

# North Bristol NHS Trust

## Quality Report

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

## Ratings

### Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

We carried out this focused inspection of the North Bristol NHS Trust to follow up on the areas that were rated as inadequate and requires improvement in our inspection in November 2014. Because we rated children's services as good in November 2014 we did not inspect them. All services had been rated as good for caring in November 2014 so we did not re-inspect this area, although we observed how people were cared for during the inspection.

The announced part of the inspection was carried out on 8, 9 and 10 December 2015 and the unannounced part of the inspection was carried out on 16 December 2015.

Overall we saw improvements had been made at this hospital, although the rating remained requires improvement.

Our key findings were as follows:

### Safety:

- Although we rated safety as requires improvement in the trust, improvements had been made.
- There were significant improvements within safety in urgent and emergency care services, with patients now receiving timely assessment on arrival.
- Systems for investigating incidents were embedded in most areas. However, improvements were required in end of life care .
- Nurse staffing levels were meeting national guidelines. A review of nurse staffing had been undertaken across the trust since our inspection in November 2014 and action taken as a result.
- Although infection control procedures were followed across the trust, there were higher rates of infection for *Clostridium difficile* and methicillin resistant *Staphylococcus aureus* (MRSA) than the target for the trust for the year. There had also been an outbreak of *Pseudomonas aeruginosa* in the critical care unit. These had been investigated and improvements in cleaning were identified and actioned as a result.

- In the community CAMHS service, young people had access to the staff kitchen at Monks Park House, which contained knives and hazardous cleaning products. The therapy rooms and waiting room were not clean.
- Therapy rooms at Monks Park House had no alarm system and staff did not follow lone working procedures.
- The trust was not meeting its target of 85% for the percentage of staff receiving mandatory training.
- A new electronic records system had been implemented in the month prior to our inspection. Although training and support had been put in place for staff, some were hesitant and found the system difficult to navigate.
- Staff within community CAMHS services had not consistently documented that they had assessed the risk to young people.
- In most areas of the trust, paper records were stored securely. However, in the theatre department and outpatients areas, some were stored in rooms which were not secured.

### Effective:

- We rated the overall effectiveness of services in the hospital as requires improvement. However, improvements had been made in urgent and emergency care services, which we rated as good.
- Across the trust there was involvement in audit and benchmarking both internally and externally. There were clear links to improvement in care within most areas.
- Mortality rates were significantly lower than expected when compared with other hospital trusts, as measured by the Hospital Standardised Mortality Ratio and the Summary Hospital-level Mortality Indicator. However, improvement was required in patient outcomes as they were below the England average in many areas.
- Improvements had been made in supporting staff within their roles, through the appointment of nurse

# Summary of findings

education practitioners and education programmes in the emergency department and in critical care. Further support was required in the theatre department for newer staff.

- Staff appraisals were undertaken across the hospital, but improvements were required within medical and community CAMHS services.
- Staff, teams and services worked well together to deliver effective care and treatment. We observed collaborative working from all staff contributing to patient care.
- Consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent. In most areas documentation relating to a patient's capacity to consent and those relating to the mental capacity act were completed appropriately. However, in some areas there was not clear evidence that account had been taken of a patient's ability or lack of ability to make specific decisions and there were omissions in the assessment and documentation of capacity.

## Responsive:

- Although there was a trust wide focus on patient flow within the hospital and improvements had been made this still required improvement. Bed occupancy within the hospital was consistently high at 96% and within critical care was above 80%. Research has shown that bed occupancy of both 85% (and above 70% within critical care services) could start to affect the quality of care provided to patients.
- The four hour target, within the emergency department, to admit or discharge patients to the hospital had been achieved for a three month period between June and August 2015. However this had deteriorated from September 2015 and in November 2015 only 82% of patients met this standard.
- There was a high level of delayed transfers of care which was frequently above 100 patients per day and at the time of the inspection was 114. However, there had been significant work undertaken since the inspection in November 2014 to facilitate patient

discharges. This included the implementation of an integrated discharge lounge in October 2015. There was a focus on embedding discharge pathways and gaining pace in discharge activity.

- Within surgical services there was not timely access for patients to treatment and operations. There were long waiting times, delays and cancellations ongoing. Action to address this was not always timely or effective and had resulted in a high number of complaints. The trust performed worse than the England average for most national targets, this included the Admitted Adjusted Referral to Treatment time (where the time from referral to treatment should be less than 18 weeks). The trust was also not meeting standards for referral to treatment pathways within outpatient services.
- The number of cancelled operations was worse (higher) than the England average and the percentage of patient not treated within 28 days of a cancelled operation was above (worse than) the England average.
- This had an impact on the critical care unit which had a high number of delayed discharges from the unit and the length of stay for patients was higher than the NHS national average. This was not optimal for patient social and psychological wellbeing.
- Within maternity services, 'flow midwives' had been introduced to provide an overarching approach to flow within the service. This enabled midwives to focus on providing direct patient care. Although bed occupancy remained high within maternity services (excluding the central delivery suite) this had improved flow within the service.
- The needs of patients with complex needs were well understood within all areas of the hospital. Patients with dementia received care and treatment that was sympathetic and knowledgeable. The work undertaken by the dementia care team within medical services was seen as outstanding. There were 100 dementia champions within the trust (including the director of facilities) and a focus on environmental changes to support patients.
- Useful information was provided to patients and visitors and communication aids including interpreters were readily available.

# Summary of findings

- Complaints were dealt with in line with trust policy. It was easy for people to complain or raise a concern and they were taken seriously when they did so. Improvements were made to the quality of care as a result of complaints and concerns.

## Well Led:

- The leadership, governance and culture of the trust promoted the delivery of high quality patient centred care.
  - The vision and values within the trust were clearly articulated by staff and board members alike. There was alignment between service and trust plans. Significant work was being undertaken on the trust strategy which was being led by the medical director. This work was to be completed in early 2016.
  - The board had developed significantly since our last inspection. A development plan had been initiated and coaching was ongoing. This was being cascaded to directorate leadership.
  - Relationships with commissioners had improved and matured. The trust saw the development of external relationships as an area for further development.
  - Governance systems had developed since our last inspection. The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately.
  - The quality and safety of patient care received sufficient coverage within board meetings and other associated meetings within the trust. There was clear visibility of risks at board level.
  - The leadership of the trust was knowledgeable about quality issues and priorities, understood the challenges are and took action to address them.
  - Financial pressures were managed so that they did not compromise the quality of care.
- We saw several areas of outstanding practice including:
- As the major trauma unit for the Severn region the department was required to report all treatment results of major trauma patients to the national trauma audit and research network (TARN). Results for 2015 showed that the emergency department at Southmead Hospital had the best survival rate of any trauma unit in England and Wales.
  - Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
  - Managers were strong and committed to the patients and also to their staff and each other.
  - There was an outstanding example of responsiveness with the work of the dementia care team and the availability of 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.
  - In the pre-admission clinic they had a pharmacist working full time who reviewed elective patients. They made sure their VTE assessment was completed. They reviewed patients' medications, wrote them up on the medication chart and gave advice to patients about their medication (what needed to be stopped prior to admission). The purpose for this was to reduce the amount of operations cancelled due to medication issues.
  - The bereavement midwife visited women in the CDS and also followed women up at home at any time, even beyond the normal time limit for postnatal midwifery care. Family support was also offered for subsequent pregnancies
  - The trust had developed some good training for staff in caring for patients living with dementia. Staff explained how they were able to offer extra time to this group of patients to ensure they were well cared for and made to feel relaxed and calm in an unfamiliar environment. Staff in the pre-operative assessment clinic were able to assess patient's cognition and report back to GPs if it was below expected levels.
  - The specialist palliative care team had worked with the acute medical unit with complex end of life patients to improve patient outcomes.
  - CCHP started the central intake team (CIT) to manage the risk of service users new to the service and subject to urgent referrals. This team managed

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new referrals for young people up to the age of 13 who were at risk of self-harm or were in need of urgent help to stabilise their mental state. Staff then referred the young person to their local team for ongoing work once the crisis had passed. The young person and their carer received contact information for the C.I.T. team and the Samaritans should they enter crisis again before their follow up appointment.

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

Importantly, the trust must:

- Improve patient flow within the hospital and ensure that there is a robust hospital-wide system of bed management so as to: significantly reduce delays in patient flow through the emergency department; reduce occupancy to recommended levels within medical services; and, ensure that there is capacity within the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and well-being.

- Records must be fully completed and provide detailed information for staff regarding the care and treatment needs of patients.
- Take action to improve the safe storage of medical notes
- Ensure patient information remains confidential through appropriate storage of records in the outpatient clinics and theatre departments to prevent unauthorised people from having access to them.
- Ensure that risk assessments in care records are consistently completed for all of the young people who use the community CAMHS service
- Ensure that the environment at Monks Park is safe for the people who use the service and staff.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to North Bristol NHS Trust

North Bristol NHS Trust is an acute trust located in Bristol that provides acute hospital and community services to a population of about 900,000 people in Bristol, South Gloucestershire and North Somerset. The trust is not a foundation trust. It also provides specialist services such as neurosciences, renal, trauma and plastics/burns to people from across the South West and in some instances nationally or internationally.

The trust has five main locations that are registered with the Care Quality Commission. It provides healthcare from Southmead Hospital, Cossham Hospital, Frenchay hospital site, Riverside and Eastgate House. The main hospital at Frenchay closed in May 2014 when the new hospital at Southmead was opened, however, the Head Injury Treatment Unit remains on the Frenchay site providing outpatient services. The trust also provides community healthcare for children and young people including mental health services across Bristol and South Gloucestershire. There are 996 beds on the Southmead Hospital site.

The trust was under significant financial pressure. The trust had a deficit of £19.8m for the 2014-2015 financial

year. The city of Bristol is ranked 79 out of 326 local authorities in the Indices of Multiple Deprivation. South Gloucestershire is less deprived with a rank score of 272 out of 326. Life expectancy for both men and woman in Bristol is slightly worse than the England average. However, it is better than the average for men and woman in South Gloucestershire. According to the last census 16% of Bristol's population was non-white (Bristol Unitary Authority). Black was the highest represented race, closely followed by Asian. Five per cent of the population of South Gloucestershire were from black and ethnic minority groups.

We carried out this focused inspection of the trust to follow up on the areas that were rated as inadequate and requires improvement in our inspection in November 2014. The inspection team inspected the following core services at the Southmead site • Accident and Emergency • Medical Care (including older people's care) • Surgery • Critical care • Maternity Services • End of life care • Outpatients • Maternity Services • We also inspected community mental health services for children and young people.

## Our inspection team

Our inspection team was led by:

**Chair:** Louise Stead, Chief Operating Officer and Director of Nursing, Royal Surrey County Hospital NHS Foundation Trust.

**Head of Hospital Inspections:** Mary Cridge, Head of Hospitals Inspection, Care Quality Commission

The team included CQC inspection managers, inspectors and a variety of specialists including: A board governance

director, a director of nursing, a divisional director of medicine, a specialist accident and emergency nurse, a specialist nurse in medicine, a specialist theatre nurse, a consultant surgeon, a junior doctor with experience in critical care and anaesthesia, a specialist critical care nurse, a consultant gynaecologist, a head of midwifery, a director of nursing for end of life care, a divisional general manager and head of nursing.

## How we carried out this inspection

We carried out the announced part of our inspection between 8 and 10 December 2015 and returned to visit some wards and departments unannounced on 16 December 2015.

During the inspection we visited a range of wards and departments within the hospital and spoke with clinical and non-clinical staff, patients, and relatives. We held focus groups to meet with groups of staff and managers.

# Summary of findings

Prior to the inspection we obtained feedback and overviews of the trust performance from Bristol and South Gloucestershire Clinical Commissioning Groups and the Trust Development Authority.

We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

## Facts and data about this trust

In 2014/15, the trust had 69,782 inpatient admissions and 82,481 attendances at the emergency department. There were 416,356 outpatient attendances. It had revenue of £552.9million, the full cost was £572.7million therefore there was a financial deficit of £19.8million.

Since the second quarter of 2013/14 the bed occupancy at the trust has been above the national average (85.9%). It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of the hospital. During the period from June 2014 to May 2015, the hospital's bed occupancy rate was on average 97%.

The trust provided services to a population of approximately 900,000 people across Bristol, South Gloucestershire and North Somerset. Bristol's population is 16.1% black and minority ethnic (BME). In North Somerset the population is 2.8% BME, while in South Gloucestershire the population is 5.1% BME. In Bristol 13.3% of the population are aged 65 and over. In North Somerset the proportion is 22.4%, and in South Gloucester it is 17.9%.

In the 2015 Indices of Multiple Deprivation, Bristol was in the worst quintile for deprivation. North Somerset was in the third quintile and South Gloucestershire was in the fifth (best) quintile.

Bristol performed worse than the England average for just under half the public health indicators. Its performance was particularly bad for prevalence of opiate and/or crack use, violent crime and hip fractures among the over-65s.

North Somerset performed better than average for just under half of the indicators. Incidence of malignant melanoma and hospital stays for self-harm were the only indicators where it performed worse than average.

South Gloucestershire performed better than the England average for most of the public health indicators. GCSE performance and incidence of malignant melanoma were the only indicators where it performed worse than average.

# Summary of findings

## Our judgements about each of our five key questions

### Are services at this trust safe?

We rated safety in the trust as requires improvement because:

- Training in all safety systems was available to staff but was not up to date in all cases.
- There had been three never events in the year prior to this inspection and infection rates for Clostridium difficile and methicillin resistant Staphylococcus aureus (MRSA) were above targets for the year. There had also been an outbreak of Pseudomonas aeruginosa within the critical care unit. Investigations for these infection control incidents showed that improvements were required in cleaning and action was taken across the trust as a result.
- There were areas where the storage of records required improvement in the theatre and outpatient departments where records were not always stored securely. Patient records were not always available in outpatient clinics. The completion of records within medical services did not consistently reflect the care needs of patients. Recording of assessments on some wards was not consistent. A new electronic records system had been implemented in the month prior to our inspection. Although training and support had been put in place for staff, some were hesitant and found the system difficult to navigate.

However:

- Performance showed steady improvements in safety.
- When something goes wrong, people receive a sincere and timely apology and are told about any actions taken to improve processes to prevent the same happening again.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. In most areas of the trust staff felt able to do so; however, within the theatre department some staff did not feel supported to raise concerns or that they would be taken seriously.
- For incidents, investigations were undertaken and lessons learned were communicated widely to support improvements across the trust.
- There had been a focus on staffing within the trust to ensure that it met recommended levels since our inspection in November 2014. Recruitment and succession planning had improved and there was visibility at board level.

### Rating

Requires improvement



# Summary of findings

- For new staff there was education and development available to ensure they were supported into their role. However, in some areas, this meant that there were reductions in the efficiency of the service provided.
- The trust used the five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist (this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications) in all surgical procedures. Compliance with the completion of this was good in most areas but required improvement in interventional radiology.

## Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff demonstrated an understanding of duty of candour responsibilities.
- The incident reporting system had a section for duty of candour which automatically became active if patient harm was reported as moderate, major or catastrophic. Root cause analysis incidents also had a duty of candour checklist included in the document template with an action to discuss the incident outcome with the patient and / or their relatives. Actions and target dates were monitored by the clinical risk committee and through the reporting system.
- All duty of candour data was monitored through the patient safety team to identify compliance and directorate managers received regular reports of the duty of candour compliance for all relevant incidents. The clinical risk and patient safety web site had a page dedicated to guidance, a checklist and letter templates on the duty of candour.

## Safeguarding

- There were clear policies and procedures in place within the trust for safeguarding vulnerable adults and children. Within the emergency department there were clear procedures for responding to patients who had experienced domestic violent, female genital mutilation (FGM) and human trafficking.
- Staff that we spoke with throughout the trust were aware of their responsibilities to protect vulnerable adults. They

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understood the safeguarding procedures that were in place and how to report concerns. However, improvements were required in the rate of update of training for staff which in some areas was below the 90% compliance level set by the trust.

- There were risk assessment tools in place within clinical records for children to assist in identifying any concerns regarding child welfare. There was also an “at risk” register which was checked for all children attending the emergency department up to and including the age of seventeen.

## Incidents

- Staff understood their responsibilities in reporting incidents and they were open, transparent and honest about reporting incidents. Systems were in place to make sure that incidents were reported and investigated appropriately. In most areas of the trust staff had no hesitation in reporting incidents and were clear about how they would do so. However, within the theatre department some staff did not report all incidents because they were short staffed and felt no improvements were made when they did report them.
- The rate of reporting incidents across the trust was slightly higher than the national average. A higher rate of reporting can indicate a more effective safety culture, as it provides the opportunity for learning and improvement. Staff were encouraged and reminded to report incidents and received feedback. Lessons were learnt and improvements put in place to improve care.
- There were four never events reported in the trust between August 2014 and December 2015. All were investigated and actions put in place to prevent reoccurrence. It was evident that a nationally recommended framework was used to structure the reports with appropriate actions arising from the investigation. A fifth was reported to us during the inspection. This was under investigation but initial immediate action had been identified and clearly communicated to staff throughout the hospital.
- The adverse events incident policy and serious incident requiring investigation policy were both aligned with the national requirements for reporting incidents.

## Cleanliness, infection control and hygiene

- Ward and clinical areas appeared clean, tidy and well maintained, although in some places equipment was not always clean.

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- There was personal protective equipment available which we saw staff using. Handwashing facilities were available at the entrance to each ward and there was hand sanitising solution available around the trust.
- There had been a significant colonisation of pseudomonas in the tap faucets in the critical care unit. This was attributed to both the design of the faucet and suboptimal cleaning regimes. A joint cleaning group had been set up between nursing and facilities staff which had proved successful. A programme of retraining had been carried out as a result of this. The medical director as the director for infection prevention and control took an active involvement in the investigation and actions taken as a result. His leadership of this was notable, driving improvements in the environment (managed by a PFI organisation) in conjunction with the director of facilities.
- The trust had had 42 cases of Clostridium difficile (C.diff) and 2 cases of MRSA bacteraemia at the time of the inspection since the beginning of April 2015. This was above the levels expected for the year. Investigation of the cases of C.diff showed that some were due to lapses in care and cleaning and action was being taken as a result of this. A full root cause analysis was carried out on each case of infection of C. Diff, MRSA and MSSA with actions identified as a result.

## Staffing

- There had been significant focus on ensuring that staffing levels met recommended levels. There had been a review of nursing and midwifery staffing across the trust and this had resulted in increased numbers of staff in urgent and emergency care, medical services, critical care, surgical services and maternity services.
- An acuity tool was used to calculate the number of nurses required within the emergency department. This tool monitored the number of patients that normally attended and the seriousness of their illness or injury. In addition nurse to patient ratios were monitored against national guidance from the National Institute for Health and Care Excellence (NICE). Nurse staffing numbers in the month prior to our inspection were sufficient to satisfy NICE guidance, and few agency nurses were used.
- Action had been taken to increase the number of midwives within maternity services. The established midwife to birth ratio was 1:28 across all areas, when there was no midwife sickness or unexpected leave. This is about the same as the England average. However, at the time of the inspection the ratio was 1:33 taking into account sickness leave.

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- The trust continued to use the Birthrate Plus intrapartum acuity tool to demonstrate how many staff were required. This meant that in addition to the ten midwives that had started at the time of the last inspection another ten had been recruited. Staff told us that the increase in the number of midwives had made a big difference to their workload and ability to provide safe care.
- According to the data the trust provided women were receiving one to one care in labour is 93.2% of the time. The trust believed this should read 100% of the time as they were confident that was what they were now providing. Senior staff told us the data collection would be reviewed as it was felt the lower percentage was as a result of incorrect data completion at the time of deliver, particularly with regards women who had experienced an elective caesarean section.
- Within critical care services nurse staffing levels were, generally, meeting the required numbers to care for patients safely. Since our last inspection in November 2015 the skills and experience of the nursing team had improved, with just under 20% of the total nursing staff not having had at least 12 months' critical care experience. To fill gaps in the full time establishment, some bank and agency nurses were being used. However, this number was decreasing month-on-month as new nurses started in the department.
- The number of supernumerary nurses within critical care services was not meeting recommended standards. The Core Standards for Intensive Care Units (2013) recommend every critical care unit has one supernumerary nurse providing coordination for the whole unit. Additionally, it recommends a further one supernumerary nurse for every additional ten beds. Although the unit had one supernumerary nurse on duty at all times, there were not always sufficient nurses to provide the additional supernumerary cover required. The head of nursing for the unit explained they were still working towards achieving this standard, with nursing recruitment ongoing into March 2016. The current establishment allowed an additional two supernumerary nurses (each one covering two pods) most of the time, but occasionally these nurses had to care for patients to ensure safe levels of staffing were being achieved for the numbers of patients in the unit.
- On surgical and medical wards levels met safer nursing staff requirements. Since our inspection in November 2014 there had been a review of staffing, skill mix and acuity of patients.

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- There had been a reduced turnover of staff. Actions taken to address turnover included ward drop-ins by HR to seek feedback from new starters, greater focus on the completion and return of exit questionnaires and plans to ensure that new starters were well supported and mentored.
- The trust had undertaken a number of overseas recruitment programmes and continued to do so in order to plan for succession across their services. There still remained vacancies for nursing staff across the hospital and some bank and agency staff were used to fill these shifts.
- The theatre department had recruited a high number of staff to fill their vacancies but these staff required training to meet the demands of the department. There had been a reduction in staff turnover within the department since our last inspection. This had been through the recruitment of 100 new staff within the department.
- Theatre management told us they were using the Association of Perioperative Practice (AFPP) model for staffing and this had been introduced since our last inspection. This was guidance about how many staff should be in each theatre to make sure patients and staff were safe.
- Alongside the recruitment of new nursing staff, in most areas of the trust education and development support was in place through nurse education practitioners. The impact of the implementation of these roles and packages were particularly evident within the emergency department and critical care unit. However, further focus on this was required within the theatre department because new staff employed to replace experienced staff were not necessarily as swift in undertaking tasks which had an impact on theatre efficiency.

## **World Health Organisation Surgical Safety Checklist**

- The trust used the five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist (this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications) in all surgical procedures. As recommended by the NHS National Patient Safety Agency (NPSA) the tool had been adapted for more specific use in areas such as ophthalmology and interventional radiology. The hospital adopted the use of the checklist as part of the introduction of the NPSA 'Five Steps to Safer Surgery 2010' guidance.
- We observed in the theatre department part of the WHO checklist being completed and all staff in the theatre were present. Each member of the team had a recognised role.

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- We saw monthly audits for compliance with the WHO surgical safety checklist in theatres and it was 98%. This was an improvement from the last inspection but still just below the trust target of 100%.
- Interventional radiology had their own WHO safety checklist. Staff told this was both paper-based and computerised. The audit results for compliance were 43% in August 2015 and this improved to 84% in October 2015. The trust said the low compliance figures were because of the recording of the data on the computer systems and not that the process had not been followed.

## Records

- The completion of records within medical services did not consistently reflect the care needs of patients. Recording of assessments on some wards was not consistent and we were unable to see that assessments for some patients had been done in a timely manner.
- Staff within community CAMHS services had not consistently documented that they had assessed the risk to young people.
- In most areas of the trust paper patient records were stored securely. However, in the theatre department and outpatients areas, some were stored in rooms which were not secured.
- A new electronic records system had been implemented in the month prior to our inspection. Although training and support had been put in place for staff, some were hesitant and found the system difficult to navigate. The new system involved more steps for emergency department staff to complete when a patient attended the department and this was having an effect on the time taken with each patient.

## Are services at this trust effective?

We rated the effectiveness of the trust as requires improvement because:

- Compliance with mandatory training was below the 85% level set by the trust. Although there was clear visibility and monitoring of compliance with mandatory training within the trust and data was targeted at directorate level. Completion of appraisal required improvement within areas of the trust. However, there had been a focus on ensuring that staff were competent and confident to undertake their roles, particularly those who were new to an area or in their first role.
- In most areas documentation relating to a patient's capacity to consent and those relating to the mental capacity act were completed appropriately. However, in some areas there were

**Requires improvement**



# Summary of findings

was not clear evidence that account had been taken of a patient's ability or lack of ability to make specific decisions and there were omissions in the assessment and documentation of capacity.

- Some staff struggled with the new electronic patient record system which meant that not all patient records had completed assessments of risk and the full range of patient needs completed.
- Outcomes for patients' care when compared with other organisations were mixed, with a number of areas where outcomes were worse than the England average. These included: National Heart Failure Audit and the Myocardial Ischaemia National Audit Project (MINAP); National Diabetes Inpatient Audit (NaDIA); an higher average length of stay for patients having hip fractures; and patient readmission rates after surgery. The results of audit were used to inform and improve the quality of patient care.

However:

- In most services, patient's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance.
- Mortality rates were significantly lower than expected when compared with other hospital trusts, as measured by the Hospital Standardised Mortality Ratio and the Summary Hospital-level Mortality Indicator.
- In the majority of services, the outcomes of patients' care and treatment were monitored. The trust participated in a number of national audits so it could benchmark its practice and performance against that of other trusts. Mortality
- Staff, teams and services worked well together to deliver effective care and treatment. We observed collaborative working from all staff contributing to patient care.
- Consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.

## **Evidence based care and treatment**

- In most services, patient's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance, for example National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines, and specialist guidance from the royal colleges.
- Some staff struggled with the new electronic patient record system which meant that not all patient records had completed

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assessments of risk and the full range of patient needs completed. This was particularly within medical and end of life care. Within medical services this was due to omissions in the completion of the electronic patient record via the new electronic recording system.

## Patient outcomes

- Mortality rates were significantly lower than expected when compared with other hospital trusts, as measured by the Hospital Standardised Mortality Ratio and the Summary Hospital-level Mortality Indicator.
- In the majority of services, the outcomes of people's care and treatment were monitored. The trust participated in a number of national audits so it could benchmark its practice and performance against that of other trusts. In most services it was clear that the results of audit were used to inform and improve the quality of patient care.
- The overall trust score for the Sentinel Stroke National Audit Programme (SSNAP) between July 2014 and June 2015 was a 'D'; the score relates to 'A' being the best and 'E' being the worst. This was the same score from the previous year's audit. However, it was noted that the trust scored 'A' for team-centred scanning indicators for all four quarters during the same period.
- The trust participated in the National Heart Failure Audit and the Myocardial Ischaemia National Audit Project (MINAP) for 2014/2015. The audit collects data on patients with an unscheduled admission to hospital who were discharged with a primary diagnosis of heart failure. MINAP provides comparative data to help clinicians and managers to monitor and improve the quality and outcomes of their local services. Data had not been published for 2014/2015. From the data available for 2013/2014 the trust performed better in the National Heart Failure Audit than the national average for patients receiving an echocardiogram (an echocardiogram creates images of the heart used in the diagnosis and management of patients with suspected or known heart diseases); but worse for six of the seven indicators relating to discharge. There were mixed results in the MINAP audit with referrals for an angiography showing 95.9% against an England average of 77.9% and admission to a cardiac ward showing 21.7% against an average of 55.6%.
- The trust participated in the National Diabetes Inpatient Audit (NaDIA). The audit was a snapshot of diabetes inpatient care in England and Wales and looked at whether diabetes management minimised the risk of avoidable complications, harm resulting from the inpatient stay, patient experience of the

# Summary of findings

inpatient stay, the change in patient feedback on the quality of care since NaDIA began. The latest data available was from September 2013 which showed the trust performed worse than the England average for 18 out of 21 patient related questions.

- The hospital had mixed performance in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015. These patients reported to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The trust performed better than the England average for both groin hernia indicators and worse than the England average for all the indicators relating to hip replacement and knee replacement. For varicose veins, the trust had not provided any data.
- Hip fracture performance for the year 2014 to 2015 was varied. In some, they were better than England average; for example, surgery on the day of admission was 85% compared to the England average of 72.1%. However, data for patients developing pressure ulcers was 5.9% compared to the England average of 2.8%. The average length of stay was 23.4 days, compared to 20.3 days for the England average. In one other measure for pre-operative assessment by a geriatrician, the hospital performance had improved over the previous year and was better than the England average.
- The trust performed well in national cancer audits. In the lung cancer audit the trust was better than the England average for discussing patients at a multidisciplinary level. In the bowel cancer audit, the trust was better than the England average for discussing patients at a multidisciplinary level, being seen by a clinical nurse specialist, and receiving a relevant scan. The trust was also above the England average of 94% for having well completed data in the bowel cancer audit.
- The trust provided data for the first patient report of the National Emergency Laparotomy Audit dated October 2015 (NELA). The audit results were rated green, amber or red based on 11 measures. This trust was rated as 'green' for three of these measures and that included a consultant surgeon present during surgery.
- Patient readmission rates after surgery between December 2013 and November 2014 (due to corrective measures being needed or infections) were worse than the England average for elective (planned) and emergency surgery.

## Competent staff

- There was clear visibility and monitoring of compliance with mandatory training within the trust. In a number of mandatory

# Summary of findings

training topics compliance was below the 85% level set by the trust and data was targeted at directorate level. There was visibility of senior staff compliance with mandatory training. Completion of appraisal required improvement within the trust.

- There had been a focus on ensuring that staff were competent and confident to undertake their roles, particularly those who were new to an area or in their first role. This was particularly evident within the emergency department and within critical care where there had been an increase to the number of staff within particularly skilled areas. Nurse education practitioners had been employed to provide targeted support in these areas. In the theatre department where there had been recruitment to roles being left by experienced practitioners, some greater focus on this was required so as to improve efficiency within the department and through theatre lists.

## Multidisciplinary working

- Staff, teams and services worked well together to deliver effective care and treatment. We observed collaborative working from all staff contributing to patient care.
- We saw evidence that staff worked professionally and cooperatively across different disciplines to ensure care was coordinated to meet the needs of patients. In medical services staff reported an increase in multidisciplinary team working with daily meetings to discuss patient's care and treatment.
- We observed a weekly multidisciplinary team meeting where three patients were reviewed. The discussions were comprehensive and detailed and included discharge planning. We also saw good multidisciplinary working through the use of the WHO surgical safety checklist within the theatre department.
- In the emergency zone there was a complex assessment and liaison service (CALs) which was aimed at developing a treatment and rehabilitation plan to avoid admission or shorten length of stay. The service was staffed by consultant physicians, advanced nurse practitioners, occupational therapists and physiotherapists. We observed the pro-active approach adopted by this team. They took trouble to identify patients who would benefit from their service before a formal referral had taken place.

## Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.

# Summary of findings

- Staff had a good understanding and guidance to follow in relation to mental capacity assessments. There were patient mental capacity assessment forms which led on to considerations of how decisions were then made in the patient's best interests. The forms followed the provisions of the Mental Capacity Act (2005) in that they recognised a patient's mental capacity to make decisions could be temporary and related to the decision in question and not all future decisions.
- In most areas documentation relating to a patient's capacity to consent and those relating to the mental capacity act were completed appropriately. However, within medical services there were omissions in the assessment and documentation of capacity; and in end of life care there were was not clear evidence that account had been take of a patient's ability or lack of ability to make specific decisions. When there was evidence, it was sometimes recorded in areas of notes that were not immediately obvious or in a format that was not clear.
- In end of life care not all do not attempt resuscitation forms, had been signed by a senior clinician or been reviewed in the appropriate time or provided objective evidence of why a patient lacked capacity.

## Are services at this trust responsive?

We rated the responsiveness of the trust as requires improvement because:

- Some people were not able to access services for assessment, diagnosis or treatment when they need to. There were long waiting times, delays or cancellations. Although there was a trust wide focus on patient flow within the hospital and improvements had been made this still required improvement.
- Bed occupancy within the hospital was consistently high and performance for the four hour target, within the emergency department, to admit or discharge patients to the hospital had deteriorated since September 2015.
- There was a high level of delayed transfers of care. However, there had been significant work undertaken since the inspection in November 2014 to facilitate patient discharges.
- The trust performed worse than the England average for most national standards, this included the Admitted Adjusted Referral to Treatment time (where the time from referral to treatment should be less than 18 weeks). The trust was also not meeting standards for referral to treatment pathways within outpatient services.

**Requires improvement**



# Summary of findings

- The number of cancelled operations was worse (higher) than the England average and the percentage of patient not treated within 28 days of a cancelled operation was above (worse than) the England average.
- Although there had been improvements in the timeliness of responding to complaints, further focus was required on the completion of investigations and the actions identified as a result.

However:

- Services are planned and delivered in a way that meets the needs of the local population. The trust engaged partners in planning and delivering services to meet the needs of the population it served.
- The needs of different people are taken into account when planning and delivering services.
- There had been a real focus on delivering high quality care to patients with complex needs. Staff throughout the trust demonstrated a good understanding of the requirements of these patients. Dementia was recognised as one of five priorities for the trust. The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged.
- The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice.

## **Service planning and delivery to meet the needs of local people**

- The trust engaged partners in planning and delivering services to meet the needs of the population it served. As a regional centre for specialist services such as neurosciences, renal, trauma and plastics/burns to people from across the South West this involved engagement with the NHS England specialist commissioning team.

## **Meeting people's individual needs**

- There had been a real focus on delivering high quality care to patients with complex needs. Staff throughout the trust demonstrated a good understanding of the requirements of these patients.

# Summary of findings

- The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice.
- Dementia was recognised as one of five priorities for the trust. It was estimated that there were 250 patients with dementia at any time in the trust. Standards for care of people with dementia had been developed both locally and nationally as part of the dementia improvement programme. The dementia care team remit was to ensure that these standards were incorporated into routine care so that people with dementia had a safe admission and discharge and as good a patient experience as possible. The team had a strategy directing their work which was updated on an annual basis.
- Patients with dementia received care and treatment that was sympathetic and knowledgeable. The work undertaken by the dementia care team within medical services was seen as outstanding. There were 100 dementia champions within the trust (including the director of facilities) and a focus on environmental changes to support patients.
- Elgar House had been refurbished to improve the environment using principles of colour to assist with way finding and identification of bed areas and bathroom, and improved signage. This was with patients with dementia in mind.
- Opportunities to improve the environment had been fewer in the main Brunel building. The installation of clocks throughout the building had been completed alongside the installation of a grabber bar on each bedroom door to hold important documents relating to the person's care and wishes. Signage on all internal bathroom doors was awaited. An environmental audit had been completed by the dementia administrator prior to her departure from the team but had not been written up. However, the team told us that findings suggested the need for improvement of the environment to make it as suitable as possible for people with dementia. For example, the provision of lighting in the bays and internally facing rooms; the use of more definitive colours to aid identification of rooms; and the provision of seating at regular intervals to help people walking in ward spaces outside their bedroom to see where to sit down.
- Because the hospital comprised of mainly single rooms, in most areas of the hospital maintaining single sex accommodation was achieved apart from within the

# Summary of findings

emergency department observation unit. This was restricted to patients who stayed overnight in the department where there was not one of the four single rooms available. Instances were reported as incidents.

## Access and flow

- Although there was a trust wide focus on patient flow within the hospital and improvements had been made this still required improvement. Bed occupancy within the hospital was consistently high at 96% and within critical care was above 80%. Research has shown that bed occupancy of both 85% (and above 70% within critical care services) could start to affect the quality of care provided to patients.
- The four hour target, within the emergency department, to admit or discharge patients to the hospital had been achieved for a three month period between June and August 2015. However this had deteriorated from September 2015 and in November 2015 only 82% of patients met this standard.
- There was a high level of delayed transfers of care which was frequently above 100 patients per day and at the time of the inspection was 114. However, there had been significant work undertaken since the inspection in November 2014 to facilitate patient discharges. This included the implementation of an integrated discharge lounge in October 2015. There was a focus on embedding discharge pathways and gaining pace in discharge activity.
- Within surgical services there was not timely access for patients to treatment and operations. There were long waiting times, delays and cancellations ongoing. Action to address this was not always timely or effective and had resulted in a high number of complaints. The trust performed worse than the England average for most national targets, this included the Admitted Adjusted Referral to Treatment time (where the time from referral to treatment should be less than 18 weeks). The trust was also not meeting standards for referral to treatment pathways within outpatient services.
- The number of cancelled operations was worse (higher) than the England average and the percentage of patient not treated within 28 days of a cancelled operation was above (worse than) the England average.
- This had an impact on the critical care unit which had a high number of delayed discharges from the unit and the length of stay for patients was higher than the NHS national average. This was not optimal for patient social and psychological wellbeing.
- Within maternity services, 'flow midwives' had been introduced to provide an overarching approach to flow within the service.

# Summary of findings

This enabled midwives to focus on providing direct patient care. Although bed occupancy remained high within maternity services (excluding the central delivery suite) this had improved flow within the service.

## Learning from complaints and concerns

- The trust had a draft complaints policy, dated September 2015, which had clear processes and guidance for investigating and responding to complaints. The policy detailed the management of complaints considering statutory requirements, response timeframes, roles and responsibility of all staff, meetings as part of the resolution process (with guidance on how they should be structured) and information about the Parliamentary Health Service Ombudsman. The policy did not refer to duty of candour by name but contained the basic principles of being open, honest and apologising for when things have gone wrong.
- The trust had, at our last inspection, a significant backlog in the number of complaints which had not been responded to or completed within timescales. Significant attention had been paid to these and the backlog had greatly reduced with plans for it to no longer exist. A programme of support and training was implemented for central and directorate complaints teams to address the overdue cases, the reasons for the backlogs and also to ensure improvements were made. The number of complaints had increased significantly within the 2014/15 year which accounted for the backlog, this was associated with the move to the new hospital building.
- Complaints were centrally managed on a day-to-day basis by the Advice and Complaints Team (ACT) on behalf of the Chief Executive.
- The iCARE programme which had been implemented in September 2014, was designed to help staff to consider their approach and communication from the patient's perspective. The training for staff for this programme used real complaints and complements to help staff look at care issues from the patient's perspective.
- Patient stories were presented at trust board meetings. They provided an opportunity to review patient experience and learning at board level. There was also an annual complaints report (for the year 2014/15) which reported to the trust board in July 2015. This provided visibility at board level of the number of complaints, trends (including reasons and directorates where complaints were made) and also details of

# Summary of findings

the number of “returns” of complaints. A return of a complaint was where the complainant returned to the trust for more information or because they were not satisfied with the responses given.

- The trust had invited the Patients Association to undertake a review of complaints within the trust in December 2014. The report identified inconsistencies in the quality of investigation and response to complaints and made recommendations for good practice that the trust was working to implement. Actions identified included: Developmental workshops to equip, encourage and support staff reviewing complaints; an improved initial response process, encouraging early telephone or face-to-face contact with complainants; and the development of an investigation toolkit to support staff.
- Our review of complaints showed that most were reviewed and responded to well. However, some improvements could be made particularly with the investigation and actions identified as a result of complaints.

## Are services at this trust well-led?

We rated the leadership of the trust as good and varied the ratings principles because:

- The leadership, governance and culture of the trust promoted the delivery of high quality patient centred care.
- The vision and values within the trust were clearly articulated by staff and board members alike. There was alignment between service and trust plans. Significant work was being undertaken on the trust strategy which was being led by the medical director. This work was to be completed in early 2016.
- The board had developed significantly since our last inspection. A development plan had been initiated and coaching was ongoing. This was being cascaded to directorate leadership. Leaders have an inspiring shared purpose, strive to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies are in place to ensure delivery and to develop the desired culture.
- Relationships with commissioners had improved and matured. The trust saw the development of external relationships as an area for further development.
- Governance systems had developed since our last inspection. The board and other levels of governance within the organisation functioned effectively and interacted with each

Good



# Summary of findings

other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

- Data and information was seen by the trust as an area for improvement. The implementation of the new Lorenzo computer system would assist with this.
- The quality and safety of patient care received sufficient coverage within board meetings and other associated meetings within the trust. There was clear visibility of risks at board level.
- The leadership of the trust was knowledgeable about quality issues and priorities, understood the challenges and took action to address them. There was an effective process in place to identify, understand, monitor and address current and future risks. Performance issues were escalated to the relevant committees and the board through clear structures and processes
- Financial pressures were managed so that they did not compromise the quality of care.
- There had been improvements in the staff survey results in 2015, although further improvement was required.

## **Vision and strategy**

- The vision of “exceptional healthcare personally delivered” was a clearly articulated throughout the organisation.
- The trust strategy was being consolidated and finalised during our inspection. The medical director was leading on this, working closely with the trust secretary to ensure that board assurance and strategic risk was integrated. There was visibility and engagement at trust board level, with the aim of finalising the strategy in early 2016.
- Although the strategy was still being delivered there was a clear focus on delivering the vision and financial balance and stability. Executives and non-executives were clear about the direction of travel within the organisation and there was a palpable focus on the quality and safety of patient care at all levels. Unusually for a trust in challenging financial circumstances, quality was talked about more than cost efficiency programmes, although there was a clear plan to deliver financial balance. There was clear executive and non-executive visibility of this but the focus of delivering safe, high quality care was at the forefront of the approach. Staff were aware of the financial pressures within the organisation.
- Business planning and strategy was aligned throughout the organisation. Individual service strategies fed into the trust strategy and plan.

# Summary of findings

- The trust had identified key priorities for improvement in 2015/16. These were: Improving care for patients with dementia; to improve patients' overall experience in hospital; improving the recognition, diagnosis and treatment of acute kidney injury (AKI); and improving the quality and timelines of information provided to GPs when patients go home to ensure there is safe handover to primary care.

## **Governance, risk management and quality measurement**

- The trust wide governance systems had been strengthened since the previous inspection. Directorates were being both supported and held to account and centrally the leadership were well informed about the strengths and challenges within directorates.
- The changes to board committee structures made in 2014 had had a positive impact in terms of separating delivering from assurance. Terms of reference had been updated and sharpened.
- Although the governance systems had been strengthened, the trust was clear that further work was required to ensure that they had data and information they needed to gain full oversight of services. The implementation of the new Lorenzo computer system would help with this and there was continued focus within the trust. Despite this, all executives were able to clearly articulate areas of concern and risk both within their portfolio and for the trust as a whole.
- Comprehensive assurance systems and service performance measures were in place. These were actively monitored and reported on through the integrated performance report at the trust board. These had been strengthened since our inspection in November 2014 and again following our inspection in May 2015. Learning from previous gaps in assurance regarding the quality and safety of patient care within the emergency department and zone was evident, with a quality dashboard having been implemented and reported on through the integrated performance report. This report set out performance across the trust in terms of CQC methodology domains. This enabled a holistic understanding of performance, including safety, quality, activity and financial performance. Although the views of people were taken into account in gaining assurance at trust board level; through patient stories and the visibility of incidents and complaints; a greater focus was planned over the next year following the appointment of the head of patient experience reporting to the director of nursing. A patient

# Summary of findings

experience improvement plan had been presented to the trust board in November 2015 providing a more strategic approach to patient experience. This plan would form a part of the wider quality strategy and trust wide strategy.

- There was a greater visibility of risks across the trust. In most services risk registers were in place and reviewed regularly. One area for improvement was within end of life care where a risk register was not in place and some risks which were evident during our inspection were not visible at trust board level.
- The trust self-assessment was broadly similar to our ratings.

## Leadership of the trust

- The team found a significant improvement in the leadership of the trust since the last inspection. The Board, further strengthened by recent non-executive director appointments that included a senior clinician and an academic, appeared cohesive, focused and determined.
- A board development programme had had a significant impact on individual board members and on the board overall. Previous development programmes had focused on knowledge whilst this one had focused on skills and behaviours. There was evidence that this had impacted on the quality of the debate with dissenting voices being heard and decisions reached in a collective way.
- The chairman and chief executive had an effective working relationship. The chairman was engaged with the quality improvement and safety agenda and displayed a breadth of knowledge together with a commitment to both patients and staff.
- Key appointments had been made to roles which supported the executive team and allowed greater capacity to lead. This was particularly within the nursing leadership. There had also been changes within the general management of directorates which were delivering improvements.
- There was shared focus and responsibility for clinical services between the director of nursing and the medical director. There was clarity in their individual responsibilities and supportive challenge between these two roles to deliver high quality and safe patient care.
- The directorate leadership was clinically led with general management support and this was the vision for leadership within the trust moving forward. This clinical director, head of nursing and general manager triumvirate approach was clear in the approach of all executive directors with focus on performance, delivery and finances being directed clearly through the management structure.

# Summary of findings

- The trust was dealing with a number of significant human resources issues including long term sickness levels, staff engagement and issues with bullying in some areas. The latest staff survey results (2014), both in terms of the low response rate (25% against the national average of 42%) and the results themselves (21 negative indicators out of 30) indicated the scale of the challenge facing the leadership team in terms of improving engagement. That said the anecdotal evidence heard during the inspection was that things were changing for the better. Staff talked about feeling respected and valued and many referred to having seen members of the executive team around the hospital and on wards. Executives were described as “approachable when you see them.”
- The trust had had considerable success in recruiting nursing staff with an additional £3.2m invested in the nursing workforce since the previous inspection. Overall a £5m investment has been made in the nursing and medical workforce. The trust had performed particularly well in being able to fill their vacancies and there was evidence that it was increasingly being seen as an attractive place to work; this aspect was mentioned to the team by a number of new staff in a range of roles and services. There had been 1400 new starters since April 2015.
- The trust had developed and matured its relationship with commissioners and regulators. Positive working relationships existed. The trust saw external relationships and engagement as an area for growth and development and there was a

## **Culture within the trust**

- It was apparent that significant improvements in the overall culture of the trust had been made since the inspection in November 2014. Staff across the trust and at all levels referred to the organisation having settled down and of having grown in confidence. The team met staff in focus groups, during interviews and on the wards who talked in terms of having settled into the new Brunel building and understanding how best to work within it.
- Whilst recognising the overall indicator for the staff engagement in NHS Staff Survey 2015 was below (worse than) the national average, when compared with hospitals of a similar type, overall staff engagement had risen and considerable improvement had occurred in many indicators. For example: Care of patients / service users is my organisation's top priority increased from 62% in 2014 to 74%; My organisation acts on concerns raised by patients/service users had increased from

# Summary of findings

55% to 67%; I would recommend my organisation as a place to work had increased from 43% to 52%; and, If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation increased from 52% to 64%.

- There was a focus on “caring for those who care” within the trust through the trust iCARE programme. All executives were focused on how best to reward staff. The director of nursing had implemented “Director of Nursing Awards” to name one newly implemented approach.
- There was a feeling among staff that morale was improving and positive changes were being made.
- There was a strong focus on improvement and safety and a new Safety Faculty had been established.
- There had been investment in first line and middle management training and development. There was a first line management training programme that the trust was considering making mandatory. There was a new development programme for ward sisters and a middle management programme aimed at matrons and speciality leads.

## Fit and Proper Persons

- The trust had made preparations to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. This regulation came into force in November 2014.
- The trust had a comprehensive policy (Fit and Proper Directors Policy) in place with procedures and processes clearly described within it. The policy referenced the regulations and reflected best employment practice. The policy was approved by the trust board in October 2015; almost 12 months after the regulation came into effect.
- The Trust Development Authority were involved in the appointment of executive and non-executive director posts in the trust and undertake some of the checks referred to in the policy. The checks covered character, qualifications, competence, skills, experience, health, misconduct, mismanagement, financial and disclosure and barring.
- Once a director has been appointed the FPPR is assessed through a combination of self-declaration and appraisal.
- We reviewed the files of a non- executive director. This demonstrated that FPPR policy had been followed.

## Public engagement

# Summary of findings

- There were systems in place to engage with the public to ensure regular feedback on service provision for analysis, action and learning. In addition to the NHS Friends and Family Test, patient were encouraged to make comments by email, letter or on twitter. There were also VOICES surveys undertaken.
- The trust operated a 'you said, we did' programme across all services where actions as a result of feedback given to wards and departments were published and displayed for people to see.
- The trust had developed a new role of head of patient experience, which had been taken up in November 2015. A plan build on and strengthen on the work already undertaken across the trust regarding seeking, understanding and responding to the experience of patients and carers, was presented to the trust board at the end of November 2015. This set out the priorities that would improve patient experience and build on existing good practice. These included: a review of how improving patient experience is embedded within the trust; to improve and embed systems at a local level around the gathering, responding to, using and learning from patient experience; empowering patients; and to link the work on staff experience as well as patient experience. There was a clear focus on improving communication with patients. This would be linked to the quality and trust wide strategy.
- The trust actively engaged with their neighbours regarding building and development of the site and also regarding transportation matters. This was led by the facilities director.

## Staff engagement

- The trust had undertaken a staff opinion survey and work had been done to improve the response rate. Senior staff described the challenge of convincing staff that something would be done with the results. A programme of engagement through the directorates was planned to start in January 2016.
- Staff confirmed that executive and non-executive walkarounds occurred. These involved discussions with both staff and patients.
- Most staff described the active engagement by the trust and their views were reflected in the planning and delivery of services and in shaping the culture. Staff were encouraged to share their views at team meetings which in most services took place regularly.

# Summary of findings

- There was a bi-monthly 'Insight' magazine published which highlighted key issues about what had been happening in the trust, news and sharing of letters from patients and their families. Staff were encouraged to tweet and email reasons for being proud to work at the trust.
- Notices called "toilet tips" were fixed to the inside of toilet doors. These had useful information including alert information following serious incidents or never events for staff, to ensure that these situations did not reoccur.
- Staff were proactive in looking at cost saving initiatives. In medical services, we were told that they were constantly looking at ways of working smarter and researching the cost of supplies and suppliers.
- There was some uncertainty and low morale amongst staff in places within the trust, due to continued change and concerns about staff recruitment and retention. However, staff were focused on driving for high-quality patient care.

## **Innovation, improvement and sustainability**

- There was innovation ongoing throughout the trust. One notable programme was within medical services where there was a focus on improving the way enhanced care was given to patients. The trust was part of this national programme, which had a focus on patients who required constant one-to-one observation and care (known as 'specialling'). There were pilot programmes which looked at how the patients could be 'cohorted' and provided step down care together and 'flash cards' were provided to staff to help them to improve and tailor care to the individual through this process.
- There was a clear sustainability strategy in place led by the director of facilities. A travel and sustainability plan was in place within the trust. There was an embedded travel and sustainability group within the trust with active non-executive membership.
- The trust had received a number of award for travel and sustainability strategies and the director of facilities was instrumental in identifying and championing sustainability initiatives for the trust. One such initiative was a personalised "your travel plan" which was sent out to each newly appointed member of staff with their letter of appointment. The trust also made available electric and normal bicycles to staff in order that they may "try before they buy".
- There was a clear focus on financial sustainability across the trust and this was focused around maintaining high-quality, safe patient care. Clinical directors, heads of nursing and general managers were engaged in identifying cost efficiency

# Summary of findings

programmes which are focused around improving patient care. For example, the innovation programme regarding 'specialling' patients in the medical services. A series of finance business partners were in place to provide support to the directorate teams given that the financial turnover of some equated to some smaller NHS trusts.

- The finance director's view of the trust and of activity within the trust was very patient care focused. An empowering approach to finances was in place holding key staff to account for budgets whilst, enabling improvements to be made where necessary.
- The trust had not allowed financial pressures to compromise potential improvement and sustainability of services. Funding for additional nursing staff across the trust had been gained, and there was a focus on the safety, quality and sustainability of services.

# Overview of ratings

## Our ratings for Southmead Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	N/A	Requires improvement	Good	Good
Medical care	Requires improvement	Requires improvement	N/A	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	N/A	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	N/A	N/A	Requires improvement	N/A	Good
Maternity and gynaecology	Good	N/A	N/A	Good	N/A	Good
End of life care	Requires improvement	Requires improvement	N/A	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	N/A	Requires improvement	N/A	Requires improvement
<b>Overall</b>	Requires improvement	Requires improvement	N/A	Requires improvement	Requires improvement	Requires improvement

## Our ratings for the community CAMHS service

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall</b>	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement

## Our ratings for North Bristol NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall trust</b>	Requires improvement	Requires improvement	N/A	Requires improvement	Good	Requires improvement

# Overview of ratings

## Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.
2. We varied the ratings principles for the overall trust rating of well led as detailed above.

# Outstanding practice and areas for improvement

## Outstanding practice

- As the major trauma unit for the Severn region the department was required to report all treatment results of major trauma patients to the national trauma audit and research network (TARN). Results for 2015 showed that the emergency department at Southmead Hospital had the best survival rate of any trauma unit in England and Wales.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- Managers were strong and committed to the patients and also to their staff and each other.
- There was an outstanding example of responsiveness with the work of the dementia care team and the availability of 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.
- In the pre-admission clinic they had a pharmacist working full time who reviewed elective patients. They made sure their VTE assessment was completed. They reviewed patients' medications, wrote them up on the medication chart and gave advice to patients about their medication (what needed to be stopped prior to admission). The purpose for this was to reduce the amount of operations cancelled due to medication issues.
- The bereavement midwife visited women in the CDS and also followed women up at home at any time, even beyond the normal time limit for postnatal midwifery care. Family support was also offered for subsequent pregnancies
- The trust had developed some good training for staff in caring for patients living with dementia. Staff explained how they were able to offer extra time to this group of patients to ensure they were well cared for and made to feel relaxed and calm in an unfamiliar environment. Staff in the pre-operative assessment clinic were able to assess patient's cognition and report back to GPs if it was below expected levels.
- CCHP started the central intake team (CIT) to manage the risk of service users new to the service and subject to urgent referrals. This team managed new referrals for young people up to the age of 13 who were at risk of self-harm or were in need of urgent help to stabilise their mental state. Staff then referred the young person to their local team for on-going work once the crisis had passed. The young person and their carer received contact information for the C.I.T. team and the Samaritans should they enter crisis again before their follow up appointment.

## Areas for improvement

### Action the trust MUST take to improve

The trust must:

- Improve patient flow within the hospital and ensure that there is a robust hospital-wide system of bed management so as to: significantly reduce delays in patient flow through the emergency department; reduce occupancy to recommended levels within medical services; and, ensure that there is capacity within the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and well-being.
- Records must be fully completed and provide detailed information for staff regarding the care and treatment needs of patients.
- Take action to improve the safe storage of medical notes
- Ensure patient information remains confidential through appropriate storage of records in the outpatient clinics and theatre departments to prevent unauthorised people from having access to them.
- Ensure that risk assessments in care records are consistently completed for all of the young people who use the community CAMHS service
- Ensure that the environment at Monks Park is safe for the people who use the service and staff.

# Outstanding practice and areas for improvement

**Action the trust SHOULD take to improve is detailed within the Southmead Hospital location report and the core service report for community CAMHS services.**

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.</p> <p>Records were not always available within outpatient clinics</p> <p>Records were not fully completed and did not provide detailed information for staff regarding the care and treatment needs of patients. These did not provide detail on the individualised care needs and requirements of patients.</p> <p>The management of patient records in outpatients and the theatre department did not ensure patient's details were safe and that confidentiality was assured. We saw records were left accessible to the public and trolleys used for records storage were not secured or placed away from public access. Medical notes were not kept in lockable containers. We also saw insecure storage of medical records in the pre-operative assessment clinic. Medical records were stored in a large cupboard without access control or lockable doors.</p>
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>Regulation 9 (1)The care and treatment of service users must –</p> <ol style="list-style-type: none"><li>1. be appropriate</li><li>2. meet their needs</li></ol>

This section is primarily information for the provider

## Requirement notices

A lack of available beds for critical care patients to be discharged to meant a high number of patients were not receiving care and treatment in the most appropriate location for their needs.

Patient bed occupancy exceeded recommended levels too frequently.