North Bristol NHS Trust

Evidence appendix

North Bristol NHS Trust
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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

Details of sites and locations registered with CQC

Three locations are registered with the Care Quality Commission.

- Southmead Hospital
- Cossham Hospital
- Frenchay Hospital

We only inspected Southmead Hospital as part of this inspection.

Background to the trust

North Bristol NHS Trust is an acute trust located in Bristol that provides acute hospital and some 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 new hospital at Southmead opened in May 2014 when the main hospital at Frenchay closed. Southmead Hospital provides a full range of acute clinical services. The trust also provides community healthcare for children and young people. Cossham Hospital provides maternity and outpatient services.

Facts and data about the trust

The trust provides a full range of acute clinical services. The trust employs 8141 staff.

(Source: Provider Information Request 2017)
There are 996 beds on the Southmead Hospital site. The population served is approximately 900,000.

Financial position

For the financial year 2016/2017, the trust’s income was £532 million. There was a deficit (shortfall) over costs incurred of £42.9 million. NHS improvement placed the trust in financial special measures with a recovery plan implemented in October 2016. The trust achieved its savings recovery plan and had special measures removed in June 2017.

As of October 2017, the trust had a planned deficit of £18.7 million, which was in line with the agreed total with NHS improvement.

What people who use the trust’s services say

In September 2017, the trust scored lower than the national average in the NHS Friends and Family Test results (percentage of patients who would recommend the hospital) in the emergency department, maternity, inpatients and outpatients.

The NHS inpatient survey 2016 had mixed results. The trust performed better than other trusts in one question (enough privacy when discussing treatment/condition) and worse than other trusts in three questions (call button response time, waiting to be admitted and transition between services, information sharing). The trust performed about the same as other trusts for the remaining questions.

Results from Patient Led Assessment of the Care Environment (PLACE) surveys showed results in line with the England average. The most recent data at the time of our inspection, published in August 2017, showed a cleanliness score of 95% against a national average for acute services of 98.4%.

The trust improved its rating in the National Cancer Patient Experience Survey, published in June 2017, an overall rating of 8.7 out of 10, which is in line with the national average and six questions benchmarking above the expected range and two below, which also improved from the previous survey.

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 largely had the appropriate range of skills, knowledge and experience to perform its role; we did identify some areas for development and we fed those back to the trust. The trust board members we met were a group of individuals with a wide range of experience, knowledge and skills and had mostly been in their positions for some time. The Chief Executive Officer had been in position since 2013. The Medical Director had been in position since 2009. The Director of Nursing had been in position since 2011. Other longstanding executives included; the Director of Operations who had been in position since 2014, the Director of Finance, Performance Planning and Information who had been in post since 2007, and the director of Estates, Facilities, and Capital Planning, who had been in position since 2000.
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 board had their skills, knowledge, experience and integrity evaluated on an ongoing basis through an annual analysis of the skills and knowledge base. This was used to identify any gaps and inform development needs going forward. However, we found that many members of the non-executive team had not received safeguarding training for four years.

Succession planning was being developed throughout the trust. Succession planning for board members included the appointment of deputies for all executive directors, together with a development programme for specialty leads.

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. We examined the files of two executive directors and three non-executive directors and found that they were all in order. The trust policy on the fit and proper person regulation had not changed since our inspection in December 2015 and was in line with the legislation. Records were kept of recruitment checks made for all executive directors. NHS Improvement (previously the Trust Development Authority) appointed non-executive directors. Disclosure and Barring Service checks were undertaken for all executive and non-executive directors at the trust. 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.

The non-executive team were well informed and engaged with the senior team and formed an integral part of the effectiveness of leadership within the trust. We spoke with the non-executive directors as part of a focus group. There was a range of skills in the non-executive directors. From the focus group, we were assured of their significant skills and experience. Some of the non-executive directors described good working between the executive and non-executive teams.

The trust was in the process of devolving leadership of divisions from a few individuals to divisional ‘service line management’.

This process had started in June 2017 and was not fully embedded during the well-led inspection. However, the trust recognised that this change was work in progress and had identified a 12-month period of implementation. Some executives found there was a lack of engagement with specialty leads with a lack of clarity around their roles. As this had been identified, they were working with these staff to develop a programme of training. A triumvirate of managers consisting of a clinical director, manager, and lead nurse led each division. A gap analysis for the leadership triumvirate had been conducted and training developed using an external company. There were also plans to introduce additional bespoke training and human factors training.

We found that one senior team member had a large portfolio of work, which meant that they were unable to give key areas of risk within those areas sufficient and consistent attention. This included managing a large number of complex services, specifically volunteering, the chaplaincy and bereavement service, patient experience, safeguarding, patient survey and complaints.

Infection prevention and control fell under the leadership of the director of nursing and medical director at the trust. Consultants for both nursing and medicine infection prevention and control reported directly to these directors and this proved an effective method for communicating relevant issues at board level. Those holding leadership positions within infection prevention and control
felt autonomous in their roles, with support available from the executive team. This enabled them to be visible and approachable at operational level, as well as using the structure around them to communicate to executive level. The infection prevention and control team produced an “Annual Infection Prevention and Control” report, which was presented with additional bi-monthly updates to the board.

Vision and strategy

There was a clear vision and set of values with quality, safety, and sustainability the top priorities. The values were:

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

The values were determined through a staff and patient engagement exercise and were reviewed in 2016. Not all staff could readily identify when asked what the values were during our focus groups, but remembered when prompted.

There was a high-level strategy (for the years 2016 to 2021) associated with the vision and values which detailed eight strategic themes. 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 board developed the strategy through a series of workshops and away days. Once the board agreed a draft, it was subject to feedback from staff, the public, patients and key stakeholders (including the local clinical commissioning groups and local authorities).

We found that despite lots of activity and actions to achieve strategic objectives and manage risk across the divisions and departments, these were not linked in with the overarching strategy. We asked various members of the executive team and found that although they could clearly detail a number of actions that they were undertaking against various objectives there did not appear to be any formal or overarching framework to ensure these aligned with the high-level strategy.

For example:

There was no specific patient experience strategy; during the inspection, we were informed that there were many ongoing actions. The head of patient experience could describe various actions being planned which including patients becoming more involved in decision making and changing the wording of text messages to improve NHS Friends and Family test results. We were shown a patient experience plan for 2017 to 2019 dated March 2017, which was aligned with the trust’s objectives.

The information management and technology team did not have a strategy. We were told this was because focus had been on improving remedial systems in need of attention in order to get to the
point of identifying a vision for the team. To address this, the team had been working to an annual plan, which clearly set out the aims of their work for the given year and was aligned with the trust’s objectives. This had worked well to focus and drive information management and technology within the trust.

There was no workforce strategy. However, a people plan was being developed and was presented to a workforce committee in early November 2017. There were no updates in the board assurance framework to state that this had been completed. A board assurance framework is a method of setting out the strategic risks facing the organisation.

There was no estates strategy. However, the uncertainty of where services would be located with the development of the local sustainability and transformation partnership the trust had other priorities. Despite this, executive and senior staff told inspectors of many actions that were ongoing. The hospitals ongoing development made up a large proportion of the actions and included how these actions fit into the wider system plans. This included proposals for the maternity unit and the local mental health trust.

At the time of the inspection, the trust did not have a quality strategy in place. However, a strategy was planned to be signed off in March 2018. This strategy planned to encompass patient experience, patient pathway, a transparent culture, effective outcomes and efficient and cost effective care.

The quality improvement team could demonstrate how they were using quality improvement methodologies. However, there was no strategy for quality improvement.

Senior staff recognised that the development of a quality safety agenda was a priority to ensure the developments of an embedded safety culture but it was not clear how this was being developed or implemented, or when this would be in place.

The executive team had mixed confidence about the trust’s ability to deliver the winter plan. All executives recognised that flow was the single biggest risk to the trust and felt that they were, in some areas, well prepared. For example, one executive said that they were confident that they had engaged staff and there was clinical ‘buy in’ into the plan. However, one executive recognised that the winter plan would only address the risk in some elements but not in entirety and felt that the pressure the trust would be under, concerning demand and capacity, would make the plan difficult to embed. Other executives said that despite the winter plan there were lots of risks and variables, which the plan could not take account of, for example surges in demand.

There were also concerns raised about the time it had taken the plan to be ready for board sign off. Executives raised with inspectors how multiple versions had gone to the trust management team meetings before it was ready. Some executives felt that the planned start of the plan in the first week of January would not be achievable and that the second or third week would be more realistic. This would increase the pressure on the hospital to manage the demand in the beginning of the calendar year. It was therefore, of concern that not all senior leaders had confidence, or were invested in the winter plan.

There was a clear sustainable development management plan, which was linked to the trust values and vision. The trust board approved the most recent sustainable development policy in March 2017. The director of estates chaired a sustainable development steering group quarterly. There were representatives from the patient panel and trade unions as part of this group. Actions that the plan has achieved included: the establishment of a sustainability impact assessment for all capital planning projects; training to raise awareness to clinical staff about sustainability; and they had adopted an environmental management procedure for estates staff and contractors.
There were clear plans aligned to a robust cost improvement process to ensure that required savings were met. We were given examples where greater savings could have been made, but were refused due to impact on patient care. These included changes to the cleaning service, and the closing down of some radiology rooms. We were also told that senior nurses’ administrative time had been protected. There were initiatives which had both created savings and improved quality. For example, the increase in substantive nurses and the reduction in agency reliance within the trust. We were told that it had been over 12 months since the last agency healthcare assistant was required. However, staff told us that there had been cuts to some services in some areas, such as housekeeping, which meant that healthcare assistants often had to take on some extra roles like cleaning and serving meals and hot drinks, which put additional pressure on them completing their set roles. Other staff told us that in reality, senior nurses were not able to complete their administrative duties in a timely way, as they were often included in the numbers of staff on the ward.

The trust had a research strategy which spanned 2017 – 2022 with a key theme being to enhance patient care using research.

The infection prevention and control team were working hard to address its identified priority areas of work. This included management of E Coli and Pseudomonas infections within the trust. Working alongside the clinical commissioning group, the team was looking at a programme of work via the quality improvement programme to reduce rates further.

There was a limited strategy associated with the quality improvement programme. However, during the factual accuracy process CQC were provided with an “infection prevention and control annual programme 2017/2018 which was aligned to trust objectives. This action plan was not dated and there was no evidence of actions being discussed or updated in the time period that this had been in use.

Culture

There was a range of experiences for staff working at the trust. During this inspection we held three focus groups: a general drop in for all staff: a nurse and allied healthcare professionals focus group; and a medical focus group) which 74 staff attended. This was separate from the Non-executive director focus group. Some staff commented that they were well supported by their managers and felt respected and valued. For example, one staff member was proud as to how they were supported to improve and develop within the organisation. However, others, particularly health care assistants, said that this level of support was not universal and felt undervalued as a result. One member of staff we spoke with described how they had their job description changed without consultation. A group of staff spoken with discussed how they were scared to speak up to their managers when they had concerns, while others escalated problems and concerns but found there was limited to no action taken as a result.

Most staff commented on the challenges with flow and capacity in the hospital. Some staff said there were not enough staff to manage the numbers of patients put on the wards, particularly out of hours. While others commented that, the computer systems they needed to use to maintain high levels of care were cumbersome and difficult to use.

Despite this, all staff were universally proud of the care they were delivering despite the challenges in the trust. One member of staff commented “I see excellent care everywhere” and another commented, “The face to face care we provide is amazing”.

The executive team felt the culture varied within different divisions, and this was being addressed in different ways. We heard how from a strategic point of view, the trust was planning to review the
values and aiming to get key groups of staff working more closely together. The medical director had a clear understanding of how the move to divisional working had been received in each of the divisions, and where they were in their journey. We noted during the inspection that despite the number of months that had passed since the service level management changes had been implemented, there remained uncertainty with some senior staff and divisional teams around accountability, roles and reporting structures. This meant that the planning and implementation of this significant change had not been as effective as it should have been; some senior staff reported to us that they were largely reacting to these changes, and had not been fully informed before they were rolled out.

The trust performed worse than other trusts in some areas of the NHS staff survey 2016. The overall engagement score was lower compared to other trusts in England. The rate of staff reporting good communication was much lower compared to other trusts in England, however had shown improvement from 2015 to 2016. The staff recommendation of the organisation was much lower compared to other trusts in England. The percentage of staff experiencing harassment, bullying or abuse from other staff was worse when compared to other trusts in England. The percentage of staff experiencing discrimination at work was better when compared to other trusts in England. The trust’s performance for the staff friends and family test remained the same between 2016 and 2017 for the percentage of staff who would recommend the trust for care. The percentage of staff that would recommend the trust as a place to work worsened between 2016 and 2017.

The NHS inpatient survey 2016 had mixed results. The trust performed better than other trusts in one question (enough privacy when discussing treatment/condition) and worse than other trusts in three questions (call button response time, waiting to be admitted and transition between services, information sharing). The trust performed about the same as other trusts for the remaining questions.

The trust published information regarding equality and diversity on its website. Since 2009, the trust had published annually its equality report. The trust also published the equality and diversity committee meeting minutes going back to February 2011. However, there had been no minutes updated since January 2017. The trust published its equality and diversity policy and its good communications guide.

In 2016, the trust undertook a census survey with an overall response rate of 32% (401 respondents in total). In the survey the percentage of BME staff reporting harassment, bullying or abuse from staff in the last 12 months had increased from 2015 (31.8% in 2016 compared with 23.7% 2015. This was higher than the average for acute trusts, which was 27%.

The percentage of BME staff expressing they had personally experienced discrimination at work from a manager, team leader of colleague had also increased. In March 2015 16.7% of BME staff expressed in the NHS staff survey that they had experienced discrimination whereas in March 2016 this had increased to 20.5%. This was higher than the national average for acute trusts, which was 14%.

During an interview with the equality and diversity lead, a number of actions to reduce bullying and harassment and discrimination were in place. This included using ‘message of the day’ emails, staff engagement meetings and introducing BME champions. However, has not been shown to be delivering improvements as the NHS staff survey had indicated as bullying and harassment was increasing. There was also limited evaluation of the actions taken. Managers could not assure inspectors that there were appropriate actions to plan and understand the issues. The equality and
diversity lead said, “People were reluctant to report” due to “fear of what will happen” and they told inspectors “if people don’t report it then we can’t do anything.”

The trust has subsequently gone on to tell us that they recognised that BME staff may be more vulnerable to negative behaviour than other members of staff and stated that it was reflected in the Trust Equality Objectives for 2017/18).

Complaints data was reported in the integrated performance report, which was presented to the board. Between November 2016 and October 2017 between 35 and 62 complaints were received each month. Between the same dates, the number of concerns received was between 50 and 71 each month. During the inspection, we found that there was not an adequate process for recording informal concerns. Any concerns raised by patients or relatives would be addressed initially by the ward staff, and not all of these when resolved, were being logged as a concern. This meant that opportunities for developing accurate themes, data, and crucially, opportunities for learning might have been missed.

The implementation of a new electronic incident management system was due to go live in December 2017 would allow all staff to enter concerns, the outcome, and actions taken.

The 2016/2017 annual complaints report presented to board in September 2017 stated that 99.85% of complaints were acknowledged in a timely way compared to a 95% national target.

Although improving over time the ‘integrated performance report’ for October 2017 indicated that only 81% of complaints were completed within the agreed timescale. Of the complaints that were overdue, five were one to ten days overdue, three were ten to 20 days overdue, and 11 were greater than 20 days overdue.

During the factual accuracy process we were presented with a management plan for complaints to improve compliance which was being completed in corroboration with the clinical commissioning group. Actions were due to be completed by February 2018.

Between January 2017 and October 2017 12 cases had been referred to the Parliamentary Health Service Ombudsman. None of these cases were fully upheld, one was partly upheld, and two were not upheld. Nine cases were still awaiting completion.

We reviewed ten complaint letters and found that the quality of letters were variable with some being worded badly. We found that some of the letters did not cover all elements of the patients concerns and in some cases were dismissive of the claims made. Patients did not receive copies of investigations nor was learning taken from the complaint always addressed.

The trust had a complaints team known as the ‘Advice and Complaints (ACT) Team’. Ward and other hospital staff were the first port of call for any concerns or complaints as the trust’s philosophy is to deal with issues immediately wherever possible. Information leaflets provided in all ward reception areas and on the trust’s website or through signposting by front line teams. We did find that physical access to the central team was restricted to some extent, as there was no patient-facing office for patients or visitors to go to while at the hospital. However, the team had a policy of ensuring calls were returned within two hours and this is routinely achieved.

The trust had appointed a named Freedom to Speak-up Guardian in line with the principles and role profile produced by the National Guardian following recommendations of the Francis report. Their role is to work with leadership teams to create a culture where people are able to speak-up in order to protect patient safety. The named guardian was a non-executive director (in position since 2015) with the director of people and transformation providing oversight of the arrangements. The November 2017 board paper noted Freedom to Speak-up Guardians had been
appointed in each division and corporate directorates to compliment the two board level guardians. Staff were due to be notified through emails and newsletters once training had been completed.

The trust whistleblowing policy was out of date. It was due for renewal in September 2016 after being published in October 2013. We spoke with the guardians who said they were looking to rectify this, as it did not take into account changes to human resource policy or joint work undertaken by NHS Intelligence and NHS England. A working group was to be set up (working collaboratively with human resources and the director of people and transformation) to achieve this. There was no recognition in board papers which identified this as a concern.

A programme of meetings was being developed to ensure that the board level guardians and the divisional level guardians met twice a year. One senior guardian discussed with inspectors how they felt this may not be the best model going forwards and was looking to find ways to get the divisional guardians more active. However, this was not recorded in any action plan.

There were plans, particularly around communication, to encourage speaking up in the trust. This included a confidential telephone line and building stronger working relationships with staff side. However, this was not recorded in any strategy, action plan, or board paper seen.

In a 12-month period, freedom to speak up was only mentioned once at board. There were no formal reports presented to board updating them on ongoing actions or projects. Therefore, we could not be assured that the board had sufficient oversight or scrutiny around speaking up and whistleblowing.

The director of information management and technology at the trust clearly articulated the link between the role of the team and patient experience and explained that this guided how work was prioritised. For example, he stressed the importance of ensuring outpatient systems worked to assure the quality of that patient’s experience.

There was an active and visible culture of research at the trust, which was communicated through a variety of sources. The leadership team encouraged development of staff and patient care through active research and development programmes.

**Governance**

Executives were clear about their roles and understood what they were accountable for, and to whom. However, some senior staff we spoke with discussed how roles were becoming unclear with the development of service line management. However, the trust was partway through a planned process to implement service line management. There was a clear organisational structure for the various corporate functions: facilities, informatics, finance, people and transformation, operations, nursing and quality and research and strategy. Each function had its own organisation chart, so staff could easily locate one another in their specific area of responsibility.

However, not all levels of governance and management functioned effectively or interacted with each other appropriately.

Executives recognised that governance arrangements within the divisions were a work in progress. There was not consistency between the divisions in terms of how they run, reporting structures or their effectiveness. Following on from the substantial changes to the service line management and the known concerns around inconsistencies within the divisional teams, the trust had plans to assess or evaluate how the divisions were run at the time of our inspection.

We were told that the corporate governance structures had not changed as part of this restructuring and that assurances were still gained through the various committees and meetings.
up to the board. However, we found that some executives did not have knowledge of some risks that were picked up during the inspection. For example, one executive was assured that mental capacity act (MCA) assessments were being completed appropriately. However, during the core services inspection we found that a significant number of MCA records checked were incomplete. Within the end of life core service, we found only one out of 35 patient records had completed mental capacity act assessments.

Concerns were expressed to CQC about staff on the ground raising concerns when they required support. We were given examples where because of escalating problems actions had been taken to improve practice (such as the implementation of the ‘happy app’ in surgery). However, we were not provided with assurance that this confidence to speak up was happening everywhere or that the trust were doing everything it could to identify and support struggling services. One executive commented that this was reflected in the areas of the staff survey that required improvement. We were given examples where senior managers could not provide assurance that processes captured all information to learn from complaints. We were told that engagement with the divisions and ownership of complaints could be improved, although we found this worked very well in the emergency department. This led to an inconsistent approach to managing complaints and variations on quality. We were told that opportunities for learning from complaints were sometimes missed and completion of action plans were not always done in a timely way. We were told that within the divisions and that evidence to uphold or not uphold a complaint could be better.

During the factual accuracy process we were provided evidence of plans for how the trust were going to utilise new computer systems being implemented in December, to monitor the quality and completion of complaints investigations.

Governance arrangements for safeguarding were clear. The trust had a specific leads for adults and children’s safeguarding with senior oversight obtained from the head of patient experience who reported to the Director of Nursing. However, due to the size of the portfolio held by the head of patient experience, we were not assured that this oversight was sufficient. There was a named safeguarding nurse who was the lead for children’s safeguarding and a named safeguarding doctor who worked clinically within the emergency department. Staff on the wards would escalate safeguarding concerns to their managers. Either concerns would be escalated to the adults safeguarding operational group or the children’s safeguarding operational groups which were held bi-monthly. This would the escalate to a safeguarding committee chaired by the director of nursing or the deputy director of nursing who would escalate concerns to a quality committee and then a quality risk management committee before being escalated to the board.

Inter-organisational governance arrangements for safeguarding were clear. The safeguarding leads were active parts of the local safeguarding board (for both South Gloucestershire local authority and Bristol local authority), parts of local authority sub groups and serious case review groups, local authority led domestic abuse forums and the PREVENT partnership forum.

With regards to patient experience, there were processes to ensure that information was gathered from partners and third-party providers. There were good links with Healthwatch who sent quarterly reports to the trust. There were also processes to work with the local community provider to gather patient experience information which translated into actions and learning.

Patient participation within the trust could be improved areas across the trust. Patients were involved with various committees and groups including clinical effectiveness, patient safety, safeguarding, clinical audit and intensive care mortality reviews. However, since the move to the new hospital in 2014, patient participation audit had stopped. Audits included a patient
engagement audit which gave good insight into patient experience and actions for staff to complete. We were not informed that this was going to be re-introduced.

The trust were implementing systems to identify learning from deaths as a result of national guidance following the publication of ‘learning, candour and accountability’. This was discussed in detail at the November 2017 public board.

There was a clear governance structure around learning from deaths. Monthly data from deaths was available in the board integrated performance report which included the number of deaths, the number of cases with completed reviews, the number completed through a structured case review as well as those declared as serious incidents. Additionally to this, going forward, a quarterly board paper would also be presented identifying themes, issues, actions taken and actions planned as well as an impact assessment of actions. A trust board paper described how an additional annual report will be provided to the quality and risk management committee and a report will be published in the trust’s quality accounts.

The trust met the standards expected of trust boards nationally by having the medical director take responsibility for the learning from deaths agenda and a non-executive director to oversee the agenda.

The trust had published a policy for the management of deaths within the timeframe set by the national guidance. However, the policy did not explain which patients are determined to be under the care of the trust or another organisation (which would determine who would conduct the review), or which patient groups would be specifically excluded. It also did not explain how to report a death within the organisation to another organisation that need to be notified. Nor did it explain the process involved if another organisation suggested a review should be undertaken. The policy did discuss how to respond to the death of an individual with a learning disability, mental health need, an infant or child death, maternal or stillborn.

Not all specialities used the same method for reviewing deaths, and at the time of the inspection one speciality (neurology) had yet to develop the necessary tools to conduct the reviews.

The policy provided a short dialogue on how staff must engage in meaningful and compassionate conversation with bereaved families and carers. However, this did not set out an auditable standard on how this would be done, measured or monitored. There was also no single point of contact explained for relatives going through the process explained in the policy. The policy also provided limited information on supporting patient with the expectations for reasons, purposes and involvement of any lawyers.

The trust was implementing a structured case note review programme of all deaths. Between April 2017 and July 2017 there had been 575 deaths. A review programme was underway in which 50% of cases had been screened. The trust’s system enabled a judgement to be made of care from ‘very poor’ to ‘excellent.’ Of the total number of deaths 85% were deemed to highlight good or excellent care with 13% being described as ‘adequate’. Two cases had been flagged as identifying poor care. One of these cases focused on post-operative ward care with actions and the second case was under investigation.

The trust board paper presented in November 2017 on deaths identified themes from the case reviews which included recognising the deterioration of patients, recognising when a patients is approaching the end of their life and medication safety. However, this report did not provide any assurance of actions taken immediately or actions to be taken in the future to improve practice and patient safety.
The capital planning programme had a focus on the information technology infrastructure at the time of the inspection. There was a programme to replace equipment to manage the upcoming changes in records management from paper to electronic systems. A capital group presents business cases to the trust management team meetings which then get discussed at board.

**Management of risk, issues and performance**

We reviewed the board assurance framework. It set out a control framework to manage them, and how the trust should satisfy itself that the controls are working as intended. Risks identified in the board assurance framework were linked to the trust’s strategic themes. When we spoke with senior managers about risks we found that what they were saying was in line with the risks identified in the board assurance framework.

The framework identified actions for the most important risks. However, deadlines of five actions were not met. There were actions regarding hospital flow (the highest risk in the organisation) which were due in July 2017 with no updates documented on progress.

The board assurance framework sought to ensure there was a balance of assurances from internal and external sources. It had been commended by an external auditor as providing “significant assurance”.

We reviewed a selection of board papers. We found that they provided a large amount of detailed information. However, we found there was limited assurance demonstrating that actions identified would be effective or would mitigate the risk.

We reviewed a selection of minutes from the quality committee and the quality and risk management committees. We found that they identified some serious risks and concerns and provided reassurance that they had been managed appropriately through reporting. However, there was limited discussion around how they will be assured such incidents would not happen again or about what learning had been taken from the incident occurring. For example, one set of meeting minutes identified issues with transport of patients from different providers. There was no discussion about lessons learnt or mitigations to prevent incidents from occurring in the future.

Some executives were concerned that due to the scale of some of the risks, they were managing the symptoms of risks rather than the risks themselves. This led to actions sometimes being reactive rather than proactive.

The process of feeding back learning to staff on the ground for specific incidents could be improved. Staff we spoke with in focus groups said they rarely got individual feedback on incidents and felt that they missed opportunities to learn from what has gone wrong. However, the trust was introducing a new computer system the week following the inspection which it was hoped would improve the mechanisms for feeding back to staff.

The non-executive directors recognised that the management of risk was not as is should be. One said that the management of risk was “not as mature as we would like it to be”. However, commented that improvements were being made, particularly around the introduction of a new incident reporting and risk management system during the week of the well led inspection.

The director of operations discussed how the trust manages the risk of demand and capacity. We were told that there used to be a queue in the emergency department corridor which has now been split to a queue in the acute medical unit. The rationale for this was to disperse risk across the site rather than hold it all in the emergency department. The deputy director of operations manager and the site management team managed this process. We asked if any risk assessment had been undertaken prior to this change in process, and the director of operations told us that
that the director of nursing would have done this. The director of nursing was not able to direct us to any risk assessment however.

During the factual accuracy process, we were provided with two risk assessments for the emergency department corridor and the use of the acute medical unit. However, we found that the emergency department corridor risk assessment was not dated and had not been reviewed since January 2016. The acute medical unit risk assessment, although issued in July 2017, had no indication that it had been approved by the relevant staff.

To manage flow throughout the hospital there were site management meetings and system review meetings with external stakeholders. Executives told us that this process was improving and was becoming more effective. Some senior staff approached us during the inspection to tell us that the site management meetings were not effective, and there was rarely any senior presence at those meetings. We were also told that the site management team had been under review for two years, but that little had changed. Some staff we spoke with did not feel that the senior managers responsible for flow and bed management were visible. We were told that there was more that could be done by the senior operational team internally to support better flow throughout the organisation, but that they did not feel their suggestions for improvement were being listened to.

The trust had a health and safety risk register which identified risks associated with regulation and guidance compliance related to the estate and infrastructure of the trust. Associated with this was an audit plan with outcomes feeding into the capital planning group and the quality improvement group.

A “Sepsis group” met monthly in the trust, and was chaired by a medical microbiologist. The group had succeeded in implementing a sepsis management tool resulting in improved performance in this area when it was audited by the quality improvement team.

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.

The safety programme at the trust had been built over the previous 10 years, enabling and empowering local teams to make improvements. This included work on sepsis screening and early warning scoring, as well as infection prevention and control.

The safeguarding team were able to appropriately respond to requests for support, however could not provide assurance that all safeguarding concerns were being picked up and acted upon appropriately. The team had recently had an increase in resource to include (in addition to the safeguarding leads – adult and children) one new specialist safeguarding practitioners and one additional administrator. This allowed the team to respond and to have more dialogue with heads of nursing within ‘service line management’ and with external agencies to provide guidance and support. The responsibility for managing safeguarding concerns was within the service lines and the safeguarding leads could not provide assurance that actions plans were being completed in a timely way, or provide assurance that all safeguarding concerns were identified and acted upon.

We reviewed ten completed serious incidents investigations as part of this inspection. We found their completeness to be mixed.
Generally the recording of basic facts and findings was positive. All incidents had a STEIS (Strategic executive information system) number indicating external reporting, individual incident reporting numbers, background summaries, descriptions of events and executive summaries. A separate front sheet contained the date of incidents, dates reported, harm levels and authors information.

The investigations were not always people focused and did not do everything possible to engage patients, families and carers. We found that in only one investigation out of ten was the patient, family or carers involved in the setting of the terms of reference. In six investigations we found no evidence that there was a support plan created for the patient, their family or their carers.

There was one incident investigation where the patient was living with a learning disability. However, we found there was limited consideration of this when involving the family and carers in the process.

Reviews and investigations focused on learning. We found that all investigations established the facts well, looked for improvements rather than blame, provided a means to sharing learning, ensured that care management and service delivery problems were recorded and ensured that action plans were created. However, in four of the ten investigations reviewed we found that areas of good practice had not been identified.

The investigations were mostly led well and credible. Investigators were independent from the care given, reports were clearly written and easy to read, contributory factors were recorded and lessons learned sections were completed and there were immediate actions and clear conclusions recorded. However, on six of the ten incident investigations the terms of reference had not been completed. On all ten of the incident investigations it was unclear who had received root cause analysis training and on only one occasion was a decision tree used. This meant the trust was not consistently following its own policy.

Where required, investigations were done in a collaborative way across the care system. There was a system-based approach taken that involved other organisations. This ensured that lessons learned were shared across a system rather than remaining within the hospital.

**Information management**

Trust leaders were able to gain a holistic understanding of performance through the trust’s integrated performance report. This was comprehensive and displayed data under the CQC’s five domains. This information came from a range of data sources including:

- Operational data (emergency department performance, delayed transfers of care, referral to treatment, operation cancellation information, and cancer standards).
- Workforce (nursing staffing, maternity staffing, staff utilisation, training).
- Safety information (documentation completeness, incidents data, medicines, infection control).
- Hospital standard mortality.
- Patient experience (friends and family test results, complaints and concerns).

Information technology systems were being used effectively to monitor and improve care at the trust. The trust was in the process of moving towards a “paper light” system. This aimed to reduce the amount of paper records used at the trust to include only the bare minimum needed to care for patients. At the time of our inspection, historical notes were in the process of being scanned onto the electronic system through a systematic programme. The vision for this process was that paper case notes would not be in use at the trust by the end of 2018.
At the time of our inspection, the trust was approaching the implementation date for a new reporting system. This aimed to improve the quality, and accuracy of information. A representation group identified the requirements of this system had been identified and presented to the project board. The same group completed user testing which aimed to provide assurance to both users and the board that the system would be fit for purpose.

The information management and technology team had a business continuity plan which aimed to build resilience into the systems used at the trust. However it was identified that this plan would need to be reviewed at such time as the trust relied more heavily on electronic systems and moved away from paper based working. As part of this drive, a business plan was approved for the finance necessary to upgrade the wireless network systems, to lessen the risk of system outage on the site of the hospital.

Board directors we spoke with were aware of national risks such as cyber security and were confident that the trust’s IT systems were suitably protected against these kinds of attacks. The assistant director of information management and technology held responsibility for the management of cyber security of the trust. Systems were backed up away from the network which protected it from the effects of cyber-attacks. The trust had not been affected by the ransomware virus attack earlier in 2017.

Senior managers could not be assured that all complaints were logged appropriately. Although many staff had been trained to use the computer system. We were also informed that current systems did not allow them to compare data to produce coherent themes. The change of computer system at the end of the inspection week however, would allow them to do this.

**Engagement**

The trust did not collect information from the bereavement team about feedback from families of deceased patients, as per the requirements of the learning from deaths policy. However, the trust had subsequently told us of plans to introduce this.

The trust was actively involved in the development of the local sustainability and transformation plan. However, many executives commented that the plans were under-developed due to a restructuring in the local clinical commissioning group arrangements.

The trust had a large cohort of volunteers who actively engaged with patients, relatives and carers. ‘Move makers’ were a large group of volunteers. They 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 and a befriender service that was allocated to wards to talk to patients.

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 friends’ 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.

There were a number of projects set up as part of the sustainable development management plan to engage with patients, relatives and carers to reduce the carbon footprint of the trust and improve healthcare sustainability. Projects included a NHS sustainability day, a green impact roadshow and a travel smart roadshow; and the establishment of a weekly staff lunchtime health walk. There were also innovative projects set up including a Southmead lavender project. This project was set up to use the lavender planted around the site to make into pouches and sell to
raise money for charity. The trust was also raising funds to set up a patient and staff allotment to promote health and wellbeing.

The hospital had an herb garden, which volunteers and staff tended to. The catering department and by clinicians used the produce from this garden to assist in active therapy to promote patient recovery.

The trust had an engaged staff side. There was a joint union committee representing eight trade unions met monthly. Between 15 and 20 people representatives attended each month. Additionally to this a joint consultation committee was health monthly with attendance from the director of human resources, director of operations, director of nursing and director of finance. Staff side also met with the chief executive three times a year.

Despite this engagement members of the staff side we spoke with felt that there were limited outcomes and that what they were told did not necessary reflect the action eventually taken.

Senior staff discussed the risks associated with the move to a new site and the ongoing management of risks relating to the site. They described a positive working relationship with the private finance company who own the building. There were also good relationships with external providers such as security firms and buildings contractors.

**Learning, continuous improvement and innovation**

The trust’s quality improvement team had a strong focus on improvement and encouraged staff to find innovative solutions to their work. The quality improvement team (consisting of one quality improvement lead, one practitioner and a consultant) had a focus on supporting staff to deliver projects. The medical director had executive oversight of the quality improvement team. A quality improvement hub was staffed every Thursday as a drop in for staff to attend and share ideas. There was also regular communication shared with the trust to encourage quality improvement.

In the July 2017 a paper was presented to the board discussing the quality improvement team's improvement plan. This plan was developed in conjunction with the national Sign up to Safety campaign. This discussed the effectiveness of the quality improvement teams training which all staff attend during induction and on an ongoing basis. Training in quality improvement has been delivered to 4000 staff and discussed new work, and the processes to implement a quality improvement project.

We were provided with various examples where the quality improvement team had a positive impact on patient care. For example, working with the trust’s diabetes team to reduce patient’s missing insulin medicines and working with the falls group on the wards to reduce falls. Various ongoing projects included work with the theatres team to introduce human factors training, and the introduction of the happy app (a real time tablet device to gain feedback from staff).

The quality improvement team were involved in the management of serious incidents. When a serious incident occurred the team attended the SWARM meetings. A SWARM meeting is a debrief for all staff within 48 hours of the incident occurring to ensure that any immediate learning taken can be implemented quickly. Actions resulting from this included a safety alert following a serious fall from wrongly assembled seating, changes to theatre practices and better communication of best practice management relating to pressure injuries.

There were divisional quality meetings held where risks would be escalated to various boards and committees. This included cancer services, clinical audit, clinical effectiveness, clinical risk, control of infection, drugs and therapeutics committee, patient experience group, quality surveillance group, risk and compliance, transitional standards group and safeguarding. This would then
escalate risks to a quality committee and then onto a quality and risk management committee before risks were raised with the board.

The trust gave innovation and research priority. The director of research at the trust held the same role within a neighbouring trust and we were told that a key aim of work in this area was to ensure equitable access to research opportunities for both patients and staff. Research was given significant attention at executive level, with pride taken in the trust being a “research friendly” organisation.

We learned of substantial research activity at the trust, which employed 96 whole time equivalent nurses within the research team. Improvement work included participation in research projects and recognised accreditation schemes. We were told that at any one time, the trust could be involved in between 400 and 600 active trials or projects. Involvement in these was further encouraged for other staff through the use of secondment opportunities. The ensured that staff had a better understanding of research at the trust. Research teams worked closely with clinical leadership to encourage innovations and ensure that developments through research resulted in clear improvements to patient care.

Ideas for research were encouraged from staff outside of the research team. The research team held a “priming fund” which aimed to support such staff to complete applications and get processes to carry out research. For example a team in the emergency department were leading their own research that looked at the benefits of a blood test which could indicate whether a patient was experiencing a heart attack at an earlier stage. The hope was that this could have significant benefits for patients, but also potentially improve flow through the department by minimising delays caused by waiting for other tests.

Where deaths were the result of a serious incident, we learned that the investigations into these, took priority over the death review process.

The trust took seriously its role as a learning organisation. For doctors who were not in a developmental post, opportunities were presented for continued learning in their role. A tutor with specific responsibility sat within the post graduate team, and managed a budget to ensure opportunities were available for these staff. Supervisors were allocated medical staff in a clinical fellows' role, who were responsible for appraisals and continued professional development.

Staff received training on female genital mutilation, child sexual exploitation and modern slavery as part of their safeguarding training. There were bespoke training packages available for the highest risk areas (the emergency department and critical care) however the safeguarding team recognised that this training could be improved for other areas, partially for medical staff.

Staff in focus groups commented positively on learning from incidents and complaints. Staff described local resolution meetings to resolve issues and locally share learning. Others described ‘listening through action’ as a process to ensure that learning was taken and cascaded appropriately when an incident occurred. One member of staff said that the “trust is willing and prepared to learn” another said that the trust “is a very supportive environment for learning”.


Acute services

Urgent and emergency care

Facts and data about this service

The trust has one emergency department (ED), located at Southmead Hospital. The ED is open twenty-four hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries, which need prompt treatment.

As the major trauma centre for the Severn region, the emergency department has a helipad to enable air ambulances to land.

The department has a six-bay resuscitation area. One resuscitation bay contains equipment for children, although children requiring an ambulance were taken to the specialist children’s emergency department at the Bristol Royal Hospital for Children. There is a major treatment area with 11 cubicles and three side rooms. Less seriously ill or injured patients are seen in the minor treatment area which has eight rooms. There are three rooms equipped to treat children and a separate waiting room with controlled access. There is an observation unit and ‘stepdown’ area for major treatment patients. Ambulatory patients are accommodated in 16 cubicles with reclining chairs. There are three side rooms, equipped with a hospital bed and two equipped with a patient trolley. There is an imaging suite within the emergency department, providing plain X-ray, CT and ultrasound.

There is an adjacent observation unit and ‘stepdown’ area for major treatment patients. Ambulatory patients are accommodated in 16 cubicles with reclining chairs. There are three side rooms, one equipped with a hospital bed and two equipped with a patient trolley.

We previously undertook a comprehensive inspection of urgent and emergency care in November 2014. We identified serious concerns, particularly in relation to crowding, and we issued a warning notice. We conducted a follow-up inspection in December 2015 and saw significant improvements had been made. The issues identified within the warning notice had been addressed and the service was rated good overall.

This was a focussed inspection, to review safety and responsiveness. We undertook this inspection because we had concerns about the service’s deteriorating performance in relation to its four hour performance. The trust had been identified as one of the 20 trusts nationally being asked to take urgent action to improve four hour performance in ED.

We visited, unannounced, on 8 and 9 November 2017 during daytime hours and on the evening of 21 November 2017. During this inspection, we observed care and treatment of patients, looked at 10 treatment records and reviewed performance information about the department. We spoke with approximately 25 members of staff, including nurses, consultants, junior doctors, receptionists, managers, support staff and ambulance crews.

Activity and patient throughput

Total number of Urgent and Emergency Care attendances at North Bristol NHS Trust compared to all acute trusts in England.
There were 86,064 attendances between July 2016 and June 2017 at North Bristol NHS Trust as indicated in the chart above. Eleven percent of these attendances were children.

(Source: NHS England)

**Urgent and Emergency Care attendances resulting in an admission**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Previous</th>
<th>Latest</th>
<th>Change</th>
<th>National comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of A&amp;E attendances admitted</td>
<td>27,387</td>
<td>28,818</td>
<td>(+5%)</td>
<td></td>
</tr>
<tr>
<td>% of total attendances</td>
<td>32.4%</td>
<td>33.5%</td>
<td>(+1%)</td>
<td></td>
</tr>
</tbody>
</table>

The percentage of ED attendances at this trust, which resulted in an admission, increased slightly between July 2015 to June 2016 and July 2016 to June 2017, from 32.4% to 33.5%. In the latter period, the trust was in the upper England quintile in terms of the proportion of attendances resulting in an admission. This may indicate that the department saw a higher proportion of acutely ill or injured patients.

(Source: CQC Insight)

**Urgent and Emergency Care attendances by disposal method (April 2016 to March 2017)**

Please note the earlier time period for this data set.
Is the service safe?

Mandatory training

The service provided comprehensive staff induction training on employment and regular ongoing mandatory training in safe systems and processes.

Induction training for nurses comprised two weeks of orientation and training, during which time they were supernumerary. Training included management of specific conditions, for example, chest pain and sepsis, adult safeguarding, child protection and domestic violence, resuscitation, trauma and ‘see and treat’ competencies such as wound assessment suturing and stapling.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of August 2017 for registered nursing and medical staff in urgent and emergency care is shown below:

(Source: Hospital Episode Statistics)
The 85% target was met for six of the 11 selected mandatory training modules shown above for registered nursing staff.

The 85% target was met for seven of the 10 selected mandatory training modules shown above for medical staff.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Major incident training completion rates
In March 2017 an external audit of the trust’s preparedness to deal with a HAZMAT (accidental contamination with a hazardous material or CBRN (deliberate act of contamination with chemical, biological or radiological material) incident. The audit reported that the trust demonstrated it conformed to all requirements in the NHS EPRR Core Standards for CBRN response. It reported there was robust documentation of training and staff competence and that the trust had completed a live HAZMAT/CBRN exercise to test their capability.

**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 and where to seek advice.

**Safeguarding training completion rates**

The clinical commissioning group set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as of August 2017 for registered nursing staff and medical staff in Urgent and Emergency Care is shown below:

(Safeeguarding training completion rate (registered nursing staff)

<table>
<thead>
<tr>
<th>Safeguarding Adults - Level 2 - Yearly</th>
<th>Safeguarding Children - Level 2 - Yearly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion (%)</td>
<td>Target (%)</td>
</tr>
<tr>
<td>76.1%</td>
<td>67.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding adults:** The 90% target set by the clinical commissioning group was not met for registered nurses or medical staff for level 2 training.

**Safeguarding children:** The Royal College of Emergency Medicine Clinical Standards state: All emergency department medical 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. Compliance with these standards was as follows:

- 88.5% of medical staff and 67.7% of registered nurses had completed level 2 training.
- 70% of senior medical staff were up to date with level 3 training. Doctors in training, who
rotated to the Bristol Royal Hospital for Children (BRHC), were required to complete level 3 training but records of this training could not be retrieved from BRHC.

- The emergency department offered level 3 training to all ED staff- 91% of sisters/charge nurses, 88% of staff nurses and 86% of healthcare assistants had received this advanced training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff understood their responsibility to report concerns, they were familiar with referral processes and knew whom to contact for advice. They were able to describe situations which would trigger a safeguarding referral, including concerns about domestic violence, human trafficking and female genital mutilation. During our inspection, we saw two safeguarding cases, one relating to domestic violence, the other in relation to concerns for the safety of an unborn child. In both cases, staff had sought advice and were in the process of making referrals.

The emergency department maintained a database of referrals and staff received feedback from the safeguarding lead on the appropriateness of referrals.

**Patients with mental health needs**

Patients assessed to be at risk of suicide or self-harm were cared for in the major treatment area. Staff told us that additional staff, including registered mental health nurses, could be deployed to ensure patients were closely supervised. Staff we spoke with were aware of the Mental Health Act 2005 holding powers and told us they would seek advice from the mental health liaison service or the intensive service (providing night time support).

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

In the 2016 CQC Emergency Department Survey, the trust scored 9.4 out of 10 for patients describing the emergency department as clean. This was better than other trusts. Most staff had received recent training in infection prevention and control. We found that the department, including equipment, was visibly clean and we saw cleaning being carried out regularly. However, we found that housekeepers’ cleaning checklists had not been completed consistently in the week prior to our inspection and there was no checklist for the week of our inspection. We advised the matron of these omissions.

Staff observed safe hand hygiene practices. Regular hand hygiene audits took place and the emergency department achieved high scores. In the most recent audit, the emergency department scored 100%. During our inspection, we observed that staff complied with the practice to be ‘bare below the elbow’ and cleaned their hands in between patients. There were plentiful appropriate hand washing sinks and hand gel dispensers. Staff wore appropriate personal protective equipment, including gloves and aprons, which were readily available.

Waste, including sharps, was appropriately segregated and disposed of. There was an appropriately designed sluice for the disposal of clinical waste.

There were side rooms available in the emergency department where infectious patients could be isolated to prevent the spread of infection.

**Environment and equipment**

The service had suitable premises and equipment, which were well maintained.
The emergency department was spacious, appropriately designed and well laid out, to allow for easy access, circulation and good lines of sight. There was a dedicated ambulance entrance, which was a short distance from the ambulance parking bays and the helipad. This enabled quick and 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, trauma and stroke.

Within the department there was an imaging suite providing plain x-ray, computerised tomography (CT) and ultrasound.

The waiting area for self-presenting patients was designed to allow for good observation of patients in this area. There was a dedicated, waiting area for children. There was audio and visual separation of this area from the main waiting area and access to the area was controlled.

There was a dedicated room for conducting assessments of patients with mental health conditions. This had two doors, one of which could be opened either way and the room was appropriately furnished (with furniture which could not be used as a missile). There were two wall-mounted push button alarms. The room had recently been inspected against safety standards set by the Royal College of Psychiatrists. It had been recommended that the alarm buttons should be replaced with buttons which were flush with the wall to prevent these being used as a ligature. We judged that this did not pose a risk to patients, as they were not left unattended in this room.

The emergency department was well equipped, and there was evidence of maintenance and cleaning. We checked the equipment in the resuscitation area. Equipment was well organised and easy to locate. There was evidence of servicing and cleaning. Most equipment was in date. However, one portable suction machine was overdue for service. There were well-stocked resuscitation trolleys and checklists had been completed, with no significant gaps.

In the major treatment area, most equipment was labelled to show recent servicing/maintenance. There was a daily equipment checklist folder where staff recorded daily checks in all of the bays, including oxygen, suction and trolleys. We found some gaps, which may have been due to the bays being occupied but checks of oxygen and suction were consistently not recorded. This meant staff could not be assured that this equipment was fit for purpose.

**Assessing and responding to patient risk**

There were effective systems in place to assess and manage risks to patients.

**Ambulance handover**

Ambulance crews spoke highly of the staff in the emergency department and we observed a friendly and cooperative relationship between the two services. We saw ambulance crews, on arrival in the emergency department, providing a verbal handover to a registered nurse and booking patients in with a receptionist based in the area known as the crossroads. During our inspection, we observed this process was handled smoothly and efficiently and there were no significant delays.

The trust monitored ambulance handover delays, which occurred at times of high demand, when the department was crowded.

We looked at sample data for the week commencing 25 September 2017. In this week

- 82% of patients were handed over within 15 minutes.
- 15% were handed over within 39 minutes.
- 3% were handed over within one hour.
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. Between August 2016 and July 2017, there were 24 breaches at the trust’s emergency department. Half of these breaches occurred in December and January 2017 (four and eight breaches respectively).

Between January and July 2017 (a seven-month period), there were four black breaches.

In the 2016 emergency department survey, the trust scored 8.5 out of 10 in response to the question: “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?” This was about the same as other trusts.

Initial assessment

There was a clear process of streaming and triage in place for both ambulance-borne and self-presenting patients, which was in line with guidance from the Royal College of Emergency Medicine (RCEM).

RCEM acknowledges that systems and processes to perform initial assessment vary and there is no ‘one size fits all’ system recommended. They have set out the objectives of initial assessment as follows:

1. Improving safety
2. Identifying acuity to ensure that the most time-critical patients are treated by the right service within appropriate time frames, and that appropriate prioritisation occurs for the remainder.
3. Improving efficiency in the system to ensure that patients do not wait unnecessarily for investigations or diagnostic decision-making.

Triage is a process of initial assessment, described by RCEM as a system which sorts patients according to a combination of their presenting complaint and measured physiological parameters at the time of arrival in the emergency department.

Streaming is also recognised by RCEM as a system used to allocate patients to the correct location / service and to the correct person to manage their clinical needs.

Ambulance-borne patients

For patients arriving by ambulance the trust was using a system of simple streaming, followed by...
an enhanced triage system. The simple streaming was carried out by an experienced registered nurse and entailed a brief face-to-face clinical assessment, taking a brief history from the ambulance crew and directing the patient to the appropriate area of the department for a more detailed clinical assessment (triage). At triage, physiological observations were recorded, an early warning score calculated and investigations initiated, such as blood tests or X-Rays to speed up the clinical decision-making process.

The emergency department did not use a system known as rapid assessment and treatment (RAT), whereby patients are seen on arrival by doctor who can make a rapid assessment and commence appropriate investigations. The system was nurse-led but we were told there was regular communication with the consultant/senior doctor in charge. We were told that when there were high numbers of incoming ambulance patients, a doctor was stationed at the crossroads with the streaming nurse.

The doctor in charge worked closely with the nurse in charge and nurse coordinator, to maintain oversight of the department and to ensure that all patients had a plan of care and treatment in place. The nurse coordinator completed an escalation status report each hour and every two hours or so, they accompanied the consultant in charge on a department round, reviewing each patient and their plan of care.

The emergency department had developed a ‘silver trauma’ triage tool to support triage staff to identify major injuries in older people. There was an e-learning training package to support learning. A consultant told us that this had significantly reduced the number of missed injuries in this patient group.

Self-presenting patients

Patients who self-presented to the emergency department reported to the reception desk, where demographic details and a brief outline of their complaint were recorded. Receptionists had guidance on ‘red flag’ presentations, which required immediate assistance, as recommended by RCEM. Staff told us they knew how to summon help and clinical staff responded promptly when called.

Patients were asked to wait in the waiting room to await triage. There were two triage nurses on duty, who performed ‘enhanced triage’. This means that they were able to order investigations at the time of assessment, such as X-Ray and ECG. One nurse saw patients with minor injury; the other saw patients with minor illness. Triage nurses were able to stream patients to the out of hours primary care service, which was located in the maternity department. The service had been extended in January 2017 to provide an additional 18 hours at the busiest times for the emergency department (Friday, Saturday, Sunday, and Monday) and emergency department nurses were able to book available slots. There were plans to move this service closer to the emergency department and increase access to this service. If there was no wait for triage, nurse practitioners were able to ‘see and treat’ patients. There was a see and treat nurse on duty twenty-four hours a day and a second nurse from 11am to 11pm. At times of escalation, a see and treat nurse may be redeployed to undertake triage. Nurses had received specific in-house training in order to perform triage.

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

The trust was not meeting the national standard which requires that ambulance-borne patients should have an initial assessment or triage within 15 minutes of arrival. The trust’s median time from arrival to initial assessment was consistently worse than the overall England median between September 2016 and August 2017. The trust’s performance over these 12 months was quite consistent, varying between 19 and 22 minutes. The England average varied between six
and seven minutes.

In August 2017, the trust's median time to initial assessment was 20 minutes, compared to the England average of seven minutes.

**Ambulance – Time to initial assessment between September 2016 and August 2017 at North Bristol NHS Trust**

![Graph showing time to initial assessment between September 2016 and August 2017 at North Bristol NHS Trust.](image)

(Source: NHS DIGITAL: A&E quality indicators)

In the 2016 emergency department survey, the trust scored 6.5 out of 10 in response to the question “How long did you wait before you first spoke to a nurse or doctor?” This was about the same as other trusts. The trust scored 6.7 out of 10 in response to the following question: “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?” This was about the same as other trusts.

(Source: CQC - Emergency Department Survey (01/09/2016 - 30/09/2016)

**Assessment and management of risks, including deteriorating patients**

The emergency department used an emergency care safety checklist, which was completed for all patients in the major treatment area. This was a time and sequence-based checklist of tasks which should be completed for every patient from first assessment to discharge or handover to another team. There were safety prompts for time-critical investigations and treatments, for example, in the assessment and treatment of stroke and sepsis. There were prompts to perform risk assessment 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 10 records and saw that risks assessments were completed and there was evidence that steps had been taken to manage risks, such as provision of air mattresses for patients at risk of developing pressure sores.

There was a clinical frailty scale and prompts for staff to identify triggers which might identify the risk of deterioration in this patient group. There were plans to introduce a silver sticker to be attached to the front page of the safety checklist booklet to identify frail elderly patients at risk. Staff were prompted to consider extra support for those patients identified at risk.

There were prompts to undertake baseline observations each hour and to calculate an early warning score at initial assessment and on handover to another team. The National Early Warning Score (NEWS) was developed in order to standardise the way in which an acutely unwell or deteriorating patient is identified. It is based on a scoring system in which a score is allocated to each physiological measurement and aggregated to provide an overall score to show if this differs, and to what degree, from the norm. Staff in the emergency department did not calculate early warning scores each time observations were recorded but we were assured that regular recording of patient’s vital signs enabled staff to identify deteriorating patients. It is
acknowledged by RCEM that early warning scores have limited use in emergency departments because they do not apply to the whole spectrum of patients and will not add benefit to the care of patients already known to be critically ill.

**Children**

There was no paediatric team on the Southmead Hospital site and the ambulance service did not convey sick or injured children there. However, the department saw approximately 8,000 self-presenting children per year, of which a proportion were seriously unwell or injured and required transfer to the Bristol Royal Hospital for Children. There was a written protocol which provided guidance on the types of presentations which would require transfer, the suggested mode and urgency of transfer.

**Mental Health**

Patients presenting with mental health problems were initially assessed by emergency department staff, using a mental health risk matrix. Patients were assigned a risk status (red, amber, green). There were prompts associated with each status, for example, initiating close observation and seeking specialist support. Staff could access a specialist assessment from the hospital's mental health liaison team. This team was available from 7am to 10pm, seven days a week. Outside of these hours, staff contacted the intensive service, run by the local mental health trust. This team only responded to high-risk (red) patients and lower risk patients had to stay in the emergency department overnight to await assessment in the morning. Emergency department staff could contact the on call junior doctor at the mental health trust for advice. The department had put together a business case to employ registered mental health nurse on every shift to support patients with mental health problems.

**Sepsis**

There was a screening and action tool used to identify and treat patients with suspected sepsis. A sepsis care pathway (sepsis 6) identified the time critical investigations and treatment. Compliance with sepsis 6 was monitored and showed consistently good performance.

**Patient escorts**

There was guidance in place (undated) for staff to ensure that high-risk patients were escorted to the CT scanner. This was put in place following two incidents and concerns raised by radiology staff.

**Fractured neck of femur**

A pathway checklist had been developed to identify and treat patients with suspected fractured neck of femur, with a range of time critical investigations and treatment identified. This pathway had been developed following a serious incident in March 2017 where a doctor failed to diagnose a fracture.

**Nurse staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

At the time of our inspection, the emergency department’s nurse staffing position was as follows:

<table>
<thead>
<tr>
<th>Emergency Department</th>
<th>WTE staff</th>
<th>Number in post as of 9 Nov 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 7 nurse</td>
<td>21.9</td>
<td>17.9</td>
</tr>
<tr>
<td>Band 6 nurse</td>
<td>13.0</td>
<td>16.7</td>
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<td>Band 5 Nurse</td>
<td>75.5</td>
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<tr>
<td>Band 4 nurse</td>
<td>14.9</td>
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<tr>
<td>Band 3 nurse</td>
<td>26.0</td>
<td>24.5</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>5.0</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>156.3</strong></td>
<td><strong>159.2</strong></td>
</tr>
</tbody>
</table>

Staffing levels and skill mix were regularly reviewed against the emergency department’s attendance and acuity profile. The department had also taken into account and applied the staff to patient ratios recommended by draft guidance issued by the National Institute of Health and Care Excellence (NICE). This guidance was subsequently withdrawn. The trust had invited the Emergency Care Improvement Programme team to conduct a review of the staffing model and current staffing numbers against the attendance profile, to provide further assurance.

There were two senior nurses employed to manage each shift, one as nurse in charge, the other, a nurse coordinator. They were supported by a band 3 nurse, known as the co-pilot, who undertook a range of administrative duties, such as liaising with ward staff in relation to patient transfers, in addition to some clinical duties as and when required in the department. The nursing staff were managed by a supernumerary ward manager and matron.

Staffing was reviewed at each staff handover, led by the nurse in charge and the nurse coordinator. Nursing and medical staff participated in a department-wide handover and a review of all patients. Staffing levels were also reviewed at daily debrief meetings attended by the lead consultant, matron and assistant general manager and at the morning and afternoon bed meeting, where there was discussion about actual and anticipated bed availability, escalation status in the emergency department and staffing levels in both the department and in other areas of the hospital.

The emergency department was mostly staffed to planned levels, with shortfalls mostly being covered by bank and agency staff. At times of surge, nursing staff from other wards and departments were deployed in the emergency department. The emergency department had produced an information/welcome document for re-deployed staff advising them what to expect and reassuring them that they would not be asked to perform tasks they were not confident to perform.

Although the ambulance service did not convey children to the emergency department, the service ensured there was a suitably skilled nurse workforce to provide care and treatment to sick or injured children. There were five whole time equivalent registered children’s nurses (RCNs) employed. This did not enable the department to ensure there was always an RCN on duty, but adult-trained nurses had received additional training, including resuscitation of children training. There were five nurses with experience in acute paediatrics. Twenty-two nurses had completed a course in Minor illness and Minor Injuries in Children and Emergency Nurse Practitioners completed paediatric training as part of their training.

**Bank and agency staff usage**

Between August 2016 and July 2017, the trust reported bank usage of 563 shifts and agency usage of 189 shifts for qualified nurses in urgent and emergency care. Over the same period,
there were 52 shifts that were not filled by bank or agency staff to cover sickness, absence or vacancies. The data supplied by the trust did not allow us to calculate usage rates.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Temporary staff were required to complete a departmental orientation on first employment or first employment in 12 weeks. Senior staff told us that most temporary staff worked regularly in the department and were familiar with the department’s systems and processes.

Medical staffing

The emergency department was staffed in accordance with guidelines issued by the Royal College of Emergency Medicine. There were 13 whole time equivalent consultants in post, against a funded establishment of 13.5. There was consultant presence in the emergency department for 15 hours per day (8am to 11pm), Sunday to Monday, with staggered shifts covering this period. Night time cover was provided by a minimum of an ST4 or equivalent staff grade doctor, supported by a non-resident consultant on call. On Saturdays and bank holidays there was nine hours’ consultant presence in the department (8am to 5pm). There was a separate trauma rota, which was staffed for 14 hours per weekday (8am to 10pm), with a resident consultant on call overnight. Trauma cover at weekends was provided by a consortium of anaesthetic, intensive care and emergency medicine consultants from 8am on Saturday to 8am on Monday.

There was a scheduled combined nurse and medical handover three times daily. This was a structured meeting using a standardised checklist to ensure that all relevant safety information was effectively communicated.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Bank and locum staff usage

Between August 2016 and July 2017, the trust reported locum usage of 780 shifts and no agency usage for medical staff in Urgent and Emergency Care. Over the same period, there were 141 medical shifts that were not filled by locum or agency staff to cover sickness, absence or vacancies. The data supplied by the trust did not allow us to calculate usage rates. The lead consultant told us that recruitment was ongoing to fill the current vacancy and adjustments were made to the rota to ensure that where possible gaps occurred during the middle day shift. Cover was reviewed daily and on occasions, additional emergency nurse practitioner cover was arranged where there was a shortfall in medical cover.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

Between June 2017 and June 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 34 whole time equivalent staff working in Urgent and Emergency Care at North Bristol NHS Trust.
Records

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

Staff maintained paper records for all patients. Records were located to maintain easy access for staff, and although not secure, were not readily accessible to (unauthorised) others. In the major treatment area records remained with patients in their cubicles. For patients being cared for in the corridor, notes were kept in storage trays. For patients in the minor treatment area, notes were stored in wall-mounted racks.

The trust had developed an emergency care safety checklist which was completed for all patients in the major treatment area. This was a time and sequence-based checklist of tasks which should be completed for every patient from first assessment to discharge or handover to another team.

The safety checklist had been in place for approximately 20 months at the time of our inspection and completion was audited each month, using a sample of 10 records per day. Audit results for overall completion ranged from 58% to 78% and showed an improving trend. There were similar results for the completion of hourly observations, with scores ranging from 60 to 80% and again, showing an improving trend. There was 100% compliance in respect of recording of an early warning score at initial assessment.

We reviewed a random sample of 10 patent records. They were clear and legible and mostly complete. There was good evidence of regular intentional rounding, pain scores, nutrition and hydration, pressure area care and physiological observations.

Medicines

The service managed medicines safely.

Medicines were stored correctly in locked cupboards or fridges. Controlled drugs were appropriately stored and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse. Medicines stored in fridges were stored at the correct temperature at the time of our visit. Records were maintained to show that fridge temperatures were regularly checked.

Staff were required to check medicines daily and we saw that this was mostly the case. However, we found there were two weeks in August and September 2017 where no checks had taken place. We raised this with the matron who advised that this had been picked up by quarterly

(Source: NHS Digital Workforce Statistics)
Staff were reminded of their responsibility to undertake checks and since then there had been no significant gaps.

Patient Group Directions (PGDs) were in place and 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 of patients without them having to see a doctor. There was a wide range of medicines which nurses were able to administer under these directions. We were shown an (undated) audit of records and use of PGDs.

Medicines administration records (MARs) formed part of the patient record (emergency care safety checklist). Staff recorded the date and time the medicine was given, the dose and route and the entry was signed and checked. Allergies were recorded. We checked 10 patient records and all MARs were completed as required.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents 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.

**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.

Between September 2016 and August 2017, the trust reported no incidents classified as never events for Urgent and Emergency Care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England between September 2016 and August 2017. Of these:

- Nine were coded as treatment delays meeting SI criteria
- Five (the majority) occurred between February and May 2017
- Four concerned waits of over 12 hours from the decision to admit until being admitted: two in October 2016, one in May 2017 (concerning three separate breaches) and one in July 2017, a total of six 12-hour breaches. In fact, the trust reported a total of 98 such 12 hour breaches to NHS England over this period, so only a fraction were reported as SIs. See the Responsive section below.
- One incident was categorised “slips/trips/falls meeting SI criteria”. This was an unwitnessed fall in June 2017.

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

Incident themes and causes were recorded and monitored on a monthly basis, as well as the timeliness of investigations. We saw that serious incidents had been investigated appropriately and a root cause analysis completed. We spoke with staff and managers about learning from incidents. We discussed two incidents, which related to sub-optimal treatment of eye injuries. A root cause analysis had been completed for both of these incidents and remedial actions had been completed and were ongoing. These included training from specialist nurses at the
specialist eye hospital. Three nurses had also spent time working there. The emergency department was developing a specific triage form for eye injuries.

Staff told us about an incident which had occurred approximately 12 months ago, when a patient was transferred to the Surgical Assessment Unit from the emergency department. The patient’s condition had deteriorated, this had not been observed by staff and the patient subsequently died. Following an investigation, it was decided that all patients should have an early warning score calculated on discharge from the emergency department, in order to alert ward staff of their level of risk. The patient safety checklist was amended to include this.

Learning from incidents was shared in a number of ways. Safety briefings formed part of twice-daily staff handovers. Safety briefings were repeated at each handover for a week so that as many staff as possible received them.

Safety messages appeared on posters displayed in the department and were included in staff newsletters. Incidents were discussed at training days for doctors and nurses.

Incidents were discussed at monthly clinical governance meetings. Minutes of these meetings were held on the department’s intranet so that they were accessible to all staff. Unexpected deaths or outcomes, and any learning from these events were discussed at each meeting.

There was openness and transparency when mistakes were made. Duty of candour was well understood by staff and applied when required. 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. We saw examples of incident investigations where duty of candour had been applied.

**Safety thermometer**

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 that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter between August 2016 and August 2017 within Urgent and Emergency Care.

*Source: Safety thermometer - Safety Thermometer*

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people.

Facilities and premises were appropriate for the services that were planned and delivered. Patients entered the emergency department via two entrances, one for patients brought by ambulance, the other for self-presenting patients. Self-presenting patients checked in at the main reception desk. Here, steps had been taken to protect patients’ privacy and dignity. There was a
sign displayed requesting patients and visitors to stand behind a line to prevent them overhearing private discussions at the reception desk. The reception desk was at an appropriate height for wheelchair users. Receptionists told us that patients who were reluctant to discuss intimate details, were invited to write down the details of their health concern or they were invited to speak in a side room. Alternatively, the health concern would simply be recorded as 'private'. Support was available for patients and visitors whose first language was not English. Receptionists told us they could contact foreign language speakers within the emergency department or they could contact the trust’s interpreter services.

There was a large waiting room, which provided adequate seating for patients and visitors during our visit. There was some reading material provided. Patients and visitors had access to drinking water and other drinks and snacks were available in vending machines. There was artwork on the walls and large signage, directing patients and visitors to different parts of the department. A touch screen monitor at the entrance directed people to other parts of the hospital. There were also ‘way finders’, who were volunteers that that assisted patients and visitors. There was information displayed in the waiting area, which explained the patient pathway through the emergency department and what patients could expect. This was displayed at the entrance to the department and may have been better located in the seating area, where more patients were likely to see it. On the reception desk, there was a sign that receptionists updated to inform patients what the approximate waiting time was.

There was a range of information available to patients and visitors about where to seek support, including alternatives to visiting the emergency department.

There was a small play area for children who accompanied adult patients. Children who were patients were directed to a separate, secure waiting area. This had been thoughtfully decorated, furnished and equipped with toys to provide a welcoming space for children. Staff had an additional supply of toys, which they used to distract children.

There were male and female toilets and toilets adapted for wheelchair users. There were facilities available for nappy changing. Receptionists told us that breast-feeding mothers would be directed to a room in the minor treatment area if they requested privacy.

Patients arriving by ambulance were usually taken directly to the resuscitation area or the major treatment area if cubicles were available. During our inspection, this occurred most of the time. On occasions, patients waiting to be seen were accommodated on the corridor. The matron told us that at times of surge, when there were no available cubicles, they tried to move patients who had been assessed and seen by a doctor to the corridor, to allow incoming patients to be assessed within a cubicle. This practice, known as ‘reverse queuing’, was not always possible, as was the case at times during our inspection.

Demand for services frequently outstripped the availability of appropriate clinical spaces to assess and treat patients. This meant the major treatment area, although spacious, frequently became crowded. A sample of data provided by the trust showed that in the week commencing 18 September 2017, a total of 306 patients spent more than 15 minutes in the emergency department corridor. Daily, this ranged from 27 to 66 patients. The total number of patient hours spent in the corridor was 583 (this excludes a 15-minute allowance for each patient for the ambulance handover process).

All of the staff we spoke with in the emergency department recognised that caring for patients in a non-clinical area was not ideal because there was little privacy and dignity afforded to these patients. Although queuing was an everyday occurrence, it was not viewed as acceptable practice by staff. The corridor was draughty because the doors from the ambulance bay were frequently
opened. However, patients we spoke with in the corridor had no complaints about their care and
told us that staff had checked that they were comfortable. Mobile screens were used at times to
preserve people’s privacy and dignity and patients were moved to a screened cubicle if any private
conversations or interventions were necessary or they needed to use a bedpan. During our visit,
we saw no interventions carried out on the corridor.

Housekeepers were employed 24 hours a day, seven days a week. In addition to cleaning duties,
they undertook regular refreshment rounds, offering hot and cold drinks to patients and relatives.
They recorded drinks offered in patients' notes so that nursing staff were aware of patients’
hydration status. There were also a number of volunteers employed; they worked under the
direction of nursing staff to support people emotionally and making them drinks.

There was a relatives’ room, which was nicely furnished to provide distressed relatives and visitors
a quiet and calm space away from the busy department. There were facilities to 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 emergency department observation unit was adjacent to the emergency department. This
consisted of 16 cubicles with reclining seats and three side rooms, one of which had a hospital
bed. There was no physical gender separation but staff endeavoured to place male and female
patients in cohorts where possible. There was one toilet and no bathroom facilities. This was not
sufficient to meet the hygiene needs of 19 patients. We had raised this as a concern at previous
inspections but no improvements had been made.

Emergency Department Survey 2016

The trust scored 7.9 out of 10 in response to the question: “Were you given enough privacy when
discussing your condition with the receptionist?” This was about the same as other trusts. The
trust scored 9.4 in response to the question: Were you given enough privacy when being
examined or treated? This was about the same as other trusts.

(Source: CQC Emergency Department Survey (01/09/2016 - 30/09/2016))

Meeting people’s individual needs

The service took account of patients’ individual needs, including patients in vulnerable
circumstances or those with complex needs. However, support for patients with mental health
needs who attended the emergency department out of hours was poor. This was because third
party organisations commissioned to provide specialist support did not provide a responsive
service out of hours.

The emergency department had undertaken some outstanding work to support frail elderly
patients, including those living with dementia. Most staff had completed mandatory training in
dementia awareness. In addition, 32 emergency department staff had completed the Alzheimer’s
Society ‘Dementia Friends’ Campaign e-learning, to become ‘dementia champions’. They wore
‘Forget me not’ dementia friend badges. The forget me not flower logo is a widely recognised
symbol used to identify people living with dementia. Staff used forget me not stickers on patients’
records and forget me not wristbands to alert all staff that patients may need extra support.

There were a number of resources which staff were encouraged to use, with support from
dementia champions, to support people living with dementia. These were kept in a ‘dementia
trolley’ 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, experiencing confusion, delirium or other communication difficulties. During our inspection, we saw this had been completed in consultation with a carer for a patient living with dementia.

- **Twiddlemuffs** - a form of distraction therapy - these are knitted gloves (knitted by volunteers), which are used to reduce restlessness and agitation in people living with dementia.
- **Reminiscence computer** – this provides distraction for agitated patients through music, activities and films. Staff told us this was used frequently in the department and was an excellent distraction tool.
- **A range of word search puzzles and colouring books used to distract patients.**

A nurse in the emergency department had produced a leaflet for patients living with dementia and their carers. The booklet, entitled *What can I expect from the emergency department if I have dementia?* was produced in large print and used simple language to explain what support was available in the emergency department to this patient group and their carers. This included the provision of nearby, free parking for carers to enable them to stay with their relative. There was also a range of literature in the main waiting room which signposted carers to charities offering support.

There were plans to adapt four cubicles in the major treatment area to become ‘dementia friendly’. The emergency department had used charitable funds to commission artwork, in consultation with service users, using bright colours, to stimulate interest and orientation. There were plans to install whiteboards where the date would be displayed and large ‘dementia friendly’ clocks to help patients to orientate themselves. Senior staff expressed frustration that plans and funding to convert these cubicles had been in place for nearly two years but as yet, there was no confirmed start date for the work to be undertaken.

The emergency department had introduced a mandatory screening tool, the Abbreviated Mental Test 4, for older adults. There was a cognitive care bundle, which staff were encouraged to use to assess patients’ individual needs. This included the completion of a ‘This is me’ booklet. This documentation would remain with the patient if they were admitted to a ward.

**Patients with mental health needs**

There was a trust-wide mental health liaison team (MHLT) which supported the emergency department. Senior emergency department staff told us this service was responsive to referrals. The service operated from 7am to 10pm, seven days a week. There was an operational policy, which set out a response time standard of one hour for referrals from the emergency department. Data provided by the trust showed that in the months of August, September and October 2017 the MHLT responded to 26%, 44% and 43% of referrals respectively within one hour. At our last inspection we were told that there were plans to extend this service to provide a 24-hour service; however, senior staff told us that funding for this had not been agreed by commissioners. This meant that the service continued to be supported at night by the intensive service run by the local mental health trust. This service was not responsive and responded only to night time referrals of patients who were identified as high risk (rated red on the mental health risk matrix). Data for the same time period showed that only four out of 227 referrals were responded to in one hour. Lower risk patients (rated amber on the risk matrix) were not assessed until the next morning and were frequently accommodated overnight in the emergency department observation unit. In the period August to October 2017, there were 82 breaches of the four-hour standard attributed to patients waiting for a mental health assessment.
Senior emergency department staff told us that support for children and young people with mental health problems was not adequate. The MHLT were commissioned to see patients between 16 and 18 years of age, although they had the discretion to refer them to another third party Child and Adolescent Mental Health Service. We were told that this was not responsive. To illustrate this, staff told us about a teenager who had recently spent a whole weekend on the emergency department observation unit because specialist support was not available.

There was an Adult Learning Disability Team, which was available for support via a referral from the emergency department. Outside of their operational hours, the MHLT team could be called upon to assist. There was an Alcohol Specialist who was employed to support the emergency department and the Acute Medical Unit.

The emergency department had produced a policy for the Management of High Impact Users in the Emergency Department. This was based on guidance issued by the Royal College of Emergency Medicine and set out a process that identified and managed patients, sometimes termed ‘frequent attenders’. These were patients with complex needs including mental illness, health anxiety, homelessness or poor home circumstances, drug or alcohol dependency, and medically unexplained symptoms. A multi-disciplinary discussion was held about all patients who attended the emergency department more than three times in a month. There was contact with the patient’s GP and other clinicians or practitioners involved in patients’ ongoing care. These included the ambulance service, police, the local mental health trust and support organisations for homeless people and people who are alcohol or drug dependant. A management plan was put in place, shared with the GP and available to emergency department staff to help them in the management of future attendances. We were provided with a report (undated) which stated that 79 patients had been identified high impact users since the process was put in place. Of these, 22 had reduced their attendances to fewer than three per month.

**Palliative/end of life care**

There was a palliative care lead in the emergency department, who had received additional training to support patients at the end of their lives and their relatives. There was a resource trolley kept in the major treatment area. The emergency department had purchased a syringe driver so that there was no delay in providing the pain relief required by patients at the end of their life. A syringe driver is a device, often used in palliative care to administer a continuous flow of injected medication in order to help control pain and other symptoms.

**Bereavement services**

There was small group of nurses in the emergency department who had done additional training to support bereaved relatives. Bereaved relatives were invited to visit the emergency department to speak with the clinicians involved in their loved ones’ care. They were also sent cards on the anniversary of their relatives’ death.

**Access and flow**

Patients were not always able to access care and treatment in a timely way. 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 treatment to begin, and the time they waited for transfer to an inpatient bed.

**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.
The trust consistently failed to meet the standard in every month between October 2016 and September 2017. The trust’s performance was also consistently worse than the England average.

The trust’s performance showed a trend of improvement between October 2016 (77%) and March 2017 (88%). This was followed by a trend of decline between March and August 2017, with August being the worst performing month in this 12-month period, at 73% and compared to the England average of 90%. In September 2017, the trust’s performance improved slightly to 80%, compared to the England average of 90%.

**Four hour target performance - North Bristol NHS Trust**

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

Performance against this standard was constantly monitored and reported on daily. Senior staff held a de-brief meeting each day to examine the previous day’s performance. Reasons for breaching the standard were monitored and reported on. A sample of data we looked at for the week commencing 25 September 2017 showed that 58% of breaches were categorised as undergoing treatment in the emergency department, while 36% were categorised as waiting for beds.

**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 in the emergency department to the time that their treatment begins is no more than one hour. The trust consistently failed to meet the standard in every month between September 2016 and August 2017.

Performance against this standard showed a trend of improvement between September 2016 (86 minutes compared to the England average of 59 minutes) and February 2017 (61 minutes compared to the England average of 57 minutes). This was followed by a trend of decline between February and July 2017 (105 minutes compared to the England average of 60 minutes). This was the trust’s worst performance in any month during the whole 12 month period between September 2016 and August 2017. In August 2017, the median time to treatment was 101 minutes compared to the England average of 53 minutes.

**Emergency Department Survey 2016**

In the 2016 emergency department survey, the trust scored 6.5 out of 10 in response to the...
question “How long did you wait before you first spoke to a nurse or doctor?” This was about the same as other trusts. The trust scored 6.7 out of 10 in response to the following question: “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?” This was about the same as other trusts.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

Between October 2016 and September 2017, the trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was consistently worse than the England average. Performance against this metric varied between 14% and 32.9%, with the worst performance in October 2016 (32.9%) followed by January 2017 (32.6%) and July 2017 (27.3%). Thus two of the three worst-performing months were outside of the winter period.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - North Bristol NHS Trust**


**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Between October 2016 and September 2017, 95 patients waited more than 12 hours from the decision to admit until being admitted. The majority of waits of more than 12 hours occurred in the three winter months: December, January and February. In this period, 66 patients waited more than 12 hours.

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<tr>
<td>Nov-16</td>
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<tr>
<td>Month</td>
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<td>England Average</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Dec-16</td>
<td>638</td>
<td>21</td>
</tr>
<tr>
<td>Jan-17</td>
<td>776</td>
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</tr>
<tr>
<td>Feb-17</td>
<td>601</td>
<td>12</td>
</tr>
<tr>
<td>Mar-17</td>
<td>414</td>
<td>1</td>
</tr>
<tr>
<td>Apr-17</td>
<td>335</td>
<td>3</td>
</tr>
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<td>584</td>
<td>6</td>
</tr>
<tr>
<td>Sep-17</td>
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(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**

This measures the percentage of patients who leave the emergency department before they have been seen by a clinician and is indicative of patient dissatisfaction with waiting times. The national standard is that this should be below 5%. Between September 2016 and June 2017 the monthly median percentage of patients leaving the trust’s Urgent and Emergency Care services before being seen for treatment was lower (better) than the England average.

The trust’s performance against this metric showed a trend of improvement between September 2016 (3% compared to the England average of 3.1%) and February 2017 (1.2% compared to the England averaged of 2.8%).

However, this was followed by deterioration in performance between February and August 2017. In both July and August, higher proportions of the trust’s patients left the emergency department before being treated compared to the England average:

In July 2017, the median percentage of patients leaving the trust’s Urgent and Emergency Care services before being seen for treatment was 3.5%, compared to the England average of 3.4%.

In August 2017, the median percentage of patients leaving the trust’s Urgent and Emergency Care services before being seen for treatment was 4%, compared to the England average of 3%.

**Percentage of patients that left the trust without being seen - North Bristol NHS Trust**
Between October 2016 and September 2017, the trust’s monthly median total time in the emergency department for all patients was consistently longer than the England average. Performance against this metric showed a trend of decline overall. There was an improvement between October 2016 (203 minutes or three hours 23 minutes compared to the England average of 148 minutes) and February 2017 (186 minutes or three hours six minutes compared to the England average of 149 minutes). This was followed by deterioration in performance between February and August 2017 (213 minutes or three hours 33 minutes compared to the England average of 144 minutes).

Managing crowding in the emergency department

Crowding was the biggest challenge faced by the emergency department. This was a daily challenge and senior staff were very focussed on managing this situation. The nurse coordinator and doctor in charge were jointly responsible for monitoring patient flow within the department.
The nurse coordinator produced an hourly escalation status report. Status was designated from ‘green’, through ‘amber’ and ‘red’ to ‘black’. There were a number of trigger factors in the emergency department, which influenced this status. These included ambulance handover times, the number of assessed and unassessed patients in each part of the department (including the number waiting in the corridor), number waiting to be seen, waiting for beds, staffing and acuity of patients, and divert status.

There were protocols for the nurse coordinator and the doctor in charge, setting out their responsibilities at each status. This included communication with senior managers in the medicine division and the wider trust, according to the status. The Emergency Department Escalation Procedure (February 2015) contained action cards for directorate managers of the day or on call and for the Clinical Site Manager.

Senior staff told us the emergency department frequently declared a status of red or black escalation. We looked at a daily status report for the week commencing 25 September 2017. Two days were rated amber, three days were rated red and two days were rated black.

There was a Standing Operating Procedure for the identification of escalation beds to facilitate the rapid transfer of emergency department patients and the use of pre-emptive transfer (reviewed December 2016). This procedure facilitated the rapid movement of patients for admission from the Acute Medical Unit (AMU) and the Trauma and Surgical Assessment Unit to areas where there are confirmed discharges or the opening of extra escalation capacity. This in turn, freed space for emergency department patients waiting for a bed. The trust regularly opened additional (escalation) beds on wards and other departments to create more capacity in the hospital.

Senior staff in the emergency department told us they were well supported by divisional managers when the department was crowded. It was felt that the operations management function were less visible and responsive.

There was a daily meeting held at 8am in the emergency department with the nurse coordinator, representatives from the Acute Medical Unit, Surgical Assessment Unit, matrons and operational management. A further similar meeting took place at 4pm. Information was shared in relation to current and anticipated bed availability and the number of patients in the emergency department waiting for a bed. However, there was no operational plan agreed to address the bed shortfall and the impact this shortfall had on flow in the emergency department.

Emergency Department Observation Unit

The emergency department had created additional capacity through the use of the observation unit (EDOU). The EDOU was used for three categories of patients:

- Majors’ chairs- Ambulatory patients who would otherwise be placed in the major treatment area or the corridor.
- ‘Step down’ patients who have been seen and are waiting for test results. These were patients who are expected to be discharged.
- Emergency department observational medicine – There were three cubicles, equipped with patient trolleys and one side room equipped with a hospital bed. Suitable patients included patients whose length of stay was anticipated to be four to 12 hours, with a high likelihood of discharge. This included, for example, patients with mental health problems, who were rated amber on risk matrix, awaiting mental health assessment, patients who had self-harmed, including self-poisoning, or patients with chest pain who were identified as low risk, patients awaiting a hospital bed or patient transport.
Admission avoidance initiatives

The trust had developed a number of admission avoidance initiatives to improve patient flow from the emergency department. The trust had recently joined the acute frailty network. This is a national initiative, which supports trusts to develop collaborative models of care to improve services for frail older people and reduce hospital admission. Addressing ‘Frailty at the front door’ was a key strand of the trust’s four hour improvement programme. The emergency department worked closely with the Complex Assessment Liaison Service (CALS). This service, 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 length of stay. Staff in the emergency department could refer patients to this team but members of the team regularly visited the department and were proactive in identifying suitable patients.

The trust also worked with the community-based rapid response team, which provided treatments in the community, such as intravenous fluid therapy, in order to avoid hospital admission.

A rapid emergency assessment care team, funded by a community healthcare trust, worked in the emergency department from 8am to 8pm, Monday to Friday. This was a team of allied health professionals and nurses who assessed and facilitated discharge for vulnerable patients, such as elderly people living alone.

There were British Red Cross volunteers who worked in the emergency department from 4pm to 10pm, providing a transport and settlement service for vulnerable patients who lived alone.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Summary of complaints

Between August 2016 and July 2017, there were 58 complaints about urgent and emergency care services. The trust took an average of 26.5 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed within 35 working days, or “45 plus” working days if a complaint is complex.

Of the 58 complaints, 51 had been closed as of 14 August 2017. The outcomes were:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld - Resolved</td>
<td>34</td>
</tr>
<tr>
<td>Partially Upheld</td>
<td>6</td>
</tr>
<tr>
<td>Not Upheld</td>
<td>5</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
</tr>
<tr>
<td>Complaint still open</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
</tr>
</tbody>
</table>

There were complaints leaflets displayed at the reception desk in the emergency department reception. Patients were invited to raise concerns, make a formal complaint or provide positive feedback in number of ways: by letter, email, phone or fax or in person. Contact details of the trust’s Advice and Complaints Team were provided, as well as those for the Independent Complaints Advocacy Service and the Parliamentary & Health Service Ombudsman.
The emergency department employed a retired nurse, who supported senior managers in the investigation of complaints and incidents. They told us they provided an “independent voice” in the investigation and management of complaints and incidents. They attended staff meetings, including the monthly clinical governance meetings, to share learning from complaints and incidents. Learning was also shared via the monthly team brief, which was displayed in the emergency department.

All complaints were ‘triaged’ to confirm the expectations of complainants. This usually took place via a telephone call and the emergency department had produced a checklist to help structure this initial contact. During the phone call, there was an explanation provided of the process and complainants were offered the opportunity to meet with the relevant clinicians if appropriate. Timescales were discussed and preferred communication methods were agreed. There was a verbal review of the complaint to ensure that the complainant’s concerns and expectations were understood and points of detail confirmed.

We looked at a sample of complaint investigations and saw that concerns had been taken seriously, investigated thoroughly and sympathetically. Complainants had been fully engaged and supported in the process.
Medical care (including older people’s care)

Facts and data about this service

We inspected North Bristol NHS Trust medical division on an unannounced visit at Southmead Hospital as part of the new phase of our inspection methodology. We did not inspect medical services at Cossham Hospital.

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 across a range of specialities including acute medical admissions, cardiology, respiratory, gastroenterology, renal medicine, complex care of the elderly and respiratory medicine.

The following wards and departments were visited during our inspection at North Bristol NHS Trust:

- Medical Assessment Unit
- Endoscopy Suite
- Gate 7a Neurology and Stroke
- Gate 8a Gastroenterology
- Gate 8b Renal and transplant medicine
- Gate 9a Stroke medicine
- Gate 9b Complex elderly medicine
- Gate 27a Cardiology
- Gate 27b Infectious Diseases Isolation Suite
- Gate 27b Respiratory medicine
- Gate 28a Complex elderly medicine
- Gate 32a Complex elderly assessment unit
- Elgar 1 Complex elderly medicine
- Interventional Radiology
- Discharge lounge

Between July 2016 and June 2017 there were 44,105 medical episodes of care carried out at North Bristol NHS Trust, this was an increase of 4% from the previous twelve-month period. Emergency admissions accounted for 22,924 (52%) medical care episodes; 20,088 (46%) were day cases, and the remaining 1,093 (2%) were elective.

Admissions for the top three medical specialties were:

- General Medicine: 20,282 admissions
- Gastroenterology: 5,892 admissions
- Clinical Haematology: 4,579 admissions

(Source: CQC Insight)

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- Spoke with 19 patients who were using the service and five relatives
- Spoke with managers or acting managers for the medical division
- Spoke with 73 other staff members, including matrons, doctors and nurses
- Observed 4 board rounds and 5 multidisciplinary meetings
- Reviewed 20 patient records relating to physical health, risk assessments and care plans

At our last inspection in April 2016, we rated the medical division as requires improvement overall with caring and well-led rated as good. The medical division was issued with two requirement notices and nine recommendations for service improvement. We looked at changes the medical division had made to address these concerns.

Is the service safe?

Mandatory training

Mandatory training did not always meet trust targets, particularly for medical staff. The hospital provided a programme of mandatory training and updates for staff, which included, for example, equality and diversity, falls, information governance and resuscitation. The trust’s target of 85% compliance with mandatory training was met in seven of the 11 selected modules for registered nursing staff and three of the 11 selected modules for medical staff. Areas of poor compliance were dementia training (level two) and conflict resolution training for nursing staff. For medical staff areas of poor compliance were information governance, dementia (level one), falls, resuscitation and infection prevention and control.

A breakdown of compliance for mandatory courses as of August 2017 for registered nursing staff and medical staff in medicine is shown below:
Safeguarding

The trust had systems, processes and practices to keep both adults and children safe from abuse. Staff had awareness and knowledge of who to contact if they had any safeguarding concerns and knowledge of the trust’s safeguarding policy. Staff told us the hospital safeguarding leads were responsive to their and the patient’s needs.

Medical staff were slightly below meeting trust targets for safeguarding training. However, nursing staff were above trust targets. Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people.

Safeguarding training completion rates

The clinical commissioning group set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of August 2017 for registered nursing staff and medical staff in medicine is shown below:
The 90% target was not met for both safeguarding children level two and safeguarding adults level two for registered nursing staff in Medicine.

The trust reported that no registered nursing staff in the medical division were required to undertake safeguarding children level one or safeguarding adults level one as this was superseded by their level two and three training.

The 90% target was not met for safeguarding children level two and safeguarding adults' levels one and two for medical staff in Medicine.

The trust reported that no medical staff in medical division were required to undertake safeguarding children level one as this was superseded by their level two and three training.
Cleanliness, infection control and hygiene

Areas used to accommodate patients in extra beds (called escalation beds) did not meet national guidance for infection control. Wards located in the Brunel building consisted of 75% single room accommodation with en-suite toilet and shower facilities. There were areas of inpatient wards that were used as escalation beds at times of increased operational pressures. An additional bed would be placed in a bay of the ward designed to accommodate four patients. This meant there was an increased risk of cross infection, and the ability to clean effectively was compromised because of insufficient space between beds. This practice did not meet the Department of Health Building Note 00-09 (2013) 3.12, which gives dimensions of the provision of sufficient space to reduce the risk of cross contamination of infections in clinical areas. However, the trust monitored infection control incidents and did not report any harm to patients who were cared for in the escalation beds on inpatient wards.

Reported cases of methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia (the presence of bacteria in the blood) was above (worse than) the national average. The trust reported ten cases of MRSA bacteraemia in the past 12 months with three reported cases in 2017/18. Data showed that the trust had been consistently above (worse than) the national average for quarterly rates of MRSA bacteraemia per 1,000 bed days since September 2016. There is a national target of zero cases of MRSA bacteraemia. Following on from incidences of MRSA bacteraemia, the trust had introduced a remedial action plan, which set out clear time frames and actions to ensure compliance.

Patients were screened for MRSA in line with national guidance: ‘Implementation of modified admission MRSA screening guidance for NHS (2014)’. The trust had a policy of focused screening in line with local risk assessments. Data captured in November 2017 highlighted a compliance of 93.2% of eligible patients screened within the acute medical assessment unit.

There was a low rate of Clostridium Difficile (C-diff) cases. The trust reported three cases of C-diff during September 2017. We looked at data from September 2016 to October 2017 and found there had been eleven cases per 1,000 bed days, which was below (better than) the national average of 14 cases per 1,000 days. Data specifically related to the medical division was not available.

Wards were visibly clean and mostly tidy. Patient bed spaces and staff areas were dust free and visibly clean in hard to reach areas including beneath beds. However, the interventional radiology unit was cluttered, with bed spaces being untidy after patients had been discharged. The environment was therefore not sufficiently clean or organised to receive new patients for interventional radiography procedures or when beds were used as escalation beds. We also observed disposable urinal bottles placed on tables on one ward, which is neither hygienic and may discourage patients from wanting to eat and drink at that table.

Not all areas were meeting the target for effective cleaning. The trust monitored standards of cleanliness using an electronic system. Data was entered onto the system when clinical areas were cleaned and inspected to evaluate the effectiveness of cleaning. Compliance with cleaning was assured by weekly cleaning audits. We looked at audit results from 30 July to 29 October 2017 for ward 27a (cardiology), 27 b (respiratory), the isolation unit and ward 8a (complex care) and found overall compliance to meet the trust target of 98% was only achieved in the isolation unit in ten of the 14 weeks the unit was audited. The other three areas did not achieve 98% and one area was below 95% on eight out of the 14 weeks, the unit was audited. Independent members of the ward domestic team carried out these audits and areas for improvement were
shared and discussed with the housekeeper who had undertaken the cleaning. The results of monitoring of these audits were discussed in the monthly control of infection committee.

Hand washbasins were available and clearly signposted on the entrance to wards and clinical areas, which encouraged staff and visitors to wash their hands before entering the ward environment. We saw relatives and visitors using the hand-washing facilities. Once inside the wards there were facilities immediately inside the door to apply gel to hands. Each pod, patient room and bay had hand-washing facilities for staff and visitors to wash their hands before leaving the immediate care environment.

We observed most staff adhered to good hand hygiene practice. Patients we spoke with told us that staff washed their hands before and after assisting them with personal or treatment procedures. Hand hygiene audits were completed on a monthly basis with the most recent months audit results displayed outside wards we visited. Data was reported as part of the integrated performance report. We reviewed compliance data across the medical division from September 2016 to August 2017, and found compliance above the trust target of 95% in nine of the 12 months. One month (December 2016) reported compliance of 92.6% and there were no reported results for August 2017. Whilst most staff observed cross infection practices, we saw episodes when effective infection prevention procedures were not followed. For example, on ward 7a and on ward 27a, we observed a staff member leaving a patient’s room still wearing an apron, which they had applied to prevent cross infection.

Waste was mostly managed safely, but there were some issues with the safe disposal of sharp instruments. Clinical waste was segregated and disposed of safely and in accordance with trust guidelines. However, we saw bins used to dispose of sharp instruments, such as needles, were sometimes filled above the safe level before being replaced, and lids were not always closed to avoid accidental injuries or spillages.

Two of the nine medical wards did not always comply with safe cannula care. The National Institute for Health and Care Excellence (QS61, 2014) statement four states that people who need a cannula should have the risk of infection minimised by the completion of specified procedures to ensure safe insertion and ongoing care. If this was not maintained, there was an increased risk of infection. The trust audited its procedures against this guideline and results showed for the month of August 2017 there were varying levels of compliance. Seven out of nine of the medical wards were 100% compliant. The two non-compliant wards were gate 9b (complex care ward) at 75% and gate 32a (complex care ward) at 81.3%.

Furniture was clean and in good condition. It was fully wipeable and compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment (2013). Staff used an ‘I am clean’ sticker when equipment, such as commodes, had been cleaned after use.

There were facilities and systems in both the medical assessment unit and endoscopy unit, to care for patients with suspected communicable diseases such as tuberculosis and influenza. There were areas within the departments with a vestibule entrance arrangement to ensure maintenance of infection control. Endoscopy patients with a suspected communicable disease were seen at the end of the day to ensure the clinic rooms could be deep cleaned post procedure so that cross infection risks were reduced.

Results from Patient Led Assessment of the Care Environment (PLACE) surveys showed acceptable results. The most recent data at the time of our inspection, published in August 2017, showed a cleanliness score of 95% against a national average for acute services of 98.4%. It should be noted the PLACE scores were for the trust overall and not just the medical wards.
Environment and equipment

Care premises and facilities did not always keep patients safe. Equipment was not always available for patients in additional beds used for escalation. This included wards and a reception area outside of the acute medical assessment unit. Patients did not have access to call bells to call for help or assistance, or access to piped oxygen and wall mounted suction equipment. The trust informed us staff assessed all patients who were moved into escalation beds and areas, to ensure the risk posed by this was reduced. Managers told us there was a designated member of staff to look after patients in the escalation area and in the enhance care bays. However, we observed there was not always a member of staff in the area looking after the patients in the escalation area outside the medical assessment unit. We spoke with patients who were looked after in this area. Patients did not have drinks close to them and they were not sure how to call for help if required. The designated member of staff in the enhanced care bays on inpatient wards was required to wear a yellow lanyard so they could be easily identified. However, this was not consistent across the hospital, and on one ward, the lanyard was hanging on the doorframe. We raised the lack of call bells with the Director of Nursing at the time of our initial inspection who assured us that this would be addressed. However, when we returned the following week on a further unannounced visit, call bells were not available for patients in additional beds or in the escalation area outside the medical assessment unit. Patients we spoke with confirmed they did not have a call bell.

Safety systems, processes and standard operating procedures were not always followed. Staff did not always follow the standard operating procedure (SOP) when allocating patients to escalation beds and areas during times of operational pressures. Due to the lack of medical beds, some medical patients were admitted to the interventional radiology unit. The ward was a purpose-built ward for patients attending the hospital for interventional radiology procedures. It was also used for day case invasive cardiac procedures for patients who were unlikely to require admission beyond day care. Medical patients who were accommodated on these wards were reviewed by a designated medical team. However, out of hours and at weekends, patients were seen by the on call medical team. At the time of our inspection on 8 November 2017, four medical patients were admitted to this unit. The SOP stated up to ten inpatients could be admitted if they met specific admission criteria. We reviewed the number of patients transferred to the interventional radiology unit between 12 October and 7 November 2017. The number of inpatients admitted to the unit exceeded 10 on eight days and in the same period, there was only one day when no inpatients had been admitted to the escalation beds.

Arrangements for the provision of food for patients admitted to the interventional radiology ward, during times of high operational pressures, did not ensure adequately hot food was always served. Staff collected meals for these patients on trolleys from nearby wards. The ward did not have a kitchen with a door to close between the clinical area and the food preparation area when staff prepared frozen meals for patients. Staff used a domestic microwave to do this, which was not provided to be used for the preparation of patient food. Staff did not have a thermometer to check the food had reached safe temperatures to ensure harmful bacteria were destroyed. This added to our concerns regarding the area not being suitable for use as an escalation area at times of high operational pressures.

Emergency equipment was not always kept in tamper evident trolleys and was not always checked daily as outlined in trust policy. We found staff did not always check resuscitation trolleys daily. For example, on cardiology ward (Gate 27a) the resuscitation trolley was not checked on four consecutive days in October 2017. We also found on Ward 8a, the resuscitation trolley was not tamper evident and there was no documentation to show the trolley had been checked during
November 2017. When we opened the trolley, we found items were out of date, this included suction, saline and a catheter mount. We raised this at the time of our inspection and were assured the out of date items would be replaced. An issue with resuscitation trolleys was an improvement recommendation from the previous Care Quality Commission inspection in 2015.

There were emergency cords in patients’ en-suite bathrooms but not always at an appropriate height. We found emergency cords near toilets to be at a height that could be reached if a patient fell. However, the shower area emergency cords were even higher, and we were not assured these could always be reached if a patient fell and was on the floor.

Some equipment had not been serviced as required. Equipment was serviced internally with a record of equipment maintenance kept centrally. Weekly reports were produced of the equipment due for maintenance. There were monthly reports for medical devices, so servicing could be scheduled within the timeframe and without interfering with clinical practice. We reviewed the maintenance on the different ward areas we visited and although most areas were compliant, within the endoscopy unit we found equipment past its service date. We informed the endoscopy coordinator of this who removed some of the out of date equipment so it could be serviced and they assured us they would check the rest.

The majority of medical items were within their expiry date. We reviewed the storerooms and stock level of consumables kept on the wards and found the majority within date. However, on ward 8A (gastroenterology) we found items on the crash trolley that were out of date and on Gate 32a (complex elderly care assessment unit), we found four sets of blood culture bottles that were out of date. We brought this to the attention of the ward managers who took immediate action to replace the items.

Most products deemed as hazardous to health were stored in locked cupboards in clinical rooms or rooms that were only accessible to authorised staff. However, we found disinfectant tablets that were required to be in secure storage in an unlocked cupboard, and the sluice room was found to be unlocked meaning it could be accessed by patients and visitors.

Assessing and responding to patient risk

There was inconsistent compliance with patient risk assessments across the medical division. While most risk assessments were completed in the records we looked at during our inspection, we were not always assured that all risk assessments were up to date. Staff completed some on paper records and some using an electronic system.

There had been a number of patient falls, of which some caused serious harm to patients. The medical division reported between 73 and 138 patient falls each month between September 2016 and July 2017. Between one and three each month were reported as resulting in serious harm to patients. The falls rate for this period was between 5.5 and 9.2 falls per 1,000 occupied bed days. The average falls per 1,000 occupied bed days was 6.9 falls. This was worse than the NHS national average of 6.1 falls per 1,000 occupied bed days.

All falls were investigated and the trust had implemented a series of actions to reduce falls. This included the use of alarm mats and non-slip socks. One member of staff working in the enhanced care bays wore a yellow lanyard. This was designed to ensure there was always one member of staff in the enhanced care bays to supervise patients. The trust had also introduced a ‘SWARM’ process for all serious falls. This included a meeting that occurred following a patient fall and within 48 hours of the fall being reported. The meeting was attended by the trust falls lead, matron, ward sister and any staff involved. The aim of the meeting was to look at any factors that may have contributed to the fall and any learning or change to practice that could occur to prevent any
future falls. We spoke with the trust’s falls lead. They explained they had found no trends for patients falling and there was no correlation between single room accommodation and the number of falls. However, the trust performed worse than the national average in four of seven measures in the National Audit Inpatient Falls 2017.

Falls risk assessments were not always completed in line with guidance from the National Institute for Health and Care Excellence (CG162, 2013). We looked the trust wide falls care bundle, and found compliance with falls risk assessments was between 87% and 92.5% for July, August and September 2017. Compliance with bed rail assessments was completed in 89% to 91% of audited records (335 records). The trust had reviewed five serious falls resulting in significant harm in the last six months on the complex elderly assessment unit (Gate 32a) and found the falls risk assessment had not been completed in three of the five incidents. The ward manager had communicated this to all staff by email.

Some of the plans to reduce falls were being acted upon, but not all were showing high levels of compliance. Nursing staff used a daily ‘intentional rounding’ process, a ‘day and night shift falls prevention checklist care plan’ and a ‘patients at risk of falling’ sticker to help reduce the risk of patients falling. Nursing staff used intentional rounding to look for emerging risks of concern. Intentional rounding ensured patients, who may be high risk of falls or other risks, were regularly reviewed. This ensured any changes or emerging risks were noticed early and acted on before an incident could occur. The trust audited compliance with completion of intentional rounding as part of the monthly trust wide ‘falls bundle audit’. Compliance with intentional rounding was 93.5% to 97% in 297 audited records. The compliance with the ‘daily shift care plan’ was between 92.4% and 93.8% for July, August and September 2017. However, there was poor compliance (52.9%) for the use of ‘falls alert stickers, in patients at risk of falls in 330 patient records reviewed.

Comprehensive risk assessments for venous thromboembolism (VTE) (blood clot) assessments were not always carried out for patients in line with national guidance. This related particularly to the requirement to re-assess the risk to a patient within 24 hours of admission. The National Institute of Health and Care Excellence (QS 4, 2010), states all patients admitted to hospital should receive a VTE risk assessment on admission and again within 24 hours of admission. Medical staff undertook a risk assessment for the development of VTE for patients admitted to medical wards. However, we did not see documented evidence in any of 20 patient medical records reviewed that the risk was reassessed within 24 hours. Compliance was audited and reported monthly through the trust’s integrated performance report. Audits results from September 2016 to July 2017 showed VTE assessments were completed for 97.2% to 98.2% of patients. However, from the audited medical records in the same period, there were between 47 and 69 records where repeat VTE reassessment was either missing or incomplete. The data did not state how many records were audited so it was not possible to determine what percentage of records this affected. The results demonstrated that the lack of VTE re-assessment was an ongoing issue that was known to leaders and managers. However, evidence showed it had not been adequately addressed to ensure all VTE assessments were repeated in line with national guidance.

Staff assessed patients and took actions to reduce the risk of patients developing pressure ulcers. The National Institute of Health and Care Excellence (NICE, QS89, 2015) states people admitted to hospital should have a pressure ulcer risk assessment within six hours of admission. We reviewed eight sets of nursing assessments and found a pressure ulcer risk assessment had been completed. However, compliance was not audited and included as part of the integrated performance report. Staff told us they had access to pressure relieving equipment and knew how to access this. Staff reported incidents of pressure ulcers including when patients were admitted.
with an existing pressure ulcer. This helped determine whether pressure ulcers were acquired while patients were in hospital.

The allocation of patients to rooms did not always take the patients’ potential for deterioration into account. Some patients on the cardiology ward (Gate 27a) were monitored remotely by the use of telemetry (continuous monitoring of heart activity). Patients received continuous monitoring where there was a risk of potential life threatening arrhythmias, which may require urgent and immediate attention. The monitoring equipment included different alarms depending on the deviation from the set alarm parameters. Staff told us, the nurse who was allocated to the care of the monitored patient was responsible for assessing and setting safe alarm parameters. We heard an alarm sounding, which meant one of the pre-set parameters had been ‘activated’. However, we observed staff did not take immediate notice. The patient was in a room furthest away from the central nurses’ station. Nurses looking after patients in ‘hubs’ away from the main nurses’ desk, relied on their colleagues to alert them to a sounding alarm. We asked if patients were risk-assessed for their suitability to be looked after in rooms a long way away from the main nurses’ station. However, staff told us patients with telemetry were not risk assessed when beds were allocated. This meant we had some concerns about the safety of patients on continuous monitoring.

Action was taken in response to other risks, such as patients going through alcohol withdrawal. The medical division used national guidance such as the ‘clinical institute withdrawal assessment’ tool to assess and manage patients’ withdrawal symptoms. In an audit of use of the tool, the trust had recognised this was not always being undertaken appropriately, due to staff not wanting to disturb patients who were asleep. In response to this, the alcohol liaison team had provided additional training for staff, and managers reported this had improved compliance rates.

The service used a national early warning score (NEWS) to alert staff to a deteriorating patient. Staff documented patients’ vital observations and calculated a score as to the level of risk. We reviewed 12 NEWS charts and found all of them were completed and calculated correctly and in line with the prescribed frequency. The charts provided guidance of how to escalate concerns depending on the calculated score. Staff were aware of their responsibilities and confident in putting them into practice. However, in one set of the 12 records we looked at, a patient was given a score of five. This would have required actions to be taken, but there was no documentation of this escalation in accordance with trust policy.

Daily safety briefings and ‘board rounds’ were undertaken to highlight any patient that may be assessed as at risk. The board rounds were attended by a mix of different healthcare professional. For example, nursing and medical staff, a pharmacist, physiotherapist, care of the elderly nurse, a mental health practitioner and alcohol addiction counsellor attended these in different wards. Each patient was reviewed alongside an overview of their previous medical history, current care provision, including diagnostics and results of investigations. A decision was taken as to any changes to their care or treatment.

**Nurse staffing**

Nurse staffing levels and skill mix were reviewed. Twice a day the wards used the Shelford Safer Staffing tool to evaluate patient acuity (intensity of care) and dependency. The safer staffing tool categorised patients according to the acuity or dependency (such as high risk of falling). The trust used an electronic tool to determine if actual staffing levels were adequate to ensure safe patient care and treatment. This took into account the combined acuity or dependency of patients on the ward at the time. The nurse in charge confirmed the rostered members of staff were on duty and the tool calculated nursing hours (shortages or excess). The information was rated red, amber of
green (RAG rated). The senior nurses’ management team reviewed and adjusted staffing levels by moving staff around or booking additional staff to work.

Recommend nursing hours were not always met on the wards to ensure the safety of patients. The calculated nursing hours were a combination of registered nurses, band 4 assistant practitioners and healthcare assistants. During daytime hours, the planned registered nurse to patient ratio on the wards was one nurse to eight patients, which was in line with national recommendations. However, this dropped to one registered nurse to eleven patients overnight.

The nurse-staffing establishment on the wards did not take into account additional patients accommodated to meet high demand. Staffing levels were based on a bed base of 32 beds per ward, but due to additional beds, the number of patients could increase to 35 per ward. On the complex elderly assessment unit (Gate 32a), the staffing tool demonstrated that the number of nursing hours were short by 35 hours on one shift based on the dependency of patients. This meant there should have been a further three nurses on duty to ensure all patients were cared for safely. Staff told us the staffing establishment had not been increased in line with the additional patients. We spoke with the deputy director of nursing about the use of the tool to assess staffing levels. They clearly understood the tool and demonstrated competence in how the tool was used. However, they could not confirm that nurses were always moved or increased in number to safe levels. Staff did not always report staff shortages as an incident unless there was a specific reason (such as a patient incident) to do so.

Some staffing to patient ratio levels were not always in line with the acuity of patients. For example, on the cardiology ward (Gate 27a), we found there were eight to 10 patients in the enhanced care bays at the time of our visit. The nursing establishment was based on a one nurse to three patients. Actual staffing levels achieved this in some cases by including the shift coordinator, other supernumerary staff (for example, the practice development or research nurses) or the ward manager in the staffing numbers giving direct care to patients. However, during the night shift when these staff were not on duty the one to three ratio was fulfilled by two registered nurses and one band four assistant practitioner. Required staffing ratios were compromised when staff left the ward to escort acutely ill patients being transferred to a nearby NHS hospital, which happened regularly.

Staffing levels met the criteria set out in British Thoracic Society guidelines for the ventilator management of acute hypercapnic respiratory failure in adults (2016). This guidance states staffing levels should be above that of a general ward with one nurse for every two non-invasive ventilated patients.

The staffing skill mix was not adjusted on surgical wards where medical patients were accommodated when there were no beds available on medical wards. Staff on wards with medical patients reported they did not feel they had the correct skill mix at times. We heard examples of a ward staffed for elective orthopaedic patients having medical patients with complex care needs, including dementia.

There were vacancies within the workforce. Between August 2016 and July 2017, the trust reported a turnover rate of 13.2% for registered nursing staff, and a vacancy rate of 8.8%. This equated to a vacancy for 27.9 whole time equivalent nursing staff. The ward with the highest shortage of staff was the Acute Medical Unit (Gates 31A&B), which had 6.6 fewer whole time equivalent nursing staff members compared to the planned establishment.

Agency and bank staff were used to cover nursing vacancies. Agency staff on the wards between August 2016 and July 2017 filled 1,266 shifts and bank covered 10,052 shifts. During the same
period, there were 2,117 shifts unfilled by bank or agency staff to cover sickness, absence or vacancies.

Overall, the medicine was short by 27.9 WTEs compared to funded establishment. The 10 wards/units with the biggest difference between WTE establishment and number of staff in post were:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE establishment</th>
<th>Number in post as of July 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit Gate 31A&amp;B</td>
<td>124.08</td>
<td>110.66</td>
<td>13.42</td>
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<tr>
<td>Ward 27A</td>
<td>20.8</td>
<td>17.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Ward 9B Flex Capacity</td>
<td>26.1</td>
<td>22.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Ward 28B (Complex)</td>
<td>20.8</td>
<td>17.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Ward 27B</td>
<td>18.3</td>
<td>15.9</td>
<td>2.4</td>
</tr>
<tr>
<td>CARE</td>
<td>5.3</td>
<td>3.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Elgar Ward 1</td>
<td>10.8</td>
<td>8.8</td>
<td>2.0</td>
</tr>
<tr>
<td>BRAHMS Unit</td>
<td>4.3</td>
<td>2.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Neuropsychiatry (non-Medical)</td>
<td>9.3</td>
<td>7.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Haematology Specialty</td>
<td>8.2</td>
<td>6.8</td>
<td>1.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Out of hours and at weekends, the interventional radiology unit was staffed by bank and agency nurses. The trust used a specific group of bank staff, and agency nurses were always paired with one of these experienced bank staff. Agency and bank staff completed an induction checklist to ensure they were safe to work on a ward or clinical area before commencing work.

Action had been taken to increase the numbers of employed staff, and thus reduce the use of agency staff. This included the introduction of trust recruitment days. On these days, stands were erected in the atrium where staff met with people interested in applying for jobs. The trust offered nurses who attended the recruitment day an interview and the job on the same day if they met the criteria for employment.

Sickness rates were in line with the NHS national average. Between August 2016 and July 2017, the trust reported a sickness rate of 3.9% for registered nursing staff in medicine.

**Medical staffing**

There was good coverage from medical staff. The trust medical staffing skill mix was slightly
different to the England average. There was a higher ratio of junior and consultant medical staff and a lower ratio of registrar and middle grade doctors.

The staffing skill mix for the whole time equivalent staff working in medicine at North Bristol NHS Trust can be seen below:

**Staffing skill mix for the 209 whole time equivalent staff working in medicine at North Bristol NHS Trust.**

<table>
<thead>
<tr>
<th>Staffing Skill Mix</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>26%</td>
<td>22%</td>
</tr>
</tbody>
</table>

*Source: NHS Digital - Workforce statistics (01/06/2017 - 30/06/2017)*

To ensure locum doctors were adequately skilled, there were set requirements before medical staff could fill these temporary roles. This included a minimum of three months UK-based experience in the last year, GMC registration, two references, an enhanced disclosure barring service check, and in date certificate of fitness to practise. The medical division used locum doctors to cover 3,058 shifts between August 2016 and July 2017.

Consultants and doctors carried out appropriate timely ward rounds. Handovers were completed twice daily with a safety briefing documentation completed each time.

Medical staff we spoke with said there was adequate consultant presence with daily consultant led ward rounds. Consultants also reviewed any new or unwell patient on weekends.

Sickness rates were in line with the NHS national average. Between August 2016 and July 2017, the trust reported a sickness rate of 1.3% for medical staff in medicine.

**Records**

Patient records were legible, timed and dated, although sometimes inconsistent in their completion. Records were stored both electronically and in paper format. Medical records were in a paper format, with plans to introduce electronic patient records in the near future. Nursing assessments and documentation were partly paper-based and partly kept electronically.

We reviewed 20 sets of patient medical records and found there was an inconsistent approach to the completion of both the electronic and paper records. Nurses could access an overview of up-to-date risk assessments. However, staff were not always sure whether risk assessments had been completed due to the two systems in use. We reviewed the completed risk assessment overview on the cardiology ward (Gate 27a) during our inspection. Although most risk assessments were up-to-date, there were some risk assessments, which were overdue by more than one day. Overdue risk assessments meant some patients may be at risk of harm,
The trust did not monitor and audit documentation about patients care and treatment. We asked for documentation audits, which the trust did not provide.

**Medicines**

Medicines were managed safely and systems ensured patients received the right medication. We spoke with pharmacists who were allocated to different inpatient wards throughout the medical division. Pharmacists reviewed patient medicine charts daily during the week. This was to ensure patients’ regular medicines were prescribed and administered accurately on the wards.

Medicines were supplied and stored securely in all clinical areas. All medicines were kept in locked cupboards with only authorised staff having access to keys.

Medicine refrigerators temperatures were not always monitored daily to ensure medicines requiring refrigerated storage were maintained at the right temperature. For example, on the medical assessment unit (Pod 4) the fridge temperature was not monitored on 19 days between 4 September 2017 and 8 November 2017. This was also the case with three other fridges we checked elsewhere.

The ordering, receipt, storage, administration and disposal of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and its associated regulations. Suitable stocks of medicines were kept to ensure they were available at all times and prevent wastage. We checked a range of medicines, and found all were within their use-by date. We did spot checks on stocks and use of controlled drugs and found all tallied with records.

The recording and documentation of medication was mostly in line with guidance. Medicine prescription charts were legible, signed and mostly completed correctly. Patients’ allergies were recorded or if patients did not have any known allergies, this was also recorded. Nurses signed when they administered medicines. We did not see any omitted medicines without a valid reason stated. However, we observed an episode where medicines were being dispensed earlier than the prescribed time. We raised this with staff who told us this was because the doctor requested the medicines to be given early based on the patient’s needs. However, this had not been documented and therefore would not be clear to other staff members. Following us raising this, the prescription was changed by a doctor to ensure this was clear.

Where antibiotics were prescribed, medical staff did not always document a clear stop date. Medicine charts did not prompt medical staff to review the antimicrobial prescription. This was not in line with National institute for Care and Health Excellence (G15, 2015).

Patients had adequate information about the medicines they would be taking home. We observed the medication name, dosage and frequency as well as the reason for taking the medicine being explained to patients on discharge home. Patients were also provided with this information in written format to take home.

**Incidents**

The medical division managed patient safety incidents well and took appropriate action in response to significant incidents. The trust had an electronic incident reporting system and staff understood their responsibilities to report incidents and near misses such as, for example, pressure ulcers, medicines errors, falls and safeguarding.

In the year to August 2017, the trust reported no incidents classified as ‘never events’ for the medical division. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has
the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened because of a specific incident occurrence for that incident to be categorised as a never event.

In accordance with the NHS Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in the medical division, which met the reporting criteria set by NHS England between September 2016 and August 2017.

The breakdown by SI type was:

Eleven of these SI’s were coded as “Slips/trips/falls meeting SI criteria”. Of these, all but three were explicitly noted to be unwitnessed falls. Five SI’s were pressure ulcers meeting SI criteria. All five were hospital-acquired grade three pressure ulcers. This is the second most serious category of pressure ulcer in terms of harm to the patient. (Source: Strategic Executive Information System (STEIS))

There was learning from both serious and other incidents and changes made to practice. For example, on the cardiology ward (Gate 27a), staff told us if patients were admitted to the ward with a cannula (a small plastic tube in a vein) this was removed and re-sited. This was a change in practice following an incident of *Methicillin-resistant Staphylococcus Aureus* (MRSA) bacteraemia being discovered in a patient admitted for an emergency invasive procedure. The investigation demonstrated it was not known if the cannula had been inserted in the ambulance on route to the hospital. However, this was thought to be a contributing factor for the infection.

Senior nursing staff completed investigations into serious incidents, including identification of lessons learnt from the incidents. We reviewed two investigations of serious incidents and found these to be comprehensive with lessons to be learnt identified and actions to mitigate the risk of reoccurrence. However, we were not assured that learning was shared with all relevant staff. In one of the investigated incidents, there was a lesson to be learnt for an individual member of staff, but the investigation did not demonstrate wider learning for the team or cross-divisional learning.

Actions to prevent incidents occurring again were identified and then shared. Staff were informed of changes to practice through feedback from the incident reporting system, as well as at team
meetings and through training. For example, on ward 32a, there had been six falls resulting in serious harm to patients in the last six months. Following completion of investigations, it was decided falls risk assessments should be completed within six hours of admission to the ward. Audits demonstrated an improvement from 20% to 80% of this risk assessment being completed in a timely manner. The trust had also introduced a process where the head of nursing, matron and ward manager, reviewed falls within 48 hours. Other staff involved were also invited to attend this meeting for learning.

Staff were encouraged to be open and honest in reporting incidents. Staff we spoke with said they felt confident in reporting incidents, and they had good knowledge of what and how to report.

Duty of candour was applied when appropriate to do so. 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 introduced to this during their induction programme including a face-to-face presentation. We saw evidence of duty of candour being applied. We looked at two letters sent to different patients; they included an apology, initial facts and the timeline for a full investigation.

The trust had effective processes to review inpatient deaths through mortality reviews. We reviewed statistical indicators, such as the hospital standardised mortality ration (HSMR) and the summary hospital-level mortality indicator (SHMI). Both of these demonstrated that mortality indicators remained below 100, which meant that mortality at the hospital was better than expected, when compared to other NHS trusts. The trust had a policy and standard operating procedure to provide up-to-date guidance for mortality reviews in accordance with national guidance. Each speciality had a medical mortality lead who reviewed all patient deaths to identify concerns relating to care and treatment. If concerns were highlighted, the medical records were scrutinised using a national framework. The trust introduced this new framework (The Royal College of Physicians: structured judgment review) in July 2017, to support the review of patients’ death in order to identify learning. At the time of our visit, the trust had reviewed 50% of all inpatient deaths and there was a backlog of mortality reviews. This was due to a requirement on medical staff to review all deaths from April 2017. There was a plan to achieve a review of 95% of all inpatient deaths by the end of June 2018, including those where no concern was identified, to ensure there were no issues being missed.

**Safety thermometer**

Harm free care was being monitored and reported. Avoidable patient harm data was collected and reported for all medical areas by using the NH Safety thermometer tool. The safety thermometer was used to record the prevalence of avoidable patient harm. This included pressure ulcers, falls with harm and certain infections. It also provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

Measurement at the frontline was intended to focus attention on patient harms and their elimination. Data collection took place one day each month, and data must be submitted to NHS Digital within ten days of the suggested data collection date.

Data from the patient safety thermometer showed the trust reported 71 new pressure ulcers, 54 falls with harm and 16 new catheter urinary tract infections between August 2016 and August 2017 for medical services. Data demonstrated the overall hospital delivered between 92% and 95% in the period from April 2017 to September 2017 against a national average of 94%.

We reviewed data on pressure sores in the integrated performance report (September 2017) and found the medical division had reported between 120 pressure injuries in the year to date. The
vast majority of these were classified as grade two pressure damage. Between July and September 2017, the prevalence of new pressure ulcer developing in patients receiving care and treatment in the medical division was 1.3 new ulcers per 100 patients sampled. This was worse than the same period in 2016 (0.6 pressure ulcers per 100 patients sampled). The hospital reported there was 0.6 pressure incidents per 1,000 bed days in September 2017. There was no national comparable data to benchmark against other and similar trusts.

Prevalence rate (number of patients per 100 surveyed) of avoidable harm at North Bristol NHS Trust:

- **Total Pressure ulcers (71)**
- **Total Falls (54)**
- **Total CAUTIs (16)**

(Source: NHS Safety thermometer)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national and evidence-based guidance. The medical division used guidance based on national quality standards from the National Institute for Health and Care Excellence (NICE). For example, in cardiology there were care pathways for patients admitted with different types of heart attack or arrhythmias. Staff knew how to access the pathways on the trust’s intranet, and there was evidence sampled pathways were regularly reviewed. For example, the ‘suspected acute coronary syndrome guideline’ was reviewed in June 2017. The pathway reflected NICE quality Standard (QS68) (2014), although this was not clearly referenced on the pathway. Other examples of evidence-based care pathways included the ‘ascitic drain pathway’ used by staff on ward 8a.)
The trust responded to NHS National Patient Safety Alerts (NPSA) to ensure safe practice was being used. For example, we reviewed the adult and child nasogastric (NG) tube insertion record, which had been updated following an NPSA alert in 2011. This concerned the safe insertion and the availability of sufficient expertise to confirm correct positioning of the NG tube. Care plans were regularly reviewed against the guidance, and were last reviewed in 2017. This followed episodes of pressure damage to patients caused by NG tubes; the care plan had been amended to encourage staff to check for pressure damage daily.

Staff were aware of national guidance for sepsis screening and management. Medical staff used a methodological approach to primary assessment to ensure acutely ill patients, including patients with sepsis (a life-threatening condition) were identified for prompt treatment. Medical staff in the medical assessment unit used a designated form for primary assessment of medical patients. If patients displayed symptoms of sepsis, there was a sepsis screening and action tool to provide guidance for treatment and escalation. If nurses identified a deterioration that could be attributed to sepsis, they used a sticker, which clearly identified this and included guidance about how to escalate concerns.

The endoscopy unit gained accreditation from the Joint Advisory Group on gastrointestinal endoscopy (JAG accreditation) in June 2017. This meant the service met all of the standards to provide a high-quality service.

**Nutrition and hydration**

Staff assessed patients’ nutritional needs on admission. Staff used an electronic based assessment tool similar to the Malnutrition Universal Screening Tool and involved the regular assessment of patients’ weight. The tool had triggers of when to alert staff to refer the patient for a dietetic assessment and review. Staff told us dietitians were easy to contact and responded quickly when patients were referred.

There were processes to follow for the safe insertion and ongoing care of patients requiring a nasogastric feeding tube (a tube inserted via the nose into the stomach). The insertion record and care plan included guidance on how to ensure safe positioning and how to care for patient with a nasogastric tube. Staff referred all patients with a nasogastric tube to the dietetics team, so patients were able to be provided with individual prescribed nutrition.

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary to support patients with specific needs.

Staff completed fluid and hydration charts for patients as required in their plan of care. The charts we reviewed were mostly completed correctly. However, we spoke with one patient who appeared dehydrated, and their beaker of water was untouched. Their fluid and hydration chart had not been completed following breakfast. The patient said they were “very thirsty” and drank all the drink when prompted. We observed water and drinks were mostly placed within arm’s reach of the patients.

**Pain relief**

Patients had their pain assessed and managed, and appropriate tools were used to help assess their level of pain. Staff used assessment tools based on national guidance to help assess pain. The medical service used two different pain assessment tools. One tool was the Visual Analogue Scale, which was used for patients to assess their pain on a scale from one to 10. The other pain assessment tool was the ‘Abbey Pain Scale’. This was a recognised tool to assess pain for patients with cognitive impairment (such as dementia), or for patients who were unable to clearly articulate how they were feeling. This tool was based on interpretation of facial expressions,
changes in body language, behavioural changes, and physiological changes. It also looked for physical indicators such as existing pressure ulcers, arthritis or similar conditions. The pain assessment tools provided guidance for clinical staff to manage patients’ pain, known as the ‘acute pain analgesic ladder for adult patients. The guidance provided information about the most effective pain relief for different severities of pain. We saw staff use the pain assessment tool effectively. Patients we spoke with told us staff asked them about pain regularly, and encouraged them to ask for pain relief if they needed to.

The trust had an acute pain team, although this was not available seven days a week. The chronic pain service was available to patients through an outpatient appointment. A pain specialist nurse supported by a specialist consultant provided the acute pain service. However, national guidance recommended a minimum of two consultants for crossover and peer support (Faculty of Pain Medicine Core Standards for Pain Management (2015) standard 5.2.1). The acute pain service was not a seven-day service and only available during the week from Monday to Friday. The chronic pain service was delivered via outpatient appointments and staff told us they were overwhelmed by the number of patients referred to this service.

**Patient outcomes**

The service performed worse overall than the England averages in six of seven national patient outcome audits we reviewed. However, it should be noted that three of the audits were based on data from 2015/16, which was the latest available data provided at the time of our inspection.

The service monitored the effectiveness of care and treatment and used the findings to improve them. They took part in a number of national audits and used local results to compare with results from other services and similar services, to learn from them.

The trust experienced a higher level than expected for readmissions for some patients. Between June 2016 and May 2017, patients at the trust had a higher than expected risk of readmission for most elective and non-elective admissions when compared to the England averages.

- Of the top three elective specialties by count of activity, patients in elective gastroenterology and nephrology had higher than expected risk of readmission than the respective England averages.

- Of the top three non-elective specialties by count of activity, patients in non-elective general medicine and respiratory medicine had higher than expected risk of readmission than the respective England averages.

**Elective Admissions – Trust Level**

![Elective Admissions Graph]

**Non-Elective Admissions – Trust Level**

![Non-Elective Admissions Graph]
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 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/06/2016 - 31/05/2017))

Sentinel Stroke National Audit Programme (SSNAP)

The trust took part in the Sentinel Stroke National Audit Programme (SSNAP). In the SSNAP audit, performance is rated from ‘A’ (being the best) to ‘E’ (being the worst). The trust’s stroke service was rated as D overall for December 2016 to March 2017.

The service was rated as ‘A’ for scanning (both patient- and team-centred) for both periods and rated as ‘B’ for thrombolysis (both patient- and team-centred) for both periods. However, its stroke unit indicator result fell to D for December 2016 to March 2017 (both patient- and team-centred). We discussed this with stroke consultants who explained one of the factors affecting this might be that the services were registered as one unit although care and treatment was delivered on two wards. The consultant also highlighted the lack of seven-day service provision to the decline in performance data.

Data summary:

Southmead Hospital

<table>
<thead>
<tr>
<th>Overall scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-Mar 17</th>
</tr>
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<tbody>
<tr>
<td>Overall Scores</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSNAP level</td>
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<td>D</td>
<td>C↑↑</td>
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<tr>
<td>Case ascertainment band</td>
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<tr>
<td>Audit compliance band</td>
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<tr>
<td>Combined Total Key Indicator level</td>
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Patient centred Performance

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<th>Aug-Nov 16</th>
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<tr>
<td>Domain 2: Stroke unit</td>
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### Domain 1: Scanning

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<td>A</td>
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### Domain 2: Stroke unit

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<th>Apr-Jul 16</th>
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<td>C</td>
<td>E↓↓</td>
<td>C↑↑</td>
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<td>D↓</td>
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### Domain 3: Thrombolysis

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<td>B↑↑</td>
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### Domain 4: Specialist assessments

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### Domain 5: Occupational therapy

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### Domain 6: Physiotherapy

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### Domain 8: Multi-disciplinary team working

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### Domain 9: Standards by discharge

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### Domain 10: Discharge processes

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### Team-centred Total Key Indicator Level

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*Source: Royal College of Physicians London, SSNAP audit*

**Heart Failure Audit**

In-hospital Care Scores:

20171116 900885 Post-inspection Evidence appendix template v3
Results for North Bristol NHS Trust in the 2015/16 Heart Failure Audit were worse than the England and Wales averages for all four of the standards relating to in-hospital care.

The trust’s results were particularly poor compared to the national average for the proportions of patients that received input from a specialist (58.4% compared to the England and Wales average of 79%) and that received an echo (74.5% compared to the England and Wales average of 90.1%). The trust had recognised the need for improvement and a business case had been submitted for the additional resources required.

Discharge Scores:

Results for North Bristol NHS Trust were worse than the England and Wales averages for all but one of the nine standards relating to patient discharge.

- The trust’s results were particularly poor compared to the national averages for the proportions of patients referred to heart failure nurse follow-up (17.6%) for all patients
compared to the national average of 54.8%.

- The referral rate to heart failure nurse for patients with left ventricular systolic dysfunction (LVSD) was 21.5% compared to the national average of 70.8%.
- Referral for cardiology follow-up was 30.4% compared to the national average (47.2%).
- Patient referral rate to cardiac rehabilitation was 1.9% compared to the national average of 12.1%.

Source: NICOR - Heart Failure Audit (01/04/2015 - 31/03/2016)

National Diabetes Inpatient Audit

The trust performed worse that the national average in six of eight measures in the 2016 National Diabetes Inpatient Audit (NaDIA). The audit measures the quality of diabetes care provided to people with diabetes and aims to support quality improvement.

The audit attributes a quartile to each metric, which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 137 in patients with diabetes at the trust.

- Lower proportions of the trust’s patients received a diabetic foot risk assessment both within 24 hours (21.9% compared to 30.1% for England) and during the whole of their hospital stay (24.8% compared to 37.5%). Both results placed the trust between the respective upper and lower England quartiles.
- The proportion of patients visited by a member of the diabetes specialist team was 24.1% compared to 34.1% nationally. This placed the trust in the lower England quartile.
- Somewhat higher proportions of the trust’s patients experienced errors in medication management (29.7% compared to 24.1% for England) and insulin errors (27.5% compared to 22.7% for England) during their stay. Both results placed the trust between the respective upper and lower England quartiles.
- The proportion of patients experiencing mild hypoglycaemic (low blood sugar levels) episodes was 22.7% and somewhat higher than the overall England proportion of 18.5%. This placed the trust in the upper (worst) quartile. However, the proportion experiencing a severe hypoglycaemic episode was 8.4%, which was very similar to the overall England proportion of 8.3%.
- A lower proportion of diabetic patients (45.1%) reported that the choice of meals was suitable, compared to 54.7% of patients nationally.
- A lower proportion of patients reported that the staff looking after them knew enough about diabetes (61.7%) compared to the overall England proportion (65%).

There was a smaller number of metrics where the trust outperformed England overall, but these included a few particularly important metrics:

- A high proportion of patients with diabetes (90.4%) reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which placed the trust in the upper (better) England quartile. The overall England proportion was 83.7%.
- The proportion of patients (75%) who reported that they were able to take control of their diabetes care was higher than the national average of 60%. This again placed the trust in the upper England quartile.

(Source: NHS Digital)
Myocardial Ischaemia National Audit Programme (MINAP) 2015/16

The trust performed worse than the overall England and Wales averages for three of the four metrics relating to patients with non-ST-elevation myocardial infarction (nSTEMI, a type of heart attack without characteristic electrocardiogram changes):

- The proportion of patients seen by a cardiologist (91.8%) was lower than the overall England and Wales proportion of 96%.
- A much lower proportion (11.4%) of patients admitted with an nSTEMI were admitted to the cardiac unit or ward. This was lower than the overall England and Wales proportion of 57.5%.
- The proportion of patients (79.2%) that received all the secondary preventive medication that they were entitled to was lower than the national proportion of 90.5%.

However,

- The proportion of the trust’s nSTEMI patients who had an angiography during their admission, 90.7%, was higher than the overall England and Wales proportion of 84%.
- The average lengths of stay were six days for ST-elevation myocardial infarction patients and seven days for non-ST elevation myocardial infarction patients.

In the published report, no data were reported for Southmead Hospital for the four metrics relating to primary percutaneous coronary intervention reperfusion therapy for patients with ST-elevation myocardial infarction (a type of heart attack with characteristic ECG changes). This was because the hospital submitted fewer than 20 relevant records to the audit, meaning that there would have been a risk of identifying the individuals concerned.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit 2016

The trust participated in the 2016 Lung Cancer Audit and performed similarly or better than the national average in four of five measures. The proportion of patients seen by a cancer nurse specialist was 54%, which was just below national average of 55%. However, this did not meet the audit minimum standard of 90%.

The results for the other measures were similar to the national average:

- The proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) receiving surgery was 32.2%, which was not significantly different from the national average of 24%.
- The proportion of fit patients with advanced NSCLC receiving chemotherapy was 72%. This was not significantly different from the national average of 64% and met the national aspirational standard of 60%.
- The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 73.9%. This was not significantly different from the national average of 69% and met the national aspirational standard of 70%.
- The one-year relative survival rate for the trust in 2016 was 49.5%. This was significantly better than the national average of 38%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The trust performed worse than the national average in four of seven measures. However, the trust’s results for the remaining three measures were significantly better than the national (England and Wales) average. The audit provided a snapshot of 30 patients audited, which
allowed for national comparison with other NHS trusts. The trust was awaiting this audit data at the time of our inspection and planned to review the data and produce action plans to improve practice. Data showed that

- The proportion of patients who had a lying and standing blood pressure assessment (if applicable) was zero - none of the audited patients had this assessment. This did not meet the national aspirational standard of 100%, and worse than the national average of 19.1%. This result was worse than the 2015 audit result.
- The proportion of patients assessed for the presence or absence of delirium (if applicable) was 15%. This did not meet the national aspirational standard of 100%. The trust’s result was worse than the national average of (39.7%) and worse than the 2015 audit (35.7%).
- The proportion of patients assessed for medication that increased falls was 8% and worse than the national average (47.8%). This was also worse than the 2015 result (16.7%).
- The proportion of patients with a call bell in sight and in reach was 73%, which was below the national average of 81.3%. This was similar to the 2015 result (75%).
- The proportion of patients who had a vision assessment (if applicable) was 57%. This did not meet the national aspirational standard of 100%, but was better than the national average of 46.2%. This had improved from the 2015 audit (37.9%).
- The proportion of patients with an appropriate mobility aid in reach (if applicable) was 100%. This met the national aspirational standard of 100%, and had improved from the 2015 audit (33.3%) and was better than the national average of 71.5%.
- The proportion of patients with a continence or toileting care plan was 86% and better than the national average (66.9%). This was an improvement of the 2015 audit result (63.6%).

(Source: Royal College of Physicians)

Competent staff

Staff had the right qualifications, skills knowledge and experience to carry out their roles. There was a process whereby through induction, new staff went through a series of competency assessments to ensure they were able to complete their tasks safely. This continued in some areas in ongoing practice. In endoscopy, for example, staff were observed annually by a nurse endoscopist, to ensure ongoing competence.

There were processes to ensure staff were trained and assessed as competent to use different medical devices such as syringe drivers or pressure relieving mattresses. However, on the respiratory ward there was limited structure to ensure all staff were assessed to be competent to use non-invasive ventilator support equipment. There were no structured modules for staff to attend to gain the learning and no timeframes for completion of competency assessments.

There was an induction programme for new staff and a checklist for temporary staff to orientate them to the ward environment. We spoke with some staff that had recently started in their new job. They told us the induction was comprehensive and they felt well supported. The medical assessment unit had a dedicated practice development nurse who oversaw all the training on the ward, including induction and competence assessments for new staff.

The trust employed assistant practitioners and supported health care assistants to undertake the qualification, which would allow them to progress to band four assistant practitioner roles.

Staff were encouraged to undertake further post registration qualifications. However, it was difficult for staff to get funding to attend these courses and the cost meant some staff said they were unable to apply themselves. Nursing staff on the cardiology ward were encouraged to
undertake immediate life support training and we were told approximately 70% of nursing staff held this qualification.

Nursing staff were encouraged and supported to undertake a post-registration cardiology course. The ward manager told us 50% of nurses held a post registration qualification. Nursing staff within the endoscopy unit had undergone additional training and some had gained additional qualifications to enable them to undertake certain low risk endoscopy procedures.

Staff felt able to deal with violence or aggression in an effective and safe manner. Staff said they had good support from mental health liaison colleagues and knew how to access support if required.

All medical staff had received clinical supervision between August 2016 and end of July 2017. There were training and development opportunities for medical staff in the division. There was a rotation programme for junior doctors. Most junior medical staff felt teaching and training was good, although some told us they did not think it was as good as they would have liked. There were some opportunities for specialist registrars (level 7/8) to gain experience by acting up at consultant level for a period of time with distant supervision.

Compliance with annual appraisals (performance reviews) was below the trust target. During appraisals, staff had the opportunity to discuss their professional development needs including revalidation for medical and registered nursing staff. However, between April 2016 and March 2017, only 64.1% of staff within the medical division received an appraisal. This was particularly poor among support staff. The trust target was to achieve annual appraisals for all staff (100%) with the exception of medical staff, at the end of the financial year (not including staff on long-term leave). Appraisals for medical staff could be delayed by up to three months within their professional revalidation system, and therefore the trust aimed to reach 100% completion in a 15-month period. Consultants received an annual appraisal as part of their revalidation, which was overseen by the medical director.

A split of appraisal rates by staff group can be seen in the graph below.

**Appraisal completion rates within Medicine, April 2016 and March 2017**
Multidisciplinary working

We saw outstanding examples of multidisciplinary working deliver effective care. Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw examples of when different healthcare professionals were involved with individual patients’ care and treatment. We reviewed patient care records, which demonstrated different health care professionals such as physiotherapists, occupational therapists and dietitians reviewed and developed care plans with patients. We spoke with a patient who commended the multidisciplinary working between different healthcare professionals in the division.

The service used ‘board rounds’ to ensure a daily multidisciplinary approach to patient care and treatment. For example, on complex elderly assessment unit (Gate 32a) there was a nurse led ‘board round ‘in the morning followed by a therapy-led lunchtime meeting. These were designed to ensure agreed care and treatment plans were implemented and helped to identify actions that would enable patients to be discharged. At various times, consultants, physiotherapists, social workers, junior doctors and nursing staff attended this meeting. There was a clear focus and discussions to ensure all patients’ needs were highlighted. We observed part of a board round on the cardiology ward (Gate 27a). The board round was attended by doctors and nursing staff, including the head of nursing, and appeared to be well organised. Staff identified the acuity (intensity of care) of patients and plans to ensure effective treatment and care to lead to their timely discharge. On the acute medical assessment unit, we observed a board round attended by 28 members of staff including five consultants, an acute oncology nurse, the complex assessment and liaison nurse, a mental health practitioner, pharmacist and an alcohol addiction counsellor.

There were clear decisions about who was responsible for patients’ care, which was in line with the Royal Colleges’ guidance for Taking Responsibility (2014). Staff knew who the accountable consultant for the patients in the ward or department was, and medical staff knew which patients were under the care of the consultant to whom they reported. The medical division had a high number of medical patients in wards that were not designated as medical wards. There were more than 60 medical patients admitted to beds in surgical units on the days we inspected the service. The trust had employed a consultant physician to ensure treatment and care of these patients was reviewed and safe. There was a team of four junior doctors who were allocated to review medical patients on surgical wards during the week from Monday to Friday. Out of hours and at weekends, this was handed over to the on-call consultant and on-call junior doctors.

Medical staff received timely reports for investigations undertaken in other departments. Medical staff requested further investigation from other departments within the trust such as pathology or the X-ray department.

Key information about patients, including those with complex needs, was shared effectively with other healthcare providers when patients were discharged from hospital. When staff discharged patients to their home or to community care services, medical staff wrote a discharge summary, which was also shared electronically with the patient’s GP.

Patients admitted to Elgar 1 did not receive continuous therapy assessments while they were waiting for transfer on discharge. This meant there was a potential for deterioration if rehabilitation activities were not maintained.

Seven-day services
In a self-assessment, the medical division did not meet one of the four seven-day services priority standards as recommended by NHS England. The four priority standards included time to first consultant review, access to diagnostics and consultant-directed interventions and ongoing review of patients. We reviewed compliance in a NHS England survey and found there was poor compliance with priority standard eight. This standard required all acutely ill patients, including those patients whose condition deteriorated, to be seen by a consultant twice daily. Compliance with this standard was 61% over seven-days, 64% on weekdays and 52% at weekends. There was also a low compliance (81%) with standard two (consultant review within 14 hours of admission) at weekends. However, we reviewed eight patient records and found good compliance with consultant review within 14 hours of admission in all of the eight records.

Seven-day consultant cover in the medical division was adequate to ensure safe care and treatment of patients. For example, in the medical assessment units there were four consultants in the unit between 8am and 10pm during the week, although this was reduced to two consultants over the weekend. Overnight there was one consultant on call, who, as per national guidance, lived within a 30-minute journey of the hospital.

Stroke services did not provide 24-hour service seven days a week but patients suffering a stroke still received care and treatment in a timely manner. The service was in the process of developing a hyper acute stroke unit to facilitate thrombolysis (a treatment to dissolve dangerous clots in blood vessels) away from the emergency department. The consultant numbers at the time of our inspection did not enable stroke consultants to cover this service seven days a week and out of hours. Stroke consultants worked Monday to Fridays. Out of hours and over the weekend, care of stroke patients was handed over to consultant neurologists. Patients admitted to hospital out of hours and over the weekend, with a stroke (blood clot on the brain) received treatment by consultants working in the emergency department. This was designed to ensure patients received treatment in a timely manner at all times.

The provision of therapy to enable effective rehabilitation for stroke patients was limited at weekends. Occupational therapists, physiotherapists and speech and language therapists mostly worked Monday to Friday with limited weekend cover.

The cardiology service did not perform emergency and urgent cardiology interventions out of hours and at weekends. Patients admitted to hospital after 5pm and at weekends with an acute heart attack that required urgent intervention, were transferred to a nearby NHS hospital. This is not unusual practice when there is a specialist service nearby providing emergency and urgent treatment. However, the service was able to provide treatment for patients requiring a temporary pacemaker 24 hours a day and seven days a week.

Pharmacists reviewed patients’ medicine management on inpatient wards every day Monday to Friday. Out of hours and at weekends pharmacists provided on call cover.

**Health promotion**

The service had processes to identify patients who may need extra support. Staff referred patients to additional support or intervention where risks to ongoing health were identified. For example, we spoke with the cardiac rehabilitation specialist team who visited the cardiology ward every day (Monday to Friday). This was in order to pick up referrals for patients who had been admitted with a heart attack. The cardiac rehabilitation team routinely offered advice and information to patients about giving up smoking, and referred patients to community services for smoking cessation support. Staff ensured nicotine replacement therapy was prescribed if patients accepted this. The cardiac rehabilitation service offered outpatient appointments to help patients to make lifestyle changes, including attending exercise classes. Other examples of health promotion guidance
offered by staff to patients included advice relating to alcohol consumption. This meant staff engaged with national priorities to improve the population’s health.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Some staff had an insufficient understanding of mental capacity assessment, and some assessments made were not formal. Staff on some wards told us mental capacity assessment was ‘informal’. We checked three sets of medical notes on the cardiology ward (Gate 27a) for patients with a deprivation of liberty safeguards application. We found no documented mental capacity assessment for these patients. When we asked, a member of staff answered ‘you just know (if patients have mental capacity or not)’.

Mental capacity assessments were not always recorded. There was a trust wide assessment to determine capacity form available via the intranet but this was not found in any of the five records we reviewed on a complex care of the elderly ward (Gate 9b). However, we saw completed examples of the abbreviated mental test score, which was used as an indicator of a patient’s memory and level of confusion.

Mental capacity assessment was not always documented on the resuscitation-decision form (documentation used to inform clinical staff about decisions around active resuscitation for a patient) in line with national guidelines. There was a space for comments if decisions were discussed with patients and/or those close to them. However, on the cardiology ward (Gate 27a) we saw three forms that were signed by consultants or a registrar, where information about mental capacity was not completed. In addition, there was no documented evidence of a discussion with patients and/or next of kin in two of the three forms reviewed. There was no treatment escalation plan documented on any of the three forms reviewed. This meant national guidance (Joint Statement, 2016) on the completion of resuscitation forms was not always followed.

The Trust provided examples of training materials and supporting guidance for staff with respect to the approach to implementing the requirements of Deprivation of Liberty Safeguards (DoLS). However, we found that staff had varied understanding of when to submit a standard application for a Deprivation of Liberty Safeguards (DoLS) authorisation. We spoke to different staff about their understanding of this. Some staff told us a DoLS application was completed if patients were unable to give consent-to being in hospital. This appeared to be a blanket decision, even if patients were not trying to leave the ward environment. This was line with the Cheshire West ruling (2014) that changed the legal test of DoLS as described in the Mental Capacity Act Code of Practice. This lays out a three stage test for a person deprived of their liberty and goes on to say that that the persons compliance or objection are not relevant. We reviewed one set of notes on the gastroenterology ward (Gate 8a) where there was no reason other than confusion documented for the DoLS application. This was insufficient information for an DOLS application.

Staff had good understanding of ‘best interest’ decisions about care when patients were not able to contribute towards decisions about their care. Staff knew how to access support, for example independent mental capacity advocates for patients lacking mental capacity.

Staff understood their roles and responsibilities under the Mental Health Act 1983. They knew how to support patients experiencing mental ill health. Staff had access to mental health liaison staff and knew how to contact them for support if required. In the acute medical assessment unit, staff worked closely with mental health liaison staff who also attended daily board rounds on the unit.

Staff had a good understanding of the consent process and what was required to gain valid informed consent. Staff were aware of asking for verbal consent from patients before tests such as
taking blood pressure or other low-risk care or treatment interventions were undertaken. Patients told us staff always asked their permission for any care or treatment was undertaken.

In the endoscopy unit, patients were sent written information prior to their appointment for an endoscopic procedure. This booklet contained information about the procedure, the possible risks and guidance about how to prepare. It included what would happen during the procedure and advice about post-procedure care. A consent form formed part of this booklet, which patients were asked to sign and bring along to their appointment. When patients attended for their appointment, staff re-confirmed the patient’s consent with them and also signed the consent form. The unit had competencies for nurses to complete before they could take confirmation of consent with patients for low-risk procedures only. Consultants confirmed consent with patients on the day of the procedure for medium to high-risk procedures.

Staff received training and regular updates in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their induction and thereafter as part of regular statutory and mandatory updates. The trust reported that as of August 2017, Mental Capacity Act and Deprivation of Liberty Safeguards training had been completed by 88.1% of staff within the medical division. Therefore, the trust’s 85% target was met.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

Staff were observed to be caring, compassionate and attentive in their interactions with patients. Staff introduced themselves to patients and took care to engage with patients. For example, we saw them bending down to make eye contact with patients and making sure they knew their names. We heard a discussion among staff about the discharge of a patient who did not have any suitable clothes to leave hospital. A member of staff suggested they would go the emergency department, where there was donated clothing for staff to give to patients when needed. This demonstrated staff cared about people as individuals.

Feedback from patients was overwhelmingly positive and confirmed staff treated them well and with compassion. We observed all staff delivering care with kindness and patience. One patient told us, “staff are so kind, whatever you ask for they do it with a smile, so kind”. Compliments and feedback from patients were displayed in ward areas. Comments included, “you made me feel very comfortable and at ease” and “you made me forget about any fears that I may have had”.

Staff took care to maintain patients’ privacy and dignity and privacy. We observed a nurse draw the curtains around a patient who was asleep, before waking them to take their blood pressure. A doctor tapped on the curtain prior being invited to enter to carry out a blood test to ensure the patients privacy and dignity was maintained. Staff closed doors to patients’ rooms and drew curtains when patients were being examined or consultations were being undertaken. However, in escalation areas where patients were being accommodated in areas not designed for beds, patients’ dignity was compromised. Although staff did their utmost to maintain patients’ privacy and dignity by using screens around the beds, the protection these offered was not ideal. This and the environment they were used in did not ensure patient’s privacy and dignity was maintained to a high standard.

The service took action on feedback from patients and their carers to help inform service improvements. For example, wards 7a (neurology) and 9a (stroke) purchased carers beds to
accommodate some carers to stay with the patient. They also ordered fans from feedback that the wards were too hot through the summer months.

**Emotional support**

Staff clearly understood the effects of a patient’s condition, both socially and emotionally. We saw discussions between doctors and nurses about the emotional effects on the relative of a patient. A plan was made to support the person to get some rest at home while the patient was closely supported by staff. We saw those closest to patients were supported as closely as patients themselves.

We saw staff gave appropriate and timely support and information to patients and those close to them in order to enable them to cope emotionally with their care, treatment and condition. For some patients this took the form of a referral to other professionals within the trust, including psychologists. For others this was providing time for private conversations with the opportunity to ask questions about their condition and the future. The chaplaincy service was available for patients and those close to them who wanted spiritual support to help them cope with their situation. Patients and those close to them who had used the service told us they found it a great comfort at difficult times.

Religious and cultural needs of patients were met and respected. The trust provided a chaplaincy service and a dedicated space was set aside for quiet contemplation elsewhere in the hospital. The chaplaincy service could arrange contact with a minister of any faith or support from a layperson. Staff knew how to access this service if required. On the acute medical assessment unit, we observed a chaplain asking staff if any patients had asked to be seen by the chaplaincy service.

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

Patients were given time to ask questions about their care and treatment and address any anxieties or fears. We observed staff explaining interactions before care or treatment was commenced. Patients we spoke with reported staff listened to their concerns, and risks and benefits of procedures were discussed.

Patients spoke of staff respecting their needs. We heard examples of cleaning staff members respecting the time patients would usually wake up. They ensured where possible cleaning was undertaken at a time that did not disturb patients. We were told by a member of staff how, “they (the cleaners) tiptoe around as to make sure they do not disturb anyone”.

Most patients were involved in decisions about their care. We observed one member of staff discuss with a patient the medication they were taking, and how this affected their blood pressure. However, we observed an incident where a senior nurse did not use communication aids to enable a patient to communicate effectively, despite the patient clearly being frustrated because they were not understood.

Healthcare professionals involved with a patient’s care introduced themselves and explained their roles and responsibilities. Patients said they felt involved in how their treatment was decided and delivered.

**Is the service responsive?**

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

Services did not always meet the needs of local people. The premises and facilities were not
always appropriate for the number of patients coming to the hospital. The Dr Foster Hospital Guide 2012 identified that occupancy rates above 85% could affect the quality of care given to patients. The trust itself had set a target of 95% to ensure patient flow within the hospital could be maintained. For the five months leading up to our inspection, the trust bed occupancy was above 98%:

- May 2017: 99.62%
- June 2017: 98.71%
- July 2017: 100.23%
- August 2017: 98.67%
- September 2017: 98.23%

These figures did not take into account additional beds. When the additional beds in use were taken into account, bed occupancy was above 100% for these five months. Senior leaders told us the trust wanted to eradicate the use of corridors as escalation areas. However, they also acknowledged that patients had been admitted to escalation beds in corridors overnight, twice in the six weeks prior to our visit. High bed occupancy levels affect both patient flow within the hospital and the quality of care given to patients.

Due to high demand for services, there were insufficient numbers of medical beds for medical patients. At the time of our inspection, there were 67 medical patients in surgical beds and we were informed by staff this was a regular occurrence. This accounted for 17% of the total number of surgical beds in the hospital. This had a negative impact on other departments in the hospital. For example, elective operations were cancelled, meaning surgical patients had a longer wait for their operation. In addition, we were told that some patients booked for procedures in the interventional radiology unit were cancelled, which extended the time they had to wait for diagnostic procedures. Staff informed us due to inpatients transferred to the unit there were frequent delays to procedure starting times. Staff stated procedures were rarely cancelled on the day, but sometimes patient appointments were cancelled for the next day at times of extreme operational pressure.

The facilities and premises used for medical patients transfer to the interventional radiology unit did not meet patient needs and were inappropriate for inpatients. There were female and male toilet facilities but only one unisex shower room. We observed this also being used by a staff member. The shower room was sited some distance away from the beds, meaning that if staff accompanied patients, they would be away from the unit leaving it without full staff cover. When the Care Quality Commission carried out the last inspection in 2015, the suitability of this ward as an area of escalation was highlighted as an area of concern. During this inspection, we did not find these concerns had been adequately addressed and staff were not able to explain any improvements made to the environment. The environment remained unfit for use as temporary inpatients beds.

Actions at ward level to reduce falls were not always in line with the trust’s escalation policy. On the complex care of the elderly wards, patients at high risk of falling were looked after in the enhanced care bays. These bays accommodated five patients although they were only designed for four patients. When patients were discharged from these bays, staff did not remove the additional bed but moved another patient at risk of falling into this bed. This was not in line with the trust’s escalation policy, which stated escalation beds should only be used at times of operational pressures.

The medical assessment unit was divided into areas, which helped to enhance patient flow. This included a primary assessment unit, secondary assessment unit and short stay units, where
patients who had an anticipated inpatient stay of less than 48 hours were accommodated. The medical assessment unit had a predictive flow of around 80 patients a day. However, on the days we visited the hospital the number of patients cared for and treated in the medical assessment unit exceeded 100 patients thus meaning patients were often admitted to escalation beds in the reception area.

Patient length of stay was variable when compared to the England average. Length of stay is important because it has been shown that patients who have a longer stay in hospital are at risk of deconditioning and deterioration. Between 1 July 2016 and 30 June 2017, the average length of stay for medical elective patients at the trust was four days, which was better than the England average of 4.2 days. For medical non-elective patients, the average length of stay was eight days, which was worse than the England average of 6.6 days.

**Elective Average Length of Stay – Trust Level**

![Graph showing elective average length of stay](image)

Average length of stay for the top three elective specialties by count of activity:

**Non-Elective Average Length of Stay – Trust Level**

![Graph showing non-elective average length of stay](image)

Average length of stay for the top three non-elective specialties by count of activity:

(Source: Hospital Episode Statistics)

The trust had set up a discharge lounge for patients who were clinically stable and ready to leave. Patients assessed as appropriate to be in this ward were determined the evening before, with further patients identified consistently throughout the day. We observed the use of the discharge lounge being discussed at a bed meeting. Staff discussed patients due to be discharged and assessed whether they were appropriate to be moved to the discharge lounge and thus a bed becoming available.

Lengths of appointment time within the endoscopy department was determined by need. A points system was in use to ensure sufficient time was given, with, for example, one point amounting to 15 minutes. Consultants who saw more complex patients were allocated more points. They were given more time compared to nurse endoscopists who would see lower-risk patients.
Changes had been made to endoscopy services in response to the needs of patients. From the 28 November 2017, the unit was introducing specific slots for patients who needed assessing following an episode of bleeding. These were slots early in the morning Monday to Friday specifically for patients who had not met the on call criteria. They were not deemed to be unable to wait until morning, but would be unsuitable to wait later in the day.

**Meeting people’s individual needs**

Reasonable adjustments were made to ensure disabled people could access and use services on an equal basis to others. Staff were alerted to patients who may need additional support using an alert on the electronic records system. The Patient-Led Assessments of the Care Environment (PLACE) showed good results for patients living with dementia or a disability. The most recent data at the time of our inspection, published in August 2017, showed a disability score of 88% (national average 81.5% for acute services) and a dementia score of 78% (national average 75.5% for acute services). It should be noted these scores were for the trust and not specific to medical wards.

Staff had a good understanding of supporting and helping patients with learning disabilities and living with dementia. Training in managing people living with dementia or a learning disability was part of regular mandatory updates. There were staff appointed as dementia leads and a dedicated email address available for staff to contact them for additional advice and support. Staff also had access to specialist learning disability nurses, who were employed by another healthcare organisation, but provided support and advice for North Bristol NHS Trust staff. Staff reported they felt well supported by their local leads in this area.

Ward areas were not dementia friendly. An assessment of the environment was completed for Elgar 1 using a national tool but there were no constructive plans to improve the environment. National guidance (NHS Improvement: Dementia assessment and improvement framework, 2017) recommend the environment areas are colour coded and supported by themed pictures. We saw some of this on Elgar 1 ward but we did not see this consistently across the complex care of the elderly wards in the Brunel building. In addition, NICE guidelines 2010 state clocks should be large, clear, accurate and analogue, and a calendar should be easily visible to a person. However, we did not observe any of this on the wards we visited.

The endoscopy unit had recently introduced purple clocks and improved signs on toilets to help people living with dementia. This was in response to a business plan put in place by their dementia champion. Staffs good understanding also extended to supporting patients with learning disabilities. If a patient with a learning disability required an endoscopy appointment, this would be flagged during pre-assessment/ Staff took necessary action to ensure patients were supported to attend appointments and given sufficient information. On one of the inpatient wards, we saw staff used ‘this is me’ information to enhance personalised care. This information was kept in a folder on the door of the patient’s room to ensure all staff were aware of the additional needs and had access to the appropriate information.

Psychiatric support was available for all patients on wards. Staff had access for mental health referrals, which were available 24 hours a day, seven days a week. We observed a mental health liaison nurse attending multidisciplinary reviews of patients, and staff reported they were responsive and supportive.

There were no mixed sex breaches within the medical division over the last 12 months. However, female and male medical patients who were accommodated at times of high demand on the interventional radiology unit only had access to one shower room.
There were suitable arrangements in place for people who needed translation services. Translators could be booked for either face-to-face translation or a service provided by telephone. Staff we spoke with reported this was an easily accessible and responsive service. We observed a member of staff arrange for an interpreter to help ensure the patient understood information about their move to a different ward.

The service made adjustments for patients’ religious, cultural and other preferences in order to ensure they had effective nutrition and hydration.

Transport services were available externally for service users with mobility problems. Staff would direct patients to this service and provide them with contact details. We were informed that if patients needed additional support, the bookings team would help arrange the required transport.

There were arrangements to manage complex patient discharges. Planned discharges were assessed and placed on a pathway based on their complexity:

- Simple discharges: the ward staff would refer directly to the community team for support.
- Complex discharges: a community partner was assigned to the ward, with the community partner assisting with the referral. Following referral, the process would be assigned to either a community healthcare or social care team.
- Complex discharge and complex referral: In these cases a trust case manager would be assigned to the discharge. They would be involved in the referral and discharge process to ensure there was follow up and appropriate support. This included discharges involving patients who may be homeless or out of area.

Staff assessed patients’ communication needs in line with the Accessible Information Standards. The Accessible Information Standards (2015) directed and defined a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients. Specifically where those are related to a disability, impairment or sensory loss. We saw assessments of patients’ ability to communicate decisions within the nursing records. There was a detailed plan for one patient, who had a learning disability, about how staff should communicate with them.

There was relevant equipment for bariatric (a term used for a branch of medicine that deals with the causes, prevention and treatment of obesity) patients. Staff informed us they could request bariatric equipment from a central store as needed.

**Access and flow**

Patients were not discharged in a timely manner, which affected access and flow. Patient flow through the hospital was severely reduced by delayed transfers of care into community hospitals and the wider care system. A delayed transfer of care (sometimes known as ‘bed blocking’) is where a patient is ready and safe to leave hospital care, but is unable to do so, and remains occupying a bed. Among other things, this can increase the likelihood of pressure ulcers and lower patient morale. It also prevents new patients coming into the hospital. At the time of our inspection, there were 121 patients who were medically fit for discharge in wards across the medical division (excluding those accommodated in escalation beds). This amounted to 28% of the medical bed base. Of these 121 patients, only 16 were due to be discharged that day.

Patients were not always able to access timely treatment because of patients being unable to be discharged home. This could be because of for example a delayed package of care arrangements. This was referred to as the number of bed days lost (the number of days beds were used by patients fit for discharge). The trust recorded this information on a Leaving Hospital Patient Database (LHPD), which contained the number of patients nearing their estimated discharge date.
At the time of our inspection, the number of patients on LHPD was 304, trust-wide. This amounted to 7,783 bed day stays (patients combined days in a hospital bed) of which 5,035 of these were delayed bed stays (beds occupied by patients ready for discharge), which equates to 64.6%. This data relates to the whole of trust and is not specific to medical division, however as medical patients take up the most amounts of beds in the hospital a proportion of these delayed bed stays are attributable.

Patients were not discharged in line with the SAFER care bundle. This bundle of care sets out the expectations for discharge and acted as standard best practice criteria:

- 80% of patients should be discharged by, or on the date deemed to be clinically stable.
- Patients in breach of their clinically stable date should be discharged within seven days.

We requested data following the inspections and found only 39% of patients were discharged by or on the date, they were deemed clinically stable against a recommended national target of 80%. Data showed 39% of patients were discharged within seven days of their clinical stable date. This meant patients were in hospital for longer than they needed to, which put patients at risk of deconditioning and deteriorating before they were discharged.

Actions had been identified to help address delayed discharges but with varied results. The trust had undertaken work alongside NHS Improvement (NHSI) to decrease the number of ‘seven-day stranded’ patients. Stranded patients were patients who had been in hospital seven days or more. It was recognised that some patients needed to be in hospital that long, and possibly longer. However, a significant proportion were known to have spent seven days in hospital unnecessarily. NHSI had set the trust a target of reducing the number of seven-day stranded patients by 50% over six months. As of 2 October 2017, there were 434 seven-day stranded patients, which equated to a further reduction of 217 patients needed.

The most recent data at the time of our inspection showed there had been a slight reduction in the number of 14-day stranded patients. However, the improvement on seven-day stranded patients had been variable with no overall improvement.

The organisation did not meet their operational standards (North Bristol Operational Standards) for patient discharge rates. The trust had set a target of “six patients above their operational standard for discharge”. This meant there was an acceptance of up to six patients not having been discharged within their planned discharge date. However, since July 2017, the trust had been consistently above 70 patients above this operational standard.

The trust were in regular contact with outside social care organisations about the pressures around access and flow of patients, and the inability to discharge patients who were medically fit for discharge. Weekly meetings were held with each local social care organisation to provide an opportunity for challenge and discuss capacity issues. However, the trust was consistently above their target for 22 patients who were delayed transfers of care, with levels being regularly above 45 patients since July 2017.

Clinical staff and allied healthcare professionals held multidisciplinary board rounds each morning using electronic screens/boards with patient details to review and update data. The medical division audited how effective information across eight different measures were completed in the data stored on the electronic boards were. These measures included information about completed therapy, discharge destination and arrangements for packages of care on discharge. We looked at a snapshot of the audit and found that the completeness of information was below 80% in 29 data entries across nine wards. This meant that we were not assured that staff in the medical division always had an accurate overview of patients’ readiness to be discharged.
Patients were not always discharged at an appropriate time of the day. Out of hours’ discharges referred to discharges occurring between 8pm and 8am. These should be kept to a minimum as evidence has shown discharge outside of these times is detrimental to patient’s health and wellbeing. In the nine weeks between 4 September 2017 to 6 November 2017, there were 191 overnight discharges from medical wards other than those in the medical assessment units.

Each ward used a tool, known as red/green day, with an aim to ensure all patients had positive daily interactions to hasten their discharge. All patients started the day as a ‘red’ day and once treatment and care activities to aid their recovery were achieved, the status was changed to ‘green’. These activities could be additional scans or rehabilitation targets set by allied healthcare professionals. This tool was used to ensure all planned treatment activities were carried out in a timely manner.

Some medical wards achieved their targets for daily discharges. For example, the respiratory ward (Gate 27b) had achieved their target of four discharges when we visited the ward on 21 November 2017. However, this was partly achieved by transferring patients to the interventional radiology unit and not by discharging patients out of the hospital. This meant an additional move for the patient and did not alleviate access and flow issues overall.

We observed daily multidisciplinary meetings and board rounds on inpatient wards. There was a focus on arranging and supporting early discharge of patients. All patients’ planned discharge dates were discussed at the daily board rounds, and adjusted where necessary if patients’ condition required this. Meetings also included consideration for each patient to identify if they would be suitable to move to another ward. However, this meant that although this helped with the effective use of beds for the most acutely ill patients, the decisions did not involve any considerations regarding the number of times the patient may already have been moved between wards. It also did not exclude patients living with dementia.

The trust did not monitor the number of bed moves and the impact this had on individual patients. There was no trust policy to guide staff as to which patients were suitable to be moved or a maximum number of bed moves that could be undertaken for individual patients. Evidence has shown how patients experiencing frequent bed moves can find it distressing and give them a poor experience. We asked the trust for data on bed moves, which they did not provide. Therefore, we were not assured the trust monitored patient moves and considered the effect this may have on patients’ wellbeing and experience.

Patients were sometimes moved at night. Bed moves at night were classified as any patient moving between 10pm and 8am. This should be kept to a minimum as it can be disturbing and stressful for the patient being moved, and other patients in the wards they are moved to and from. The average number of bed moves at night per month over a 12-month period for each medical ward can be found below:

<table>
<thead>
<tr>
<th>Gate/Area</th>
<th>Number of moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>G31a</td>
<td>118</td>
</tr>
<tr>
<td>G31b</td>
<td>331</td>
</tr>
<tr>
<td>G32a</td>
<td>10</td>
</tr>
<tr>
<td>G19</td>
<td>5</td>
</tr>
</tbody>
</table>
The numbers of moves were high for gate 31a and 31b, as these were medical admission units and patients would be moved from these wards as soon as a bed was available elsewhere in the hospital.

On the medical assessment unit, pharmacists worked with medical and nursing staff to ensure rapid access to dispensing of medicines to take home when patients were discharged from the unit. This helped to improve flow and patient experience.

**Referral to treatment times**

The trust performed similar or better than the national average for meeting incomplete referral to treatment time pathway targets in four out of the five areas within the medical division.

When taken as an average, based on the number of patients, in August 2017 (the most recent published data) the referral time for patients waiting to start treatment within 18 weeks (incomplete pathways) was better than the national average for:

- General medicine 100% against a national average of 93.9%
- Rheumatology 95.9% against a national average of 93.8%
- Neurology 92.6% against a national average of 88.4%
- Geriatric medicine 100% against a national average of 96.8%

However, the trust was not meeting the national average (91%) for patients within thoracic medicine waiting to start treatment within 18 weeks. In August 2017, 81.6% of patients were being seen within the 18 weeks’ target.

Where waiting lists had increased, there had been some recognition and action taken in certain areas. For example, in December 2016, there was a backlog of 1,286 endoscopy patients waiting to be seen. A root cause analysis was undertaken to determine the cause for the backlog and to develop an action plan to address those waiting and ensure no harm had come to patients. This action plan included the use of additional weekend and late clinics. The backlog was subsequently cleared by March 2017, and at the time of our inspection, there was no backlog of patients waiting.

**Learning from complaints and concerns**
Complaints were managed in a timely manner. The NHS Constitution gives people the right to have complaints dealt with effectively, be investigated, and to know the outcome of an investigation. Between August 2016 and July 2017, there were 86 complaints made about the medical division. The trust took an average of 43.7 working days to investigate and close complaints. Response time was not always in line with the trust’s policy, which stated that complaints should be closed within 35 working days or, if the complaint is complex, “45 plus” working days.

The outcomes were:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld - Resolved</td>
<td>58</td>
</tr>
<tr>
<td>Partially Upheld</td>
<td>9</td>
</tr>
<tr>
<td>Not Upheld</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>8</td>
</tr>
<tr>
<td>Blank</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
</tr>
</tbody>
</table>

The breakdown by subject was:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Aspects Of Clinical Treatment</td>
<td>35</td>
</tr>
<tr>
<td>Communication/Information</td>
<td>22</td>
</tr>
<tr>
<td>Admission/discharge/transfer</td>
<td>10</td>
</tr>
<tr>
<td>Attitude Of Staff</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Patients' Privacy/Dignity</td>
<td>2</td>
</tr>
<tr>
<td>Patients' Property/Expenses</td>
<td>2</td>
</tr>
<tr>
<td>All Aspects Of Clinical Treatment</td>
<td>1</td>
</tr>
<tr>
<td>Failure To Follow Agreed Procedures</td>
<td>1</td>
</tr>
<tr>
<td>Aids/Appliances/Access Etc.</td>
<td>1</td>
</tr>
<tr>
<td>Delay/Cancellation Inpatient</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
</tr>
</tbody>
</table>
Staff had a good understanding of the complaints procedure and what should be done if a patient complained. There were patient leaflets in ward entrances containing information for patients about how to raise concerns about their care.

Where lessons had been learnt from concerns and complaints following investigation, this was shared with the complainant. We saw two responses sent to people who had complained. They included a response to each aspect of the complaint, what the investigation had showed, an apology and action that had been taken to improve practice. Lessons were then further shared with staff through team meetings.

Is the service well-led?

Leadership

Managers could articulate challenges caused by the continuing operational pressures, and the impact this had on the quality and delivery of sustainable services. However, they did not consistently look for or make changes that would improve service delivery. We met with senior managers and discussed one of the biggest challenges, which was to ensure effective patient access and flow through the hospital and the medical division in particular. Senior managers told us they were proud of the changes to infrastructure and the way the division managed bed escalation areas. However, operational pressures meant the medical division had experienced high occupancy levels for many months and with additional beds in use for patients during periods of excess demand almost all of the time. Through discussion with senior managers, we were concerned the use of additional beds had become ‘accepted’ and therefore staff did not perceive these pressures as unusual. For example, staff (at all levels) rarely reported daily staff shortages as an incident when the dependency tool showed there were not enough staff on duty.

Staff knew who their leaders were and told us the executive team visited the wards regularly. Ward managers worked closely with staff in the team they managed. The head of nursing and matrons were visible on the wards most days, and staff told us they were approachable. Staff on the cardiology ward (Gate 27b) explained that a member of the executive team had worked as a healthcare assistant on the ward one morning to help look after patients. Staff at all levels felt they were listened to by their managers. All staff felt able to raise concerns with senior staff, managers, matrons or senior management level if the need arose.

Vision and strategy

The trust had a vision for the organisation, and a strategy to deliver this. The vision was supported by a set of four core values centred on individual patient care, putting patients first, teamwork and striving for excellence. We were not told of any divisional vision specifically for medicine, but staff were aware of the organisational vision and core values.

Some wards had their own vision. For example, the acute medical assessment unit’s vision included ‘providing high quality acute medical care for every patient, delivered personally, professionally and compassionately by an expert team’. The stroke service had a vision to become a seven-day service within five years. On the complex elderly assessment unit (Gate 32a), there was a vision to accept patients directly from GP admissions, to improve patient experience and access. This GP admission work was part of the Joint Acute Frailty network and involved a review of staffing levels, flow through the ward and additional training for staff.
We visited Elgar 1, where staff told us of plans to make improvements to the environment, including the creation of an outdoor garden/courtyard with flowerpots, a hut, and facilities to grow tomatoes. This vision was to improve the environment for the benefit of the high number of patients living with dementia on the ward.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All managers and senior managers said they were proud of the team they managed, and told us the workforce was positive and upbeat despite the operational pressures.

Staff described a good culture and enjoyed their work at the hospital. We spoke with staff of different grades and seniority and working in many different roles. The overall feedback was staff enjoyed their work even though it the hospital was busy. Most junior doctors and medical students felt working at the hospital was a great experience, with good teamwork and an excellent culture and atmosphere.

The medical division had introduced a SWARM process, which was used to review falls on wards. This process allowed for a review of all the contributing factors to a fall and was attended by the head of nursing (medical), the matron, the ward manager and any staff members that had been on duty when the patient fell. This was carried out in a supportive environment with a ‘no blame’ culture to allow for collective reflection and learning. We spoke with people from different departments who all said this process was supportive towards staff that may be emotionally affected by patient falls.

The junior doctors we spoke with felt well supported by consultants and senior medical staff. They reported the culture was positive and there was great teamwork.

On a complex care of the elderly ward (Gate 28b), staff told us of health promotion for staff wellbeing, which included advice on managing stress.

Governance

The division had a governance structure to support the delivery of care and treatment. A clinical director, general manager and head of nursing, which were accountable for service delivery, including care quality, were responsible for managing the medical division. The head of nursing was responsible for quality governance, which incorporated ward level safety and quality of care and treatment. Divisional governance was exercised through the clinical operational lines and operationally supported by the general managers and their support teams.

There were arrangements to facilitate effective sharing of information from ‘board to ward’ and ‘ward to board’. Delegated staff attended trust management meetings and shared information with the divisional and clinical leads. Information was passed from the clinical leads to other staff through meetings at different levels and shared with front line staff by their clinical managers. Staff we spoke with knew how to raise concerns about safe care to their managers or matrons and felt able to do so if required.

Incidents were reviewed at a weekly ‘quality improvement productivity and prevention meeting’. In this meeting all incident investigations, complaints and workforce issues were discussed. This meeting presented an update and any identified trends in incidents to the divisional management board.

We spoke with different teams about their governance structure. For example, in the acute assessment ward there was a weekly business meeting, a monthly operational meeting and a
quality improvement meeting. Multidisciplinary healthcare professionals attended all of these meetings. The unit reviewed all patient deaths that happened within the unit and presented findings in the unit clinical governance meeting.

Staff were clear about their roles and understood what they were accountable for. We spoke with numerous staff that were clearly able to describe how their role fitted within the larger team and in turn the wider trust. Staff were clear about who their managers were and the different ways in which they could contact them.

Each speciality held regular mortality and morbidity meetings to share outcomes of mortality reviews. In addition, mortality reviews were discussed in the quality surveillance group, which reviewed these to identify possible trends and ensure cross-divisional learning. We spoke with the trust lead for mortality and morbidity reviews who discussed the processes and structures to review a proportion of all deaths in the hospital. They discussed examples of learning from mortality reviews including the management of insulin. This work stream included input from diabetes consultants, pharmacists and specialist nurses and led to teaching of staff to enhance knowledge about safe insulin management.

The trust performed worse than the England average in six of seven national audits. The trust had an audit committee, which met twice a month. In these meetings, the outcomes of different audits, including national audits, were discussed to ensure action plans were developed where necessary to improve service delivery.

**Management of risk, issues and performance**

Senior managers did not discuss clear plans of how to manage an increased number of medical patients, when there were already significantly high occupancy levels. We asked senior management about plans to manage winter pressures at a time when occupancy levels exceeded 95%. We looked at the trust’s winter plan (November 2017) and found that the predicted shortages of beds at a 95% bed occupancy was a shortage of up to 75 medical beds. The preferred option allowed for an additional 38 beds for medical patients. The proposed option had been risk assessed to identify advantages and risks (including the impact on surgical admissions) of each proposal. However, the senior managers did not discuss either of these plans when we spoke with them.

There were processes at ward level to review and manage patient risk, which were not always used effectively. Each ward held twice-daily safety briefings with staff. We reviewed the contents of the safety briefing. This included information about patients’ safety such as falls risk, if patients had catheters, assessments such as deprivation of liberty safeguards, infections, particular concerns around nutrition or medication and discharge arrangements. Alongside this was a framework with requirements for staff to allocate daily safety tasks for the shift coordinator to carry out as part of the daily safety briefing documentation. This framework was not being used. There was, therefore a lack of oversight and monitoring to ensure all daily tasks such as checking emergency resuscitation equipment or fridge temperatures were always carried out.

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The executive team held quarterly performance reviews with each division, which helped ensure a management level of accountability for the quality of care delivered. The medical division had a risk register where 54 risks to services were logged (September 2017). Of these, three risks were considered as extreme high risks including an increase in the reported incidents concerned with administering insulin, gaps in recruitment of consultants to three medical specialities, and the risks associated with admitting patients to escalation/additional beds. The risk register demonstrated regular reviews and information about
mitigating actions to reduce the risks. The risk relating to the use of additional beds had been active for 333 continual days as a high risk, which confirmed the consistent use of escalation beds on the wards. The risk described safety issues, such as lack of oxygen ports, and the lack of patient privacy and dignity. We met with the director of nursing who told us the trust was working with NHS Improvement to review and mitigate associated risks and produce an action plan.

The medical division completed a number of local audits for areas such as infection control, pressure ulcers, falls, safe staffing and feedback from patients. The data was presented in a monthly integrated performance report and discussed in monthly divisional governance meetings. The monthly integrated performance report formed part of the monthly board meetings, which provided the board of directors with local audit and performance data.

There were processes to follow and staff knew what to do if a major incident was declared. On Gate 32a, we saw the trust’s major incident policy had been recently put into practice. The day prior to our inspection, there was a major incident declared, and staff had followed procedures to identify six patients for ‘stepdown’ care to release beds for emergency admissions should it be needed. The major incident was de-escalated before the patients were moved, but demonstrated staff knew what to do and that tasks were carried out effectively.

**Information management**

Patient records were not always held securely. Patients’ medical records were kept in designated closed trolleys on most inpatient wards although the trolleys were not locked or keypad protected. However, on Gate 27a, the notes were kept in open trolleys. Although these trolleys were situated by the reception desk, it could not be guaranteed there were always staff supervising patient records and preventing unauthorised access to information about patients. In the cardiology ward (Gate 27a) and in the interventional radiology ward, we saw a number of patient records, which were unattended on desks or stored in crates underneath desks at the nurses’ station. On ward 9a, we noticed patient handover information was left unattended on the reception desk. This document held information about patient names, date of birth, previous medical history and the plan of treatment and care. This lack of security of patient records was highlighted in the previous Care Quality Commission inspection report as an improvement requirement, and had not been resolved.

Information stored electronically was secure. We observed computers being locked when not in use, and these were password protected to prevent unauthorised access. Inpatient wards had electronic patient information screens positioned by the main reception area of the ward. These contained information about patients’ names, their consultants, and medical speciality of care, date and time of admission, primary assessment and destination on discharge. These screens were updated throughout the day and contained current information about patients and their treatment, and were used as a vital part of the daily board rounds. Staff had to log into the system to access detailed information about patients, and to edit information. However, we observed staff did not routinely log out, which meant visitors or other unauthorised people could access information about patients from these screens.

All staff had access to the trust intranet and knew how to navigate this to find the information they needed. Staff knew how to access trust policies and care pathways although none of the staff we asked were able to find the trust policy providing guidance in relation to deprivation of liberty safeguards. All staff we asked had secure access to relevant electronic information. Staff had an email account and received updates and information from ward managers. However, some staff said it was difficult to find the time to check and read their emails. This was a concern as managers told us all important information was shared via email.
Engagement

Ward meetings were not held regularly on all wards. For example, on the cardiology ward there had not been a staff meeting for the past three months. Managers told us that it was difficult to get all staff together for meetings. Managers shared a monthly newsletter electronically with all staff. We read one of these newsletters, which held information about personal celebrations such as sharing news about new babies born to colleagues and special birthdays.

The trust engaged with patients and staff to plan and manage services, and collaborated with partner organisations effectively. For example, we spoke with a respiratory specialist nurse who told us about the care and support the team delivered to patients when they were discharged. The specialist nurses had capacity to visit patients in their homes for ongoing support.

In response to challenging feedback within the staff survey, and to support national ‘commissioning for quality and innovation’, the trust had implemented a comprehensive staff health and wellbeing programme. This programme included enhanced support for staff with muscular-skeletal problems or stress and anxiety related problems. We were told the trust had introduced Schwartz rounds, which offers an opportunity for staff to reflect on the emotional aspects of their work. This is a tool that can support staff in handling sensitive issues and other non-clinical aspects of care with increased confidence.

Between August 2016 and July 2017, the NHS Friends and Family Test, response rate for medicine at the trust was approximately 27%, which was slightly higher than the England average of 25%.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. The trust had a ‘Quality and Safety Improvement Team’ (QSIT) to embed improvement across the organisation through quality improvement awareness sessions, bespoke group sessions, junior medical staff forums, and detailed workshops. Mentoring and coaching were provided by QSIT through supporting specific improvement projects such as intravenous fluid prescribing, recording and management, acute kidney injury, discharge documentation, sepsis, care bundles, insulin management, and access to clinical guidelines.

The trust had a weekly ‘Quality Improvement Hub’ for staff to drop in and learn more about the improvement work across the organisation, showcase their own work and get support and advice. The trust had developed a website, which contained resources and tools for improvement, details of upcoming events to share work externally, details of completed quality improvement projects and the overall trust quality and safety programme. A quarterly newsletter went out to staff as well as a communication via the trust’s weekly staff bulletin and the message of the day.

North Bristol NHS Trust was awarded ‘Network of Excellence’ status for its care of people with muscular dystrophy. The network pooled the skills of over 20 neurologists, physiotherapists, psychologists and support staff to provide faster referrals, improved service and better coordination for patients. The network also supported community teams who worked in the more rural areas across the region to ensure they have the knowledge and support to care for people with muscle-wasting conditions close to home.

The trust had received a large grant for a ‘Prepare for Kidney Care research project’. This project will examine the effectiveness of responsive management versus dialysis in frail, older patients with advanced chronic kidney disease.
Surgery

Facts and data about this service

We inspected North Bristol NHS Trust on an unannounced visit as part of the new phase inspection methodology.

The service provides day surgery, elective (planned) and emergency inpatient surgical treatment across specialities, which included, burns and plastics, neurosurgery elective and trauma orthopaedics, urology and vascular surgery.

The emergency inpatient surgical service is supported by a suite of six emergency operating theatres, including two 24 hour theatres. The elective inpatient surgical service is delivered from a bed base of 395 beds within the Brunel Building and 23 elective operating theatres.

The trust had 51,392 surgical admissions between July 2016 and June 2017. Emergency admissions accounted for 12,973 (25.2%), 27,997 (54.5%) were day case, and the remaining 10,422 (20.3%) were elective. *(Source: CQC Insight)*

Wards were located at gates and at each gate, there were two 32 bedded wards and each ward had 24 single rooms and two four bedded bays.

The operating theatres incorporated a unique mediroom model of care, which was used instead of traditional anaesthetic and recovery rooms. The medirooms were individual rooms adjoining each theatre department. Day case and very occasional short stay patients received pre-operative and post-operative care and were discharged from these rooms. There were 69 medirooms over the two floors.

During the unannounced visit, we visited the following theatres, department and wards:

- Gate 20 and 21 which included 69 medirooms and 21 emergency and elective theatres
- Pre-operative assessment unit and the discharge lounge.
- Gate 7b, which cared for patients having elective orthopaedic operations and neurological monitoring.
- Gate 25a, which cared for patients receiving neurology and neurosurgery.
- Gate 25b, which cared for trauma & orthopaedic patients.
- Gate 26a, which cared for elective orthopaedics.
- Gate 26b, which cared for trauma & orthopaedics and general surgery.
- Gate 32b, which was the surgical assessment unit and the ‘Hot Clinic’.
- Gate 33a, which cared for burns and plastics patients.
- Gate 33b, which cared for vascular patients.
- Gate 34a, which cared for general surgical and general medical patients
- Gate 36, which cared for patients undergoing their pre-operative assessments.

Since our last inspection, the infrastructure had changed within the hospital. The anaesthetics, surgery, critical care and renal divisions had merged to form the Anaesthetics, Surgical, Critical Care and Renal (ASCR) division. However, we have reported on ward or departmental data wherever possible. We did not inspect the critical care unit as part of this unannounced inspection as this is a separate core service within the CQC inspection framework.

The inspection team for surgery comprised of one lead inspector and one team inspector and four specialist advisors. During our inspection the team;

- Observed staff giving care.
• Reviewed patient records.
• Reviewed performance information and data from, and about the trust.
• Spoke with eight patients and four relatives.
• Spoke with over 40 members of staff at different grades including porters, doctors, nurses, healthcare assistants, non-clinical staff, ward managers and theatre managers.

The service is managerially split into two divisions with general surgery, plastics, burns, urology, vascular and transplant surgery hosted alongside theatres and anaesthesia in the anaesthetics, surgery, critical care and renal (ASCR) division. Neurosurgery, orthopaedics and musculoskeletal surgery are located within the neurology and musculoskeletal division. The trust has 13 surgical wards, which are all located at Southmead Hospital.

The Care Quality Commission last inspected the hospital in December 2015 and rated surgery as requires improvement overall. The surgery division was issued with one requirement notice and nine recommendations for service improvements in safety. We looked at changes the surgery division had made to address these concerns.

Is the service safe?

Mandatory training

Not all areas or staff groups had completed their mandatory training within the timeframes expected by the trust. The service provided mandatory training in key skills to all staff within the surgical core service. All staff were aware of the programme and thought the training delivered was of good quality. The training delivered was predominantly based online and had elements of face-to-face delivery. Completion of staff training was monitored and reported on a rolling month on month basis.

The trust set a target of 85% for completion of mandatory training, see below for a breakdown of compliance for mandatory courses as of August 2017 for registered nursing staff. The 85% target was met for only seven of the 11 selected mandatory training modules.
The 85% target was met for seven of the 11 selected mandatory training modules shown above for medical staff.

A breakdown of compliance for mandatory courses as of August 2017 non-registered nursing staff. The 85% target was only met for two of the 11 selected mandatory training modules shown above.
Not all senior staff were aware of how many staff were up to date with their mandatory training. We discussed mandatory training with individual ward leaders and received varying levels of oversight. All senior staff told us that they received an email if a staff member was out of date with specific areas of their training however there was limited oversight of an individual’s total compliance.

Staff told us work pressures had prevented them from attending some mandatory training. A recent review of staffing levels had resulted in more staff being allocated to the surgical division wards where patients required enhanced nursing. Senior staff told us this would allow staff to attend mandatory training sessions and expected an improvement in mandatory training compliance levels.

The trust had provided additional staff training in the recognition and management of patients with sepsis. Sepsis training was not part of the mandatory training but was included in the induction programme for new staff (registered and unregistered). The additional training was initially provided for 600 staff, which included healthcare assistants, registered nurses, junior doctors and consultants. Each staff member that received the training was encouraged to train a further six staff and the cascade continued to ensure all relevant staff received the required training. The trust told us this exceeded their goal and 1219 staff had been trained. Staff spoke favourably of the campaign to cascade sepsis training and were aware of the trust’s sepsis management policy and how to access further support from the sepsis lead.

Mandatory training for all staff covered dementia-training level one and two. The trust reported that as of August 2017, the 85% target was met as Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training had been completed by 87.8% of staff within ASCR. However, we saw no evidence that staff had received specific training on the potential needs of people living with mental health conditions, learning disabilities or autism.

**Major incident training completion rates**

The training data supplied by the trust did not include major incident training as a separate item. Until September 2017, it was included as a module within the trust induction-training course. The trust had a plan in place to produce an e-learning package to deliver this training. Major incident training was still included in the junior doctor induction and the consultant training update.

**Safeguarding**

Staff followed the systems, processes and practices put in place by the trust to protect patients from abuse, neglect, harassment and breaches to their dignity and respect. Safeguarding adults and children was led by specialists in safeguarding and represented at executive level by the director of nursing. Since January 2017, a new role of head of safeguarding (adults and children) had been recruited. The person in the role was to provide strategic and corporate direction for all matters relating to safeguarding within the trust. The safeguarding team also led on issues relating to the Mental Capacity Act, Deprivation of Liberty Safeguards, Prevent and domestic abuse. Prevent training aims to safeguard vulnerable people from being radicalised to supporting...
terrorism or becoming terrorists themselves. There were two safeguarding specialists who came into post in August 2016 and were managed by the adult safeguarding lead.

Staff within the ASCR division were expected to complete training in safeguarding adults, the Mental Capacity Act, Deprivation of Liberty Safeguards, domestic abuse, female genital mutilation, and human trafficking awareness. Staff also received Prevent training, which aimed to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.

All of these training programmes were provided as part of the statutory mandatory programme, which included induction, a three-year refresh, and specialist training.

The clinical commissioning group set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses, as of August 2017, for registered nursing staff and medical staff in surgery is shown below. The trust reported their mandatory training compliance on a rolling month on month basis.

The arrangements to safeguard adults and children from abuse and neglect reflected relevant legislation and local requirements. The 90% target was not met for both safeguarding children level 2 and safeguarding adults’ level 2 for registered nursing staff in Surgery. The trust reported that no registered nursing staff in surgery were eligible for safeguarding adults’ level one or safeguarding children level one. The 90% target was not met for safeguarding adults’ level two for medical staff in ASCR as 89.1% of medical staff had completed the training.

(Source: Trust Provider Information Request)

Staff understood their responsibilities and adhered to safeguarding policies and procedures, including working in partnership with other agencies. On each ward, staff had access to relevant contact details of people within and outside of the trust who they could approach for additional advice. Staff described how they would identify adults and children at risk of, or suffering, significant harm and when they would make a safeguarding referral. If a safeguarding concern was identified the staff member involved would use the trust’s electronic reporting system to raise an alert. Staff told us they could also send an alert to the safeguarding team via email, phone or in person and received support when they requested it.

Cleanliness, infection control and hygiene
Control measures were in place to maintain hygiene and prevent the spread of infection but staff compliance was variable.

The trust reported two infection control serious incidents both of which involved the re-use of incorrectly sterilised equipment on patients. The root cause analysis for both these incidents identified reasons such as staff not following best practice due to pressure to perform during busy periods and a failure in the process of the identification of clean and used equipment. Recommendations were that staffing levels would be examined, standard operating procedures would be re-drafted, staff would be re-trained on procedures and would be required to complete competencies to achieve compliance. The root cause analysis for both incidents contained detailed action plans with dates all actions had been completed apart from staffing recruitment, which was ongoing inspection.

Data received on trust wide reported cases of methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia (the presence of bacteria in the blood) was above national average however, the reported cases of Clostridium difficile (C-diff) were below the national average. We were not given a breakdown of data, which specifically related to the ASCR division. The trust reported three cases of C-diff during September 2017. We looked at data from September 2016 to October 2017 and found there had been eleven cases per 1,000 bed days, which was below (better than) the national average of 14 cases per 1,000 days.

The trust reported ten cases of MRSA bacteraemia in the past 12 months with three reported cases in 2017/18. Data showed that the trust had been consistently above the national average for quarterly rate of MRSA bacteraemia per 1,000 bed days since September 2016. There is a national target of zero cases of MRSA bacteraemia. Following on from incidences of MRSA bacteraemia, the trust had introduced a remedial action plan, which set out clear time frames and actions to ensure compliance.

However, patients were not always screened for MRSA in accordance with trust policy. We were supplied with the information for emergency admissions for the period of April 2016 to February 2017 only one of the four wards achieved a screening compliance of 85% or above.

Staff were expected to attend infection prevention and control training every two years as part of their mandatory training programme. Registered nursing staff had achieved compliance above the trust’s target for the training modules. However, medical staff had only achieved 80% compliance for their two-year training. This meant not all medical staff were fully up to date with measures to control infection.

Arrangements on the ward helped to protect people from healthcare-associated infections but staff did not consistently follow correct protocol. The majority of patients on wards had their own rooms. This meant if a patient had an infection, they could be isolated from other patients in order to reduce the risk of an infection spreading. Additional measures were taken to protect patients from infection. Signs on the outside of patient rooms highlighted when a patient had an infection. They also provided instructions for staff and visitors to wear protective equipment, keep the door closed and decontaminate their hands before and after each contact. This complied with national guidance such as World Health Organizations five moments for hand hygiene and National Institute for Health and Care Excellence (NICE) guidance (QS 61 statement three). However, we saw that staff on the wards did not always follow the instructions. We saw some staff failed to wear protective equipment or wash their hands when entering and leaving the room.

Staff from different divisions of the hospital wore ‘scrubs’ (loose clothing of the type worn by theatre staff). To prevent cross-contamination from their clothing, theatre staff were expected to change out of their scrubs when not in the surgical environment. However, because all scrubs
were the same colour theatre staff could not be differentiated from other staff. Plans were in place to provide scrubs of different colours allocated to different departments so that non-compliance could be identified.

Practices for waste management across the wards and theatres were inconsistent and presented a potential hazard to patient safety. The security of rooms was not maintained and as an example, we saw three occasions where sluice room doors were left unlocked. In these rooms, we saw blood products used on patients left out on the side and not disposed of and consumables stored on a sluice room floor. We also saw theatre staff walking into sterile areas in casual clothes. The trust told us that this contravened their code of conduct for theatre staff and that the matron for theatres removed the staff member and reminded them of the code of conduct.

The intraoperative phase of patient care and preparation was in line with the National Institute for Heath and Care Excellence (NICE) clinical guidance 74. Staff scrubbed aseptically for theatre, wore the correct sterile gowns and gloves and administered the correct antiseptic skin preparation.

Patients who required a vascular access device had their risk of infection assessed according to standards in 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. We checked four visual infusion phlebitis score records and all were fully completed.

People who required a urinary catheter had their risk of infection minimised in line with NICE QS61 (Statement 4) 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 in place had a urinary catheter care pathway which detailed twice-daily checks and actions required to maintain infection free care. We reviewed two catheter care plans and saw that all actions had been completed.

Cleaning tasks were allocated to staff members each day and logged in an allocation book. All clinical areas appeared visibly clean. The three months of records we reviewed had been signed as completed by the staff member it was allocated to.

The trust’s surgical sterilisation department (SSD) was compliant with the standards set out in the decontamination of surgical instruments Health Technical Memoranda (HTM 01-01). The service was being audited in January 2018 in preparation for the implementation of the new standards, which were being implemented in 2019. Staff were confident they would pass the audit. The service was now based onsite as it had moved from an offsite facility in October 2016. Staff felt this had improved the service, as there were reduced delays in turnaround of equipment and instruments. The amount of cancelled surgeries relating to delays in decontamination of equipment had reduced. The amount of people working as washers within the service had increased from five to nine.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well. Each surgical ward had 33 patient beds, consisting of 24 individual patient rooms, two four bedded bays and one treatment room, which could be used as a patient room. Each individual patient room had its own facilities including toilet/shower room. On each ward corridor, there were handrails for patients and visitors to use to help mobilise. Overhead hoists above each bed were used to assist moving and handling in a way that was safe for both patients and staff. Each bed space had dedicated oxygen outlets, vacuum outlets and an emergency call bell. Patients in four-bedded bays had access to shared bathroom facilities.
Two areas we visited regularly admitted additional patients to four-bedded bays in times of high demand. The patients were admitted on beds, which were placed in the middle of two patient bays. These patients did not have oxygen or vacuum outlets but did have a portable call bell. If required, patients were provided with portable oxygen and suction machines. In order to protect the patient’s dignity and privacy, the curtain from the adjacent bay was used to shield one side and a screen was used for the other. This was not ideal as patients could be seen over the screen. These patients had limited personal space, did not have their own lockers to store personal equipment and limited space for visitors. The trust recognised that this was far from ideal and had entered it as a high risk onto the trust wide risk register.

Equipment was kept in storerooms when not in use and corridors were kept free of clutter, which helped to reduce the risk of falls and maintain clear access in case of an emergency.

During our last inspection, clinical waste in theatres was removed and transported in cages. These cages were not secure and allowed liquids to leak through. Improvements had been made and we saw bespoke plastic bins with no holes were now provided.

The maintenance of equipment kept people safe. Equipment in use on the wards and all had undergone recent safety checks and services. We checked twenty pieces of theatre equipment, 19 of which had an in date portable appliance test. Equipment included a suction machine, a bladder scanner, a diathermy machine, weighing scales and defibrillation and anaesthetic equipment. However, we saw one item, which was faulty and out of date. This was escalated to the nurse in charge, removed and sent for repair immediately. The division carried out regular bariatric surgery and specialist equipment was available for use.

We checked single use sterile items such as nasal tubes, dressing packs and electrocardiogram dots, all were in date, securely stored off the ground and were unopened.

Resuscitation equipment was available and fit for purpose but was not always checked in line with professional guidance. Each ward and theatre department we visited had a resuscitation trolley, which was tamper evident and contained all the appropriate equipment. Resuscitation equipment and trolleys on the ward and in theatres were visibly clean and free from dust. Upon review, we saw the three months of daily and monthly checks in theatre units and some wards were completed incorrectly. However, some areas were less compliant with checking than others. Over a three month period, we saw some daily checks had not been signed as carried out; single use equipment 2 years past its expiry date of 09/2015 (this was removed by the senior nurse after we brought it to their attention); one area which had no daily check log.

In theatres, only seven out of 29 theatres had doors with windows fitted. This had been raised during our last inspection and although seven had been fitted, there were still an insufficient number of doors where visibility into theatres could not be achieved. This was a risk as inexperienced visitors into the department may accidentally walk into the theatre suite and staff had highlighted this to us during the inspection. The trust advised us that all doors were part of a refurbishment programme and three further stages were planned.

Sluices on wards and in the theatre department had locks to control entry but not all were locked. Inside all of the unlocked sluices were unlocked cupboards, which contained hazardous cleaning chemicals accessible by the public.

Waste management was inconsistent. Areas we visited in the surgical theatres managed waste well but ward areas did not always follow trust protocol. Waste bags were colour coded to ensure that waste was appropriately disposed of. An incorrect waste bag was used in one bin we saw, which was also overfull. This could lead to clinical waste being treated as household waste and create risks for infection control. We saw numerous sharps bins outside of wards and single rooms
that were overfull and left open posing a risk to patients or visitors. However, arrangements for managing waste and clinical specimens in theatres kept people safe. Disposable items of equipment were discarded appropriately, either in clinical waste bins or in sharp instrument containers. Used sharps bins awaiting removal were closed, sealed and stored in the dirty utility. Theatre staff said waste bins were emptied regularly and none of the bins or containers were over filled. A waste stream robot was in place for theatres; this was an automated guided vehicle, which collected the segregated waste and removed it by a dedicated lift, which was separate to the clean lift. This reduced the risks to staff associated with handling clinical contaminated clinical waste.

Assessing and responding to patient risk

The service used safety-monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information in theatres and across the wards to identify risk and improve the service. They achieved this by following national guidance and monitoring staff compliance

NHS England published national Safety Standards for Invasive Procedures (NatSSIPs) in 2015, to support organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. The NatSSIPs had enhanced the World Health Organisations Surgical Safety Checklist, which included safety-briefing, sign in, time out, sign out and debriefing. This did not replace the existing WHO Surgical Checklist, but rather enhanced it by looking at additional factors and we saw examples of, handovers and information transfer from theatres to the wards, procedural verification and site marking. We observed all staff being fully engaged with three safety briefings, sign in, stop before you block and time out.

The Theatre Efficiency Group included both WHO checklist and ‘5 Steps to Safer Surgery’ on the weekly audit dashboard. Theatres told us that they had moved from a single reporting figure to auditing the practice in every individual operating theatre. This highlighted best practice and challenged individual areas. The service ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. We saw staff adhering to guidance and practice within theatres which was audited weekly. Each theatre’s weekly audit results were collected and used in a safety dashboard, which was monitored by theatre managers. This enabled the service to highlight best practice and challenge poor performance. The audit results were published every month and were posted outside each individual theatre. If a theatre team achieved 100% on their audits, the success was celebrated with a paper certificate. The service had recently started to address poor performance with the surgeon responsible for an individual theatre. The WHO compliance moved from 93% in February 2016 to 96% in July 2017, with theatres regularly achieving 100%. The service changed their internal target for WHO compliance from 95% to 100% as of June 2017.

There was a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response. All people admitted acutely were continually assessed using the National Early Warning System (NEWS). This system was based on a simple scoring system in which a score was allocated to physiological measurements undertaken when patients were being monitored in hospital. We checked eight set of NEWS scores and saw that scoring was entered correctly, actioned and documented appropriately. However, completion of the NEWS scores was audited by the trust and results for the surgical division showed compliance was below their set target of 95%. For example in July:

- 77.1% of all wards were compliant with recording NEWS scores.
- 80% of all wards had a documented observation chart.
• When required and appropriate to do so, 74.3% of all wards had escalated a patient within 15 minutes.
• When escalated, 68.6% of patients had a medical or senior nurse practitioner review within 30 minutes.

The results of the audit showed not all staff were compliant with the trust’s practices, processes and policies. The audit highlighted the 95% target for escalating a patient within 15 minutes of when their NEWS score was five or more and had only been met in August and September 2016. In October 2016, November 2016 and February 2017, compliance was less than 75%. It was also highlighted that the trust target of 95% for ensuring a medical or senior nurse practitioner review took place within 30 minutes was only met twice in the previous 11 months, in August and September 2017.

The trust did not have a critical care outreach team but had an escalation policy for patients with presumed/confirmed sepsis who required immediate review. The trust had a sticker for staff to complete when they needed to escalate a deteriorating patient. The sticker prompted staff to use the Situation, Background, Assessment and Recommendation communication tool (SBAR) to assess the deteriorating patient, document when the patient had been escalated and if there was no response within 15 minutes than the senior registrar must be called. The trust had a sepsis policy and all the staff we spoke with were aware of how to escalate patients who were presenting with the first stages of sepsis. A hotline number was available to escalate patients to the junior doctors should they present with sepsis. Staff used the sepsis screening and action tool, which delivered treatment to patients with presumed sepsis within the recommended sepsis pathway timelines. Sepsis and compliance with the sepsis 6 pathway was monitored by the sepsis lead, who identified gaps in training through an audit of compliance, staff told us that if they had completed the bundle correctly or escalated in time in line with the sepsis 6 pathway then the lead would “chase up staff and train them”. We requested audit data to show how compliant staff were but did not receive this.

At the beginning of each shift, a safety briefing took place. The safety brief was a tool to increase awareness of key issues for patients amongst front line staff. We observed two safety briefings on during which staff were informed of the following:

• Who was holding the controlled drug keys;
• Who the coordinator was and who had possession of the ward mobile telephone;
• The issues around the hospital that day;
• Which patients had a catheter, at risk of a fall, had pressure ulcer or infection;
• Which patients were living with dementia or a learning disability.
• Which patients had a Deprivation of Liberty Safeguards (DoLS) in place and information about when this required review.
• Which patients were a cause of concern, based on their NEWS score; and
• Which patients had a do not attempt cardiopulmonary resuscitation (DNACPR)

Staff felt the safety briefing enabled them to deliver safe care and treatment to patients, as they were aware of potential issues at the start of their shift. They felt this enabled them to be proactive rather than reactive as they knew what potential steps would need to be taken for each patient. The safety brief had a list of topics to be covered but also allowed staff to add further alerts and we observed the passing on of arrangements that were put in place for an end of life patient who could potentially suffer a life threatening haemorrhage. Staff had gained special permission to have both the rapid tranquilisation kit and the life threatening haemorrhage kit in the patient’s room.
should such an event occur. As this was handed over on the safety brief all staff were aware of the potential risk.

The trust had a dementia strategy and comprehensive cognitive care bundle, which advised staff what to do if patients who experienced delirium for three days or more but had no dementia diagnosis. Staff were to highlight this to medical teams to order specific blood tests and scans. The pathway also advised all information to be added to the discharge summary for GP follow up.

Staff on the Burns Unit had access to 24/7 specialist mental health liaison support if they were concerned about risks associated with a patient’s mental health. Staff knew how to make an urgent referral to them and told us that typically and dependent on what time of day the response was within two hours. The bays were situated close to the nurses’ station, which meant staff had good visibility of the patients within them. Patients with mobility difficulties, at a higher risk of falls or living with dementia were placed in the four-bedded bays. This was to reduce the potential of higher risk patients coming to harm as staff could see patients from the nurses’ station.

Patients who were seen at the pre-operative assessment unit were assessed using the ASA (American Society of Anaesthesiologists) classification. The hospital ensured that appropriate pre-op assessment was recorded. We reviewed three sets of notes and could see that preoperative assessments were well documented. All patients were assessed using the ASA classification, which was documented in the anaesthetic record sheet. The score was reviewed in line with the national ASA Classification System. For those with ASA II or higher the patient was reviewed by a senior anaesthetist. Staff in the pre-admission unit told us that if necessary patients would be referred back to their GP for further follow up and/or treatment. Each theatre held a safety briefing prior to the start of the day. In theatre three, we saw a discussion take place between the surgeon and anaesthetist regarding the risk factors associated with a patient’s ASA classification level.

We saw how staff in theatre prepared prior to bariatric surgery. The theatres had a regularly updated folder, which identified what was required for bariatric surgery. This included specialist equipment, surgeon’s preferences and specific positioning of patients. The anaesthetic assistant orientation checklist and information pack set out in pictures and text how patients should be positioned. This enabled staff to be fully prepared prior to the list starting. We observed how this worked in practice and observed one theatre department were fully prepared and had made sure that they had a bariatric specialist nurse available during the operation.

Day surgery and overnight stay booklets had risk assessments which pre-operative assessment staff had to complete. These included venous thromboembolism (VTE), bleeding risk and infection control. There were guidelines of what should be done if results triggered a risk.

Every ward we visited displayed safety information at the entrance to the ward. Safety crosses showed how many falls, pressure ulcers and infections had happened over the previous month to date and all information was up to date and clearly displayed. Wards also displayed safety thermometer information and action plans.

Staff on the wards risk assessed their patients daily and inputted results into an electronic system. This highlighted to staff which patients were a risk. We reviewed six sets of records, which showed daily re-assessments for risks such as falls and phlebitis score. Of the six records, we checked all the information on the daily phlebitis scores was completed.

Staff completed malnutrition screening of all patients admitted for patients staying over 24 hours. However, from July to September 2017 completion fell just below the trust target of 85%, the board report stated that targeted work with ward sisters was ongoing and we saw evidence of nutrition information and daily risk assessments for vulnerable patients across the wards. We observed how staff discussed those patients who had potential for malnutrition during the ward
handover and senior staff included prompts to remind staff to complete the malnutrition screening tool during the safety briefing.

The October board report identified two serious falls on one of the wards in the ASCR division. Concerns were discussed and the falls prevention group undertook reviews of the cases. A recent staffing uplift had taken into account the need for extra staff to maintain the safety of certain patients. Enhanced nurses were placed in bays where patients were at increased risk of harm, such as falling.

**Nurse staffing**

There were some concerns about staffing. A safe staffing tool was used to assess staffing needs daily by each ward and escalated to senior teams should staffing be considered unsafe. Between August 2016 and July 2017, the trust reported a turnover rate of 20.6% for registered nursing staff in Surgery (higher than the national average total registered turnover rate for 2017 of 14.6 %.) The trust were actively recruiting at the time of our inspection.

The trust reported their staffing numbers for ASCR as of July 2017. Overall Surgery was short by 35.8 whole time equivalent (WTE) staff compared to their funded establishment. The three wards/units with the biggest difference between WTE establishment and number of staff in post were:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff</th>
<th>Number in post as of July 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery / Med</td>
<td>59.7</td>
<td>44.2</td>
<td>15.4</td>
</tr>
<tr>
<td>Theatre/Anaesthetics - Nursing</td>
<td>30.9</td>
<td>20.5</td>
<td>10.4</td>
</tr>
<tr>
<td>Ward 6B (Mainly Neuro)</td>
<td>55.16</td>
<td>53.06</td>
<td>2.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

The surgical assessment unit had recently had a review of staffing establishment. This was because the unit was only 12 months old and previously used as a gastrointestinal ward. It was determined additional registered nurses were needed to account for the change in acuity. As a result, the ward was recruiting for five additional registered nurses.

Staff in some areas felt the staffing levels were a problem. Staff told us bank and agency staff were regularly used. Staff rotas showed shifts were regularly filled with four/five bank or agency staff. Where only one or two trust staff worked with a high number of temporary staff, their time was spent inducting, supervising or assisting the bank and agency staff. Staff felt this had not caused any safety issues so far but felt it was a potential risk.

A recent staffing review had taken place and senior staff at ward level told us how in certain areas funding for an extra nurse was provided to maintain patient safety. This role was called an enhanced care nurse and was a shift filled by a health care assistant who would be dedicated to certain patients or cohorts of patients that required a higher level of observation to maintain their
safety. Staff told us that the recent uplift in staffing levels would help to improve retention and moral.

The staffing levels on the ward were displayed at the nurses’ station using a board. On each ward we visited, the nursing and healthcare assistant numbers for the day, late and night shift were displayed for staff, patients and visitors to see. The board showed the planned levels against the actual levels and on each day of the inspection, the actual staffing levels on each ward matched the planned levels. There was also another board, which identified who the nurse co-ordinator and the names of registered nurses and healthcare assistants on that shift were.

Between August 2016 and July 2017, the trust reported a slightly high sickness rate of 4.7% for registered nursing staff in ASCR against a national average of 4.29%.

(Source: Routine Provider Information Request)

However, staff told us of their concerns around sickness and how shifts could not always be filled with bank, and that it was often difficult to gain permission to deploy agency staff. Between August 2016 and July 2017, the trust reported bank usage of 9,812 shifts and agency usage of 2,366 shifts for qualified nurses in Surgery. Over the same period, bank or agency staff to cover sickness, absence or vacancies did not fill 2,833 shifts. The data supplied by the trust did not allow us to calculate usage rates (Source: Routine Provider Information Request).

Concerns over staffing in certain areas had been added to the divisional risk register. A recent staffing review had identified a need to recruit additional staff in areas and this had been updated on the register.

The staffing on wards included a nurse coordinator who was supernumerary for the morning part of the shift and although the nurse in charge did not have a patient caseload, they were responsible for the overall running and safety of the ward. If agency staff were required, the nurse in charge would escalate to their matron who would then seek permission from the head of nursing. If this was refused or staff could not be located then the nurse coordinators would have to take a patient caseload. This meant that the co-ordinator would be unable to perform all of their usual duties and have a full oversight of the safety of the ward.

In the theatre department, the scrub area had the highest vacancies and had been raised in the theatre board report. In April 2017, vacancies had reached 22 WTE and this led to an increase in agency use. Work had been undertaken to improve retention of staff such as the introduction of the HappyApp, which allowed the staff to express their thoughts and feelings in real time. Staff told us this worked well and they could see how actions were taking place to address issues that they communicated through the HappyApp. In October 2017, there were 17 whole time equivalent vacancies in anaesthetic assistants; the trust had ten staff in training and five waiting to be trained but recognised that they were not attracting enough candidates into this area. The board meeting minutes for the theatre department reported that agencies were helping during recruitment days and we saw posters displayed around the department detailing how recruitment was progressing.

**Medical staffing**

Staffing levels and skill mix were planned and reviewed so people received safe care and treatment when numbers allowed. Between August 2016 and July 2017, the trust reported a vacancy rate of 13.8% for medical staff in Surgery. Ophthalmology, trauma, and orthopaedics reported the biggest short falls between establishment and number of staff in post, 14.5 and 6.2 Whole time equivalent respectively. (Source: Routine Provider Information Request)

Between June 2016 and June 2017, staffing of consultants and junior level (foundation year 1-2)
was higher than the England average. However, there were staffing gaps across all teams, particularly mid-grade doctors. This was reflected in the trust reported locum usage of 2,826 shifts and agency usage of 181 shifts for medical staff in surgery. Over the same period, 429 shifts were not filled by locum or agency staff to cover sickness, absence or vacancies. The data supplied by the trust did not allow us to calculate usage rates.

(Source: Routine Provider Information Request)

These gaps were discussed at the ASCR general surgery cluster meetings. We could see how nurse led roles, rota changes, and adaptations and recruitment were planned and discussed to combat shortfalls.

**Staffing skill mix for the whole time equivalent staff working 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>52%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>13%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Sickness rates were below the national average, between August 2016 and July 2017, the trust reported a sickness rate of 0.8% for medical staff in Surgery.

(Source: Routine Provider Information Request)

Between August 2016 and July 2017, the trust reported a higher than the national average turnover rate of 50.8% for medical staff in Surgery.

(Source: Routine Provider Information Request (RPIR) P18 Turnover).

Staff felt that on call arrangements for doctors was safe. If the on call consultants were in theatre than the registrar would attend the ward to carry out rounds. Each speciality had a slightly different rota for ensuring on call cover. This included a consultant of the week model (in vascular surgery), which ensured the same consultant attended to patients on the ward on a daily basis. The consultant on duty was available from 8am until the early evening and there was a change in consultant every Monday. Overnight there was always a vascular registrar and consultant on call. Junior doctors had access to support from senior medical staff and when they were on call at weekends they covered their speciality wards only.

**Other Staffing**

At the time of our inspection, gate 34b (urology ward) did not have a receptionist seven days a week. In order to deal with the situation the receptionist duties were shared by housekeeping staff and the nurse in charge (nurse coordinator). If the nurse coordinator was carrying out
receptionist duties, it meant time was taken away from their other duties. This included actions taken to increase flow in/out of the ward and capacity to attend board rounds or multidisciplinary team meetings. This had been escalated but staff were