.

A consultant obstetrician had been the clinical lead for the maternity service for approximately four years. This member of staff also took the lead for governance for the service. There was an obstetrician lead for the central delivery suite. Staff knew who this person was and felt able to speak to them.

The management structure of the service flowed and worked reasonably well across all elements of the maternity framework. The leadership team had access to the trust board and felt supported by the board. There was a maternity safety champion at board level. There was a rota of experienced midwives as labour ward shift coordinators supernumerary to the staffing numbers required for one to one care. On the post-natal ward, there was a designated midwife in charge.
who carried out clinical duties such as administering medicines but did not have a designated caseload.

However, the matron was covering two posts and did not have clear oversight of all risks in the service. Essential leadership tasks had not been completed. For example, the completion of staff appraisals was far below the trust target. Leaders acknowledged there were gaps in the leadership structure at an operational level and planned to recruit another matron for the service and to develop a deputy matron role for an existing band 7 midwife.

During our inspection, local leads were approachable, visible and accessible. Clinical leads were visibly present in clinical areas, and we saw that members of the team approached them for advice without hesitation. The matron was available to staff. Staff in the clinical areas told us they regularly saw members of the maternity senior leadership team. Leaders participated in a weekly walk around of the maternity unit.

The senior leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them. For example, the leadership team had successfully secured funding for the refurbishment of the existing estate. Managers were seeking alternative accommodation for the fatal medicine service to free up more space in the maternity antenatal clinic for scanning.

Leadership development opportunities were available, including opportunities for staff below team manager level. There was a development programme for midwives at bands five through to 7. This focussed on identifying and nurturing leaders for the future. We saw that staff in junior positions volunteered to take on leadership projects. For example, in 2019, the midwifery care assistants on Mendip ward had organised the first midwifery care assistant conference in the UK.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The leaders of the service were reviewing the vision for the service in collaboration with the trust quality improvement team. This team had engaged with staff about their ideas for this vision. There was a robust and realistic strategy for achieving service priorities and developing good quality, sustainable care. The needs for service improvement were clearly identified in the business plan and actions to address these were effectively prioritised in terms of risk and available resources.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. For example, the service leads involved all relevant stakeholders in discussions regarding the future direction and utilisation of the Cossham Unit.

The service aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. For example, the service was looking at commissioning an information technology system that would be shared with the maternity service at a nearby trust.

Leaders had planned services to take into account the needs of the local population. The maternity service recognised that more women were being referred for induction of labour and this was a challenge for resourcing across the city. In order to ensure decisions to induce were reasonably justified, leaders were working with a nearby acute trust to produce joint guidelines for
the treatment of women who presented with reduced fetal movements or whose fetus appeared to be small for gestational age.

The vision for the service included services in the wider community and linked to the local health economy. For example, the leadership team were involved in planning the requirements of a new build for maternity services.

**Culture**

**Staff felt respected, supported and valued.** They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Staff felt respected, supported and valued. All staff we spoke with said they were valued for the work they did. The staff survey highlighted three priorities for the coming year: increase the involvement of staff in service decisions and improve communication channels, focus on health and well-being of staff, and focus on retention and scrutiny of recruitment.

The strategy and values underpinned a culture which was patient-centred. Staff felt positive and proud about working for the service and their team. Staff told us their team felt like a family. All staff were committed to giving the best patient care and were proud to deliver this.

The leaders of the service recognised staff success with staff awards and through feedback. For example, we saw that the fetal medicine team had been nominated for a trust level award for their patient care. We heard managers giving their team praise for good work. Managers addressed poor staff performance where needed.

Staff felt able to raise concerns without fear of retribution. During our inspection, all staff told us they felt comfortable to approach all leads with their concerns.

Staff knew how to use the Freedom to Speak Up process and about the role of the Freedom to Speak Up Guardian. During the 12 months preceding our inspection, staff had used the Freedom to Speak Up Guardian service, and leads had taken action to address the concerns raised.

The service applied Duty of Candour appropriately. The service had processes to ensure they met the duty of candour, including a policy, relevant training and support for staff. Incident investigation reports showed evidence that the duty of candour had been followed.

The trust took appropriate learning and action as a result of concerns raised. When new, less experienced staff raised concerns about feeling overwhelmed with work on Percy Philips ward, leaders re-organised staffing to allow a designated midwife to be in charge for each shift. This member of staff took responsibility for administering medicines and processing discharge paperwork so that allocated midwives could focus more on patient care.

Teams had positive relationships, worked well together and addressed any conflict appropriately. We observed that teams communicated well. For example, there was a monthly forum where the maternity team met with the neonatal team. At this meeting, the teams discussed how they could jointly improve care considering individual cases.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
There were effective structures, systems and processes to support the governance of the service. There were internal governance forums to enable staff to share areas of good practice or report concerns. These included the weekly patient safety meeting, the monthly maternity clinical governance meeting, the monthly maternity clinical team meeting, the monthly ward performance review and the monthly divisional management board meeting. Our review of minutes of these meetings showed that these governance processes permitted/provided several pathways to escalate concerns from the wards to the trust board and for senior staff to cascade information to maternity staff.

Maternity staff were included in trust-wide speciality governance structures. For example, the maternity safeguarding midwife attended a trust-wide safeguarding operational group. Safeguarding issues were shared at this meeting and cascaded to the wider staff.

Managers used meetings to share essential information such as learning from and taking appropriate action in response to incidents and complaints. A division operational meeting took place weekly. Minutes from the meeting were available on the intranet. The meeting was attended by ward managers across maternity, neonatal and gynaecology services, head of midwifery, deputy director of midwifery and the general manager of the division. The meeting provided oversight and discussion of mortality investigations, clinical incidents, ongoing root cause analysis investigations and unexpected admission to neonatal intensive care unit to ensure patients received correct care and treatment. The meeting was open to all staff, and those on a development or leadership programme were actively encouraged to attend.

The maternity service participated in external governance processes. For example, the team successfully completed the NHS Resolution Maternity Incentive Scheme that demonstrates safety against 10 measures.

All members of the maternity leadership team were clear about their areas of responsibility. Staff at all levels of the service understood their roles and responsibilities and what to escalate to a more senior person.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were systems to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. There was an up-to-date risk management policy.

Leaders were satisfied that clinical and internal audits were enough to provide assurance. Teams acted on results where needed. There was a midwife and a consultant who led the team in audit activity. Maternity audit leads participated in a trust-wide forum where priorities for service level audits were set according to agreed criteria. The audit lead used a database to check that actions from audits were completed.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The division's risk manager reviewed all incident reports which highlighted a moderate or severe risk of harm to patients. The incidents were reviewed at the monthly divisional governance
meeting. New and existing risks were discussed at the monthly Women’s Health and Neonatal Medicine Clinical Governance Group meeting.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. For example, risks associated with the expired life expectancy of the air handling units in maternity theatre were considered carefully in relation to the risks to patient care of closing the theatre to facilitate essential repairs or replacement work.

Where risks were identified, mitigating actions were clear. The senior leadership team had a clear understanding of the risks affecting patient care and service delivery. Leaders were fully informed about the plans to mitigate these risks. However, the service leads did not have sight of all the significant risks at a ward level. Matrons did not have enough oversight of safety systems and processes such as security, infection prevention and control, and medicines management. Some areas of risk were not monitored by relevant staff. For example, at the time of our inspection, the risk manager for maternity services did not have oversight of the frequency of women delivering outside of the central delivery suite.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Service leads received holistic information on service quality and sustainability. Information was in an accessible format, timely, accurate and identified areas for improvement. The leads used the maternity dashboard to access the most recent performance data. This included all relevant metrics. The data was colour coded to identify areas of concern. This data fed into a board assurance framework.

The trust board was aware of the performance of the maternity service using key performance indicators and other metrics. The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance and to make decisions and improvements. For example, we saw in the minutes of the patient safety meeting that the director of nursing had queried the stillbirth rate. Clinical staff were able to clarify and explain the reason for the rate being falsely higher than expected.

For example, the board papers for March 2019 included reference to response rates and outcomes of the friends and families test, updates regarding staffing, data regarding rates of caesarean section, induction of labour, and overview of occurrences when the central delivery suite could not meet demand. The fetal medicine service reported on several key performance indicators, including response times for women waiting to be seen by a consultant in this clinic.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. The senior manager acting as the single point of contact for the service had a clear, daily view of staffing. Matrons and relevant managers were automatically informed of all patient safety incidents reported. Matrons could access up to date information regarding mandatory training compliance of individual staff members. Senior staff expressed confidence in the quality of the data.

Staff had access to most of the information technology equipment and systems needed to do their work. However, not all information technology systems were working well. The centralised monitoring system was not effective. The leads of the service were working in conjunction with a
nearby acute trust to identify a system they could jointly utilise. The system for submitting
gestation periods to the national database of Hospital Episode Statistics (HES) was not mapping
correctly. The business intelligence team were working to resolve this.

**Engagement**

**Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.**

The service had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The maternity service had worked with the Maternity Voice Partnerships to implement the '15 steps for maternity' toolkit. This toolkit supports collaborative working between all those involved in using, reviewing, designing and delivering maternity services so improvements can be identified and delivered together. This initiative had led to improvements in facilities for partners on the central delivery suite, including the purchase of new armchairs. The matron of the central delivery suite was engaging with a local charity who were supporting the refurbishment and redesign of the bereavement suite.

The teams could access feedback from women using the service, carers and staff and were using this to make improvements. The views of service users were obtained and used to make decisions about the service. We saw in minutes of maternity clinical team meetings that women using the service were consulted regarding the presentation and contents of the infographics on the maternity dashboard.

Staff, patients and carers had access to up to date information about the work of the trust and the services they used. There was a monthly newsletter that provided an overview of developments and included updates and information relating to incidents and sharing of learning.

Patients and carers and staff had opportunities to give feedback on the service. However, the results of the friend and families test for September 2018 and January 2019 were suppressed due to low response rates. Friends and family test questionnaires were displayed in reception and clinical areas. There was no formal system for distributing these to women. Staff did not receive ward specific feedback from these results.

Staff were involved in decision making about changes to the maternity services. There was a maternity safety champion who took the lead for maternity at executive board level. Clinical leads confirmed the trust board was listening to their concerns.

Patients, staff and carers were able to meet with members of the leadership team. For example, when members of the public were concerned about the closure of the Cossham Unit, leaders met with key representatives to discuss plans and provide reassurance. Members of the maternity leadership team were holding listening events every four weeks at different locations in the hospital and the community.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The service actively sought to participate in national improvement and innovation projects. The maternity service participated in wave three of the maternal and neonatal health safety collaborative. This is a three-year programme led by the patient safety team of NHS Improvement to support improvement in the quality and safety of maternal and neonatal units across England.
The service promoted a culture of learning and continuous improvement to maximise quality and outcomes. This was evident in the multi-professional training. Leaders reviewed this each year to take account of current patient safety themes such as learning from incidents and drills, national reports and guidelines.

The service was actively participating in clinical research studies. The maternity service had participated in several research projects. For example, teams had participated in a study comparing the benefits of using three different medicines to actively manage the birth of the placenta (the third stage of labour).

There were two part time research midwives in post who were band 7. The research midwives coordinated participation in research trials. These trials included, for example, a trial of a new device to assist child birth. This was part of the suite of initiatives aimed at reducing vaginal tears.

There were systems to support improvement and innovation work. Staff were receiving training in improvement methodologies. The trust quality improvement team were working with staff using a recognised methodology to drive sustainable behavioural change to achieve identified common goals within the maternity service. At the time of our inspection, the maternity service was recruiting a quality and improvement midwife to lead these changes going forward.

There were effective systems to identify and learn from unanticipated deaths. The team reviewed incidents of mortality and morbidity. Learning was identified through this forum and shared with relevant teams. For example, a review of a still birth had identified that community midwives needed to be reminded of the requirement to plot symphysial fundal height (a measurement of the baby's growth) in the patient record.

Staff used data to drive improvement. The trust was the second most improved organisation overall, according to a maternity survey carried out by a charity in 2018. This survey explored the experience of mothers across their maternity care pathway.

Leaders shared learning from the results of the survey with staff to improve patient experience. For example, staff were reminded to give women the out of hours telephone number for support with infant feeding post-discharge.
End of life care

Facts and data about this service

End of life care (EOLC) at the trust is provided by a multi-disciplinary team of healthcare professionals to provide care and support for patients who are approaching the end of their life due to both malignant and non-malignant conditions. The trust provided end of life care for 1,724 people in 2018, across all areas. The main focus of the end of life care strategy at the trust is on delivering compassionate patient centred care.

The Specialist Palliative care team is a multidisciplinary team consisting of consultants, clinical nurse specialists and occupational therapists, with close liaison with chaplains and social workers. Visits by the team are made from Monday to Friday, 8.30am to 5pm. The team also delivers an extensive education programme to many groups of staff in the hospital aiming to develop knowledge and skills in palliative and end of life care.

The trust works collaboratively within the local palliative and end of life care community, liaising with a local hospice about patient care and transfer of patients between settings.

(Source: Routine Provider Information Request (RPIR) – Context acute, EOLC networks tabs and Trust website)

The Specialist Palliative Care Team comprised of four whole time equivalent consultants, six whole time equivalent clinical nurse specialists, and three occupational therapists. The team worked closely with colleagues in acute oncology, care of the elderly teams, and other site specific groups via multidisciplinary teams and outpatient clinics.

The trust provides a bereavement office which provides practical help, advice and support for death registration and other aspects of care after death. The service works alongside the mortuary services, helping to facilitate efficient death certification and HM Coroner cases. The service also arranges viewings for those bereaved by the death of patients.

The trust provides a chaplaincy service which aims to help facilitate the spiritual care of patients and their visitors, and to meet any religious needs. The chaplaincy service consists of chaplains from various faiths and helps with the spiritual care of patients and visitors. A chaplain is available during working hours, Monday to Friday 8am to 6pm. Outside of these hours chaplaincy support can be gained using an “on-call” system.

During this inspection visit the inspection team:

- Talked with four patients and those close to them
- Observed staff giving care
- Reviewed nine sets of patient records, including care records, treatment escalation records, do not attempt cardio pulmonary resuscitation records (DNACPR), and medication records
- Looked at staff records and trust policies
- Looked at performance information and data from and about the trust
• Talked with 39 members of staff at different levels including doctors, nurses, healthcare assistants, non-clinical staff, ward managers and mortuary staff.

End of life care was rated as requires improvement overall during our last inspection, undertaken in November 2017, details can be found within the inspection report published in 2018. Safe and effective were rated as requires improvement, caring was outstanding and responsive and well led were rated as good. The end of life service was told it must improve some areas of its work and should improve others. During the course of this inspection, we looked at whether these areas of improvement had been implemented.

Is the service safe?
By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training
The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates
The trust set a target of 85% for completion of mandatory training.

Nursing staff received and kept up to date with their mandatory training.

A breakdown of compliance for mandatory training courses as at April 2019 at trust level for Specialist Nurses in the Palliative Care Team is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at April 2019</th>
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<tr>
<td></td>
<td>Staff trained</td>
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<tr>
<td>Infection Prevention and Control - 2 year expiry</td>
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</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>8</td>
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<tr>
<td>Patient Handling</td>
<td>8</td>
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<tr>
<td>Dementia Level 2</td>
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<tr>
<td>Conflict Resolution</td>
<td>8</td>
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<tr>
<td>Equality and Diversity</td>
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<td>Information governance</td>
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<td>Falls</td>
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<td>Resuscitation</td>
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<td>Fire</td>
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<tr>
<td>Waste Management (Clinical)</td>
<td>8</td>
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<tr>
<td>Food Safety - 2 yearly expiry</td>
<td>1</td>
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<tr>
<td>Health and Safety</td>
<td>8</td>
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</tbody>
</table>

In end of life care the 85% target was met for all of the mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
The mandatory training was comprehensive and met the needs of patients and staff. Staff told us they felt training they undertook, helped to prepare them for the role.
Managers monitored mandatory training and alerted staff when they needed to update their training.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training modules as at April 2019 at trust level for registered nursing staff in end of life care is shown below:

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<tr>
<th>Training module name</th>
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<tbody>
<tr>
<td></td>
<td>Staff trained</td>
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<tr>
<td>Safeguarding children level two</td>
<td>8</td>
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<tr>
<td>Safeguarding adults level two</td>
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</tr>
</tbody>
</table>

In end of life care the 85% target was met for all the safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Information provided to us during the inspection confirmed that all medical staff within the specialist palliative care team had also completed all the required safeguarding training modules for which they were eligible with a completion rate of 100%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

**Cleanliness, infection control and hygiene**

**Staff used infection control measures when visiting patients on wards and transporting patients after death.**

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records in the mortuary were up to date and demonstrated that all areas were cleaned regularly. There were clear guidelines and processes for mortuary staff to follow.

There were reliable systems to prevent and protect people from infection. The mortuary used a form to record where a deceased patient had infectious diseases. This enabled them to communicate this when needed with others who may come into contact with the body and ensure that appropriate prevention of cross infection processes were used.

Where cross contamination was still a risk, equipment was available for staff to use that provided extra protection following death of patients. Processes were used that ensured the use of body
bags for the transfer of the deceased, rather than covers alone to mitigate the risk to others. The bags were equipped with pockets to carry documents that explained why the bag was in use.

Staff followed infection control principles including the use of personal protective equipment (PPE).

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment usually kept people safe. The environment in the mortuary sometimes prohibited staff from managing products of conception, and neonates in line with regulations.

The design of the environment promoted privacy and dignity for patients at end of life. Seventy-five percent of beds at the Southmead Hospital site were in single rooms, with en-suite facilities. For those close to patients at the very end of life, these rooms were large enough for an additional bed to be added if they wished to stay with their loved one. Temporary beds were readily available if required.

The service had enough suitable equipment to help them to safely care for patients. The trust had an equipment library which contained items such as syringe pumps used in the last stages of life to deliver continuous small doses of symptom-relieving medicines. There was also plentiful supplies of pressure relieving mattresses and other equipment should the need arise.

During our previous inspection we found that the temperatures of the main fridges in the adult mortuary were connected to a central system that monitored fluctuations and alerted relevant people in the event of a malfunction. However, extra capacity fridges which were only used when demand was high were not connected to this system. Neither was the fridge containing the remains of products of conception, or the fridge that housed babies who had died. During this inspection we found that this had been remedied with the introduction of a new system that used mobile technology to alert people via a bleep or mobile phone if the temperatures deviated from acceptable parameters. This system was monitored at all times of the day and night and, during the mortuary closing hours, alarms were directed to an agreed person at the trust.

During this inspection, we checked on the fridges containing the remains of products of conception, and babies who had died. We were not assured that the capacity of the fridge for the remains of products of conception met the demand for this space. During our inspection, this fridge was full, beyond capacity preventing the contents from being stored in an orderly or dignified way. Furthermore, there was insufficient workspace in the area of the mortuary for the staff to be able to process and manage the contents of the fridge in a safe or dignified way. A makeshift unit had been created for the purpose, but this was porous, and not fit for purpose.

The fridge containing babies who had died was not clearly labelled and presented a risk of misidentification. Whilst there were multiple processes to be followed in identifying babies that included wristbands and identifiable features these were not robust enough to mitigate the risk entirely. For example, at the time of our inspection, there were no infant sized wrist bands in the mortuary (although these had been ordered) and we heard how it was not uncommon for wristbands to slip off. Within the fridge, the trays that contained the babies were not labelled, although the shelves were. The corresponding labels on the front of the fridge did also not provide assurance that labelling mitigated the risks of misidentification because the identification of shelves was written in an ink that could be wiped away.

However, we brought the issues related to both of the fridges to the attention of the director of nursing who took immediate action to mitigate the risks. A process for the securing of new equipment and fridges was started and for the intervening time systems enacted to mitigate any
immediate risk. We were therefore assured of the immediate mitigation of the risks identified during our inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff were able to recognise patients at end of life, and requiring end of life care. Rationale for decisions about care were clearly documented and discussed. The use of a “Purple Butterfly” scheme to identify patients in the last stages of life enabled easy identification of this patient group – both in paper records and electronic systems. The specialist palliative care team were able to support both those patients that were referred to them, and also the teams of ward staff supporting other patients identified at end of life through easy recognition of the “purple butterfly” on the system. This meant that changing needs of patients, and support requirements of both patients and staff could be enacted and responded to as and when needed.

On all wards we visited, there were resources to support the transition to care in the final stages of life. This had been improved since our previous inspection with consideration given to how to equip staff to ask the right questions to gain an understanding of patients’ experiences of symptoms.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools.

Patients receiving care in the last stages of life in hospital were assessed regularly by both ward staff and the specialist palliative care team. Symptom observations were colour coded and aimed to trigger staff to take action when needed to manage symptoms. In all of the records we looked at we saw that this tool was being used to assess patient comfort and support decisions about ongoing management.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health.

Staff shared key information to keep patients safe when handing over their care to others.

Staff were able and confident to seek support from more senior colleagues. Challenge between colleagues was seen as a healthy part of the care given to patients at end of life and discussions encouraged between all staff groups when deciding on pathways of care.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The specialist palliative care team had seven clinical nurse specialists, which equated to six whole time equivalent posts. These nurses had additional specialist palliative care qualifications which enabled them to support operational, ward based staff. The service did not utilise temporary staff within the team.

Nurse staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover or sickness.

(Source: Routine Provider Information Request (RPIR) - Vacancy, Turnover and Sickness tabs)
Additionally to the clinical nurse specialists, each ward or department at the trust had an end of life link nurse. The purpose of this role was to support staff at ward level with patients receiving end of life care. Each ward we visited had at least one of these link nurses, with some wards having more than one.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The specialist palliative care team employed a team of five consultants covering four whole time equivalent posts. The service had employed the services of a locum to cover maternity leave within the team.

Consultant numbers had increased since our last inspection and allowed for the service to provide an in-house, on-call service out of hours.

Medical staff within the specialist palliative care team worked closely with medics from multiple areas to provide support and training in the delivery of end of life care.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patients who were identified as requiring end of life care had decisions, care and treatment documented on a specific set of documentation, designed specifically for their needs. This documentation was identified as “purple butterfly” and was easily identifiable. Since our last inspection documentation for patients at end of life had been refined in order to make it a more effective and useful tool for recording care and treatment. Divided into clear sections for use by different people delivering care, the purple butterfly documentation provided for a comprehensive and holistic assessment and recording of care delivered to patients at end of life, and after death. Purple butterfly documentation was clearly identifiable, with purple borders and the butterfly logo. The butterfly logo was also used on the electronic system to quickly highlight to the user if the patient was being cared for at end of life.

We reviewed the records of patients who were using the purple butterfly documentation. Completion was consistent, comprehensive and information was easily accessible. We found that completion of purple butterfly documentation was timely once the patient was identified and this was an improvement on our previous inspection.

The service carried out an audit of end of life care documentation for 2018. The audit reviewed 54 sets of notes. Of these, 28 patients had end of life documentation in place, and 12 patients had no formal documentation in place. The audit showed an overall improvement in:

- The decisions for a do not attempt cardio pulmonary resuscitation document being signed by a consultant
- As required medicines being accurately prescribed
- Good evidence of daily review
- Overall well documented conversations with the family/ relatives
The main areas identified for improvement were:

- Very poor evidence of spiritual assessment which was corroborated by the findings of the NACEL audit.
- Documented evidence that the chaplaincy team had been to see patients.
- Poor evidence of escalation for sustained uncontrolled symptoms.
- Poor completion of notification of death letters sent out to GPs (46%), although better than previous sample which was 20%.
- Nursing staff initial assessment form only completed for 71% of patients.

Clear actions were identified as a result of this audit, and at the time of our inspection we found little evidence that the areas identified for improvement still existed.

Systems enabled contact with community-based providers of end of life care, for example GPs and hospices. This often phone based contact, ensured that information could be shared with these services when patients were being discharged with care needs. However, sharing of written summaries and information posed difficulties for the team due to the lack of secure methods to send and share information.

The specialist palliative care team used an electronic referral system, which contained referral information and assessment to aid prioritisation of triage. This system was effective in supporting the team to make assessments of priority and managing their workload.

Electronic records were held securely using a password protected system. The main body of patient records were held in lockable cabinets in non-patient areas in well observed areas. Nursing assessments were held at the patients’ bed for ease of access and completion.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. We looked at medicine records for patients at end of life. Anticipatory medicines (medicines that are prescribed in advance of being required for the timely relief of symptoms) were prescribed in an individual way to meet differing needs. The effectiveness of these was regularly reviewed to ensure patients were as comfortable as possible. Clear rationale was discussed and recorded and systems were in line with national guidance. Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

Staff stored and managed all medicines and prescribing documents in line with trust policy. Wards had supplies of the most commonly used medicines needed in end of life care. Staff were able to easily source other medicines if required and spoke of responsive support from the trust pharmacy.

One of the clinical nurse specialists in the palliative care team was a non-medical prescriber, which further enhanced the ability of the team to work in a responsive way in managing the availability of medicines to patients.
Work had continued since our last inspection to enhance the provision of community based prescriptions for patients leaving hospital at the end of their lives. The enhanced processes improved the security of community provisions whilst ensuring that post-discharge, patients had ready access to medicines.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The management of incidents relating to end of life care was much improved since our last inspection. The trust had procured a different incident reporting system since our last visit, which enabled the user to identify incidents specifically related to end of life care.

All staff knew what incidents to report and how to report them. Additionally, staff were better able to describe the types of incidents that may be classified as related to end of life so we were assured this information was being better captured.

We examined the minutes of the end of life group meetings and saw that incidents were discussed and changes or learning agreed and disseminated. Furthermore, the specialist palliative care team were able to view and analyse incidents in real time using the electronic system. We saw examples of where they had been able to make immediate improvements to mitigate risk and feedback in a timely way to those who had reported the incidents.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2018 to April 2019, the trust reported no incidents which were classified as never events for end of life care.

(Source: Strategic Executive Information System (STEIS))

Staff we met were clear on what type of incident may constitute a never event, and the actions they would take should the need arise.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) which met the reporting criteria set by NHS England from March 2018 to April 2019 in end of life care.

(Source: Strategic Executive Information System (STEIS))

Staff were able to describe the types of incidents that may meet the threshold of a serious incident and what actions they would take if such an event occurred.
Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Systems were available that enabled managers to investigate incidents thoroughly. Patients and their families were involved in these investigations when it was appropriate.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Documentation and systems called “Purple Butterfly” were used to provide end of life care that was based upon national guidance for best practice, including the “Five Priorities of Care”. These priorities recognised the dying person and those important to them should be involved in decisions about treatment and care.

At the end of life strategy group meetings, the use of the “Purple Butterfly” system was discussed. The annual end of life report detailed the delivery of end of life care at the trust – the improvements and challenges and set out clearly how this was monitored.

End of life care at the trust was driven by “Ambitions for Palliative and End of Life Care; A national framework for local action 2015 – 2020.” This framework was developed by a partnership of national organisations, and set out a vision to improve end of life care through partnership and collaborative actions at local level throughout England.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Furthermore, this was discussed on an ongoing basis at board rounds, and between different teams involved in patient care.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had the food and fluids that they wanted and needed, particularly those with specialist nutrition and hydration needs. It was recognised through work completed by the specialist palliative care team that the nutritional preferences of patients at end of life were significantly different to those of the general patient group. The service had worked with the kitchen at the trust to develop a menu that specifically reflected the preferences of patients at end of life. The menu contained items such as scrambled eggs, mashed potato and ice cream and was available at any time to patients at end of life. Preferences were clearly recorded in patient records.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed, and made intelligent decisions about when such charts should be discontinued for patients at end of life.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it.
Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients’ pain and gave pain relief in line with individual needs and best practice. The service had reviewed its practice with regards the use of opiate based medicines following a national review and modified it’s practice accordingly. We saw that anticipatory medicines for the relief of pain and other symptoms was prescribed in accordance with national guidance in the records we checked.

Patients received pain relief soon after requesting it. Patients and those close to them told us their pain was well controlled.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in the National Audit of Care at the End of Life (NACEL) audit. The service performed well in this audit and the service used the results to improve services further. Areas for improvement identified through the audit included the documentation of spiritual and cultural assessments, provision of face to face out of hours reviews by the palliative care team, and the documentation of preferred place of death. At the time of our inspection the service was taking action to address all three of these issues with clear plans to improve these areas in the months that followed.

The service carried out additional audits relevant to end of life care. In 2018, the service carried out an audit of the use of syringe pumps for patients at end of life. This also included findings related to the correct prescription of anticipatory medicines. In almost all areas there were improvements since the previous audit. As a result of this audit further actions were identified to make further improvements and this was presented and ratified by the end of life care group.

The team shared and made sure staff understood information from the audits. We saw in practice, changes that had been made as a result of these audit outcomes.

Plans were made to monitor and check on planned improvements.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff working at the trust received training in end of life care as part of their induction. In addition, staff who held the ward based “link nurse” role for end of life care received additional training and cascaded this learning to colleagues.

In the mortuary, porters had their competencies assessed to transport the deceased from wards to the mortuary and were not able to do so without having completed the assessment.

Volunteers recruited within the chaplaincy service received comprehensive training to carry out their roles.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us they felt they had been well equipped to provide end of life care – mainly through their work with the link nurses or interactions with the palliative care team.
Appraisal rates
Managers supported staff to develop through yearly, constructive appraisals of their work. (use this if data covers all staff groups)

From April 2018 to March 2019, all of the required staff in end of life care received an appraisal compared to a trust target of 90%. This relates to seven members of qualified nursing staff in the palliative care team.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers could also identify any training needs, or specialist training, their staff required to provide opportunities to develop their skills and knowledge. Staff spoke positively to us about the appraisal process.

Both nursing staff and medical staff were supported to develop through regular, constructive clinical supervision of their work. The palliative care team were well supported by the lead consultant with arrangements made for regular supervision and training.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. We reviewed the notes of these meetings and found them to be comprehensive and informative.

Managers made sure staff received any specialist training for their role.

Systems allowed managers to identify poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Multidisciplinary working was woven into the fabric of end of life care at the trust.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended two of these and found them to be very effective in planning and delivering care to patients at end of life.

Staff worked across health care disciplines and with other agencies when required to care for patients. The palliative care team was made up of doctors, nurses and occupational therapists who worked together seamlessly on a daily basis. Furthermore, the palliative care team worked effortlessly with ward-based staff, the chaplaincy, the patient experience team, and a number of other areas of the trust to provide a complete package of end of life care to patients. Staff on wards worked effectively together to provide end of life care, and were comfortable to challenge multidisciplinary colleagues in the endeavour to provide effective end of life care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We were assured through our conversations with staff that they were confident and competent to identify the need for, and source support from mental health colleagues.

Seven-day services

Some, but not all services were available seven days a week to support timely patient care.

Between Monday and Friday from 8.30am until 5pm there was a full specialist palliative care team presence at the trust. Out of hours and at weekends cover was provided over the phone by an on
call consultant from the palliative care team. This was an improvement from our last inspection where out of hours support was provided by an external organisation.

In response to the outcome of the NACEL audit, and a recognition from within the palliative care team, a business case had been submitted to the senior leadership team to evidence the need for clinical nurse specialist palliative care support at weekends as an additional face to face service provision. It was hoped that this service could begin as soon as possible once the business case was approved.

The mortuary was open for the same hours as the palliative care team, although there was an on call provision available to support viewings out of hours.

Volunteers and chaplaincy services were available for core hours, but could also be summoned when needed at any time.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

**Health promotion**

*Staff gave patients practical support to help them live well until they died.*

The service had relevant information promoting healthy lifestyles and support on every area we visited.

Staff assessed each patient's health when admitted and provided support for any individual needs to support their choices at end of life.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

*Staff supported patients or those close to them, to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, capacity assessments were not recorded correctly.*

When we asked, staff demonstrated they understood how and when to assess whether a patient had the capacity to make decisions about their care. However, when we looked at records surrounding “Do not attempt cardio pulmonary resuscitation” (DNACPR) the capacity and assessment of, was not clearly recorded in any of the records we looked at. We found through further examination of records and exploration with staff that often such conversations were in fact being held and individuals capacity assessed. However, this was not easy to establish and certainly not in a format that could be accessed quickly. We had raised this at the previous inspection.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions where possible.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients’ records.

**Mental Capacity Act and Deprivation of Liberty training completion**

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Trust level**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.
As at April 2019, the trust reported that mental capacity and DoLS training was completed by all staff in the palliative care team.

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<tr>
<th>Training module name</th>
<th>As of April 2019</th>
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<tr>
<td></td>
<td>Staff trained</td>
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<tr>
<td>Mental capacity and DoLS</td>
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(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

In all areas of end of life care we visited, we saw that staff were truly person centred. As much emphasis was placed in the caring for and about those close to patients as patients themselves. In the emergency department the team had identified the need to support the bereaved children of patients who had died, and had worked hard to be able to provide services to them that met their needs. Staff described the support they had given to a child to enable them to continue to see their pet after their parent died. Feedback to the trust included a number of comments similar to, “staff cared for me as well as my husband. Nothing seemed to be any trouble.”

In the mortuary “business as usual” included attending after hours to facilitate viewings, talking with relatives about their deceased and exuding an authentic warmth to everyone involved with a deceased patient.

The chaplaincy service was fully inclusive and provided support to those of all faiths and those of none. All staff clearly understood and respected the personal, cultural, social and religious needs of people. Greater attention was being paid to identifying what these needs might be and recording them clearly.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All the patients and those close to them we spoke with, said staff treated them well and with kindness.

Staff followed policy, and respected the need to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient’s personal, cultural and religious needs.
Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff clearly understood the impact a person’s care, treatment and condition had on their wellbeing and those close to them and responded to this. We witnessed on numerous occasions staff from all teams taking time to provide care and support in an unhurried, calm and caring manner. Relatives that we spoke with told us they felt cared for and that they also really mattered to staff.

Staff supported patients and those close to them who became distressed in an open environment, and helped them maintain their privacy and dignity. Relatives were given quiet spaces so they could digest information privately. Staff demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Our discussions with staff demonstrated a strong commitment to ensuring they understood the entirety of a patient’s situation and its impact.

The patient experience team had worked hard to ensure that the process for collecting the death certificate and other post-death tasks had been smoothed and made as simple as possible for those close to patients.

For bereaved children of parents that had died, the trust had developed memory boxes. These boxes contained a combination of materials to support children living with grief, and mementos of their parents – for example kits to make handprints, or locks of hair.

**Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff took the time to ensure that patients and those close to them were active partners in their care wherever possible.

Staff were fully committed to working in partnership with people and making this a reality for each person. We saw numerous conversations take place about options for ongoing treatment – or none – where this was felt appropriate. Staff were knowledgeable about what could be offered to patients at end of life – inside and outside of the hospital.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Communication was unhurried, and repeated when necessary and staff ensured that patients and those close to them were in full possession of the information about their health and care. This included supporting patients to make advance decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the needs of the local population. The trust served a population of multiple faiths, and those of none. The chaplaincy service met the needs of the whole population, with the chaplaincy lead having worked hard to secure good working relationships from colleagues of all faiths inside and out of the trust.

The palliative care team provided a face to face service between the hours of 8:30am and 5pm Monday to Friday. During this time, without exception everyone we asked said they were a responsive and visible team. Outside of these hours, the doctors of the team provided an on call phone support service which was also well thought of.

Whilst the palliative care team captured information about the destination of patients it discharged, it remained the case from the last inspection that preferred place of death or care was not consistently recorded. We saw documents that aimed to capture this information but it was not consistently completed.

Facilities and premises were appropriate for the services being delivered. Seventy five per cent of beds at the trust were in side rooms. This enabled all patients at end of life who wanted one, were able to be cared for in the privacy of their own room. Side rooms were also large enough for family members to stay with patients at end of life, and the trust had a ready supply of fold up beds.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

We saw that people’s individual needs and preferences were central to the delivery of tailored services providing end of life care. The palliative care team had undertaken an exercise in “patient shadowing”. Patient shadowing was a real-time observational tool which allowed staff from all backgrounds, clinical and non-clinical, to see a care experience through the eyes of the patient. As a result of spending time shadowing patients receiving end of life care, the team made a number of subtle but important changes to the way in which care was delivered at end of life and embedded these changes into the supporting documentation used for this cohort of patients. Patient shadowing gave rise to the introduction of the “purple butterfly menu” – specifically designed to reflect the dietary preferences of those patients at end of life. Another development was the use of call bells with clips to stop them falling out of reach of patients enabling them to summon help when they wanted it.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust employed a learning disability lead nurse who was able to advise and support for this cohort of patients who may be end of life. Staff were also able to confidently describe processes they could follow to support patients at end of life who may have additional mental health support needs.
The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Choices of food and drink to meet cultural and religious preferences were readily available.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs. At our last inspection, discussions around advance care planning were limited at the trust to those patients in the last stages of life. At this inspection, we found there had been a shift in emphasis on advance care planning to include all patients who may be deemed to be in the last year of life. Conversations were being had more readily with both patients, and their community health providers such as GPs about ongoing care needs and preferences to ensure that patient wishes and clinical prognosis were factored into patient care at an earlier point in their end of life care. This was a marked improvement from our last inspection.

For patients who were in hospital at the last stages of life we saw documented, and witnessed a number of occasions where open discussions were held about when and how treatment may be stopped in the best interests of patients. This was delivered in informative but gentle manner, with options explained, and implications discussed openly. Patients and those close to them were supported to make decisions that were right for them, and their wishes respected.

The mortuary had the necessary facilities and processes to enable them to manage the deaths of patients from a variety of faiths, including those who may require ritual washing. There were good links with funeral directors in the area of multiple faiths which enabled the service to responsive to individual need.

**Access and flow**

**Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.**

The staffing level of the palliative care team had increased since our previous inspection. The effects of this were clear to see in the wholesale quality and responsiveness of service provision across the trust. Between 1st April 2018 and 31st March 2019, there were 1724 deaths at NBT. In this time period, there were 1663 referrals to the palliative care team and all of these patients were seen within one working day of a referral. Whilst the operating hours of the palliative care team did not constitute a face to face 24/7 service, the out of hours provision had improved since our last inspection. The on-call service of the palliative care team was staffed by the team’s own consultants as opposed to externally as at the last inspection. Additionally, over the Christmas, Easter and May Bank Holiday periods, the team had trialled having the clinical nurse specialists of the palliative care team providing a face to face service. This had worked well and a subsequent business case was submitted to provide a face to face presence at weekends and bank holidays. There was a clear drive to increase the presence of the palliative care team at the trust, and clear actions were planned to achieve this. The team clearly articulated the benefits of what had already increased and the potential benefits of further development.

On a daily basis, the team gathered information about patients referred to their caseload and divided the work into triage of newly referred patients, and review of existing ones. This process had improved since our last inspection, with the team also now having the capacity to provide additional support to ward staff who may be looking after patients not referred to the team but who were at end of life care stage.
Staff worked hard to make sure patients at end of life did not stay in hospital any longer than they needed to. All staff we met worked hard to enable patients at the end of their life to be discharged to their preferred place of care wherever possible. Improvements had been made to the application for fasttrack funding process that prevented undue hold ups with securing necessary funding. The provision of care packages remained difficult, and there had been occasions where patients were not able to be discharged because of this. However, the service had good links with the hospice and community provision and worked hard to ensure wherever possible patients were discharged if this was their preference. Of the 1663 referrals to the Palliative Care team, 58% were discharged from hospital.

Managers monitored that patient moves between wards/services were kept to a minimum. For patients identified as end of life, and therefore receiving care aligned to the “purple butterfly” this was identified on the flow boards on wards. This meant that moving these patients should never happen, and had resulted in patients at end of life being protected from unplanned ward or bed moves. The service moved patients only when there was a clear medical reason or in their best interest.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns. We spoke with those close to the patients we met who told us they would raise concerns with staff if they needed to and knew how to do this.

Staff understood the policy on complaints and knew how to handle them. All staff we met spoke confidently about how complaints should be captured and managed. There were mechanisms for distinguishing between informal concerns and formal complaints. We saw that the palliative care team used an electronic system to monitor all complaints and concerns and this aided the timely response to these. We saw examples of corrective actions being taken within 24 hours of initial complaints being made, and feedback being given to complainants.

Managers investigated complaints and identified themes. Complaints were discussed at end of life strategy group meetings. We reviewed the minutes of these meetings which described a clear ambition to better capture complaint activity and learning.

In addition, the complaints team compiled a report relating to complaints relating to end of life care. Learning was clearly identified, and systems allowed for this information to be cascaded effectively. During our previous inspection, staff were unable to describe to us any changes that had occurred as a result of complaints about end of life care. At this inspection, staff were much more abreast of end of life related issues and learning that had taken place as a result of complaints.

Trust level

Between January 2019 and June 2019 the trust received 6 complaints that directly related to end of life care. This represented 3% of total complaints made to the trust at that time.

Number of compliments made to the trust

The trust did not provide a breakdown by core service of compliments received. From February
2018 to January 2019, the trust received 8,435 compliments trust wide. 
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills, knowledge, experience and integrity that they needed to provide exceptional end of life care.

The director of nursing was the executive lead for end of life care at the trust. There was also a non-executive lead for end of life care who was visible and conversant in the end of life service. The director of nursing was kept abreast of end of life related activity and was able to confidently describe how end of life care was delivered at the trust. The clinical lead for quality and the director of nursing met both formally and informally on a regular basis to plan and discuss delivery of end of life care. Leaders demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

Comprehensive and successful leadership processes were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. Staff were aware of the trust leaders, both executive and clinical for end of life care. Everyone we spoke with said they felt well supported by their colleagues and managers and this was evident in the interactions we observed. All staff we met were clearly inspired and motivated by the clinical lead for end of life care, and this translated into the delivery of high quality end of life care.

We also saw high quality leadership from the bereavement and chaplaincy services. Leaders were truly visible and active in their teams, and took the time to support them in their roles.

There was a trust wide end of life care steering group that was representative of the breadth of end of life care. This was an active group that met regularly and discuss the full breadth of end of life care at the trust.

Vision and strategy

End of life care at the trust was supported by a vision and strategy based on national objectives for end of life care.

The trust’s end of life strategy was based on the objectives outlined in the national “Ambitions for Palliative and End of life care” framework. It aimed to improve end of life care and ensure that it was seen as everybody’s business. When we spoke to staff on wards they were aware of the direction of travel of end of life care albeit they did not necessarily attribute it to a strategy. When we asked for the end of life strategy we were given a work plan which outlined a series of actions aimed to achieve these objectives. They were however clear, and aimed to drive improvements in the service.

The strategy, in it’s form, was owned and reviewed by the end of life strategy group which was attended by representatives from across divisions. Link nurses in the areas of the trust they worked disseminated the actions of the strategy to staff to enable it to be communicated widely.

The actions outlined in the strategy document contained elements that had been outlined in our previous inspection. These included for example, improvements in governance arrangements for end of life care.
Culture

The culture of end of life care at the trust was truly person centred, and encouraged openness and honesty at all levels of the organisation. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders had an inspiring shared purpose, and strived to deliver and motivate staff to succeed. End of life care was given high priority in all areas we visited. Staff spoke passionately about wanting to ensure the care they gave to patients at end of life was as good as it could be. People we met spoke of feeling privileged to be involved with patients and those close to them at such an important life event. We observed that this translated into action both on the wards we visited, in the mortuary and through speaking with others connected with end of life care, such as the chaplaincy service.

Where services fell short, we saw that staff didn’t hesitate to provide an apology, and be open and honest. Staff we spoke to were clear on what duty of candour meant and were keen to do the right thing in such an event.

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care. Staff felt wholly supported to deliver excellent end of life care and were clearly competent to do so. Relationships between different teams were positive and authentic and always put the patient at the centre of everything they did. We saw truly cooperative, supportive and appreciative relationships among staff, and teams worked collaboratively to deliver services.

The culture encouraged openness and honesty at all levels within the service, including with people who used services. Staff told us they felt confident to raise concerns, or make challenges across professions.

There were mechanisms in the services we visited for staff to develop, and become more confident and competent to deliver end of life care. Appraisals had been completed for everybody in the palliative care team, and a number of the nurse specialists were undertaking a masters degree module as part of that development. Elsewhere staff told us they felt they were competent to deliver end of life care and had ready access to support and training should the need be identified.

Governance

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services in end of life care.

Governance processes had improved greatly since our last inspection, and were continuing to be developed. The development of the incident reporting system had added the functionality to include end of life specific incidents. As a result, the team were able to evaluate, discuss and learn from incidents – often in real time, which was a vast improvement. A secondary system allowed for the team to monitor themes, and implement learning – both within the palliative care team and in end of life care more widely. This enabled a more robust oversight of the service and provided assurance of such at leadership level. We saw that this enhanced oversight and “real time” information about incidents ensured it was more widely understood and staff spoke fluently about reporting of, and learning from incidents.

There were quarterly clinical governance meetings where discussions were held about incidents, concerns and complaints, items on the risk register and recommendations agreed on actions to the medicine division clinical governance meetings and end of life group meetings.
End of life care sat within the medicine division at the trust. Reporting at board level happened via the director of nursing who was the executive lead for end of life care. End of life care was monitored by the end of life committee. This fed into the patient care and experience committee which was a sub-committee of the board. End of life care was enjoying an increased profile at board which enabled leaders to gain assurance of the service delivery.

Staff delivering end of life care at all levels were clear about levels of responsibility and the roles of others. This clarity manifested itself in effective channels of communication which were appreciated by staff. Accountability was clear, and this worked well with staff feeling supported in their roles.

The executive and clinical leads for end of life care met regularly, both formally and informally to discuss the service. This ensured that at executive level there was real time, clear understanding of how end of life care was being delivered at the trust.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The end of life service had a risk register that was overseen by the end of life committee to ensure it functioned effectively, risks were mitigated and actions taken. At the time we inspected, the two main issues on the register surrounded the communication with GPs in the community on discharge and the lack of systems to support this, and concerns about the difficult management of symptoms for patients at end of life and the lack of escalation of such. The latter issue was being well managed at the time of our inspection with the introduction of controls to mitigate the risk. There was also work ongoing to improve systems around communications with GPs although this was complex was not resolved as a risk at the time of our inspection. The risk register was overseen by the end of life committee, with clear channels of communicating such risks to relevant leaders when needed.

There was a programme of clinical audit designed to enable the end of life service to monitor it’s performance and drive improvements. The team held monthly meetings dedicated quarterly to clinical governance and clinical audit. There was a named doctor and nurse lead for clinical governance and clinical audit. At the quarterly clinical audit meeting discussions were held about recently completed local and national audits, and action plans were generated and reviewed.

Incidents relating to End of Life Care were reviewed weekly by the palliative care team. From July 2018 to June 2019 there were 610 incidents reported via the electronic system for patients receiving end of life care. Of these, 70 were for incidents relating directly to an aspect of palliative or end of life care and the palliative care team gave comments to assist the investigating manager and suggested actions to be taken. The other 540 incidents related to other aspects of care and other teams such as safeguarding, tissue viability and pharmacy. There was a clear understanding of how incidents were screened to ensure that the end of life service was able to manage and learn from incidents. This was an improvement from our last inspection.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.
Information about end of life care, for example anticipatory medicines, was available on the wards. Policies and protocols could be accessed through the trust’s intranet.

Electronic systems supported paper records to enable staff to access information about patients. This ensured all staff working with patients had up to date information about people in their care. The use of the “purple butterfly” to identify patients receiving end of life care worked effectively to enable all staff to quickly recognise this patient group. This was supported by a demonstrated commitment at all levels to sharing data and information proactively, effectively and efficiently, to drive and support internal decision making for patients at end of life.

**Engagement**

*Leaders and staff actively and openly engaged with patients, staff, and the public to plan and manage services.*

As part of the Purple Butterfly project, the service identified a potential to improve patient and carer involvement in both their nursing and medical care and in enabling them to convey what was really important to them. The palliative care team designed a form called “What Matters to You”, based on “This Is Me” form for patients with dementia and gave patients, families and staff opportunities to share this information to enhance their experience of care. It was recognised that this was a big project in its own right and a nurse from the palliative care team was undertaking an evaluation of the form and acceptability of it as part of a masters module.

The end of life service used patient and carer feedback in shaping services. This included identifying where things had gone well through thank you cards and letters, feedback from the “voices” patient survey, outcomes of patient shadowing, and the “What matters to you” project.

As a result of patient shadowing, the team used real experiences of patients to identify improvements, and implemented these as part of the “Purple Butterfly” project. The full “Voices” survey was presented to the trust end of life group and the “Nursing, Midwifery and Therapy Forum” to share the learning from the feedback.

The bereavement team worked hard with families of patients to understand how they could better improve the services on offer. Since our last inspection they had implemented systems to minimise the delays caused to relatives being able to pick up death certificates by engaging with medical staff to facilitate the more efficient completion of documentation.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services.*

Since our last inspection the service had worked incredibly hard to enable staff to deliver high quality end of life care. The profile and ownership of end of life care had branched out of the palliative care team and was embodied by staff from all areas – both clinical and non clinical. Staff spoke of feeling inspired and empowered by the work of the clinical lead for end of life care and this translated into fluent and effective services being delivered across the trust.

Learning from and evaluation of end of life care had become truly embedded across the trust since our last inspection. However, this was not seen as an end point, but as a continuous process for improvement that was owned by everyone we met.

The work that had been undertaken on the “Purple Butterfly” had been recognised nationally with an award for the palliative care team and complex care ward, and was felt to represent a step change in the delivery of end of life care at the trust.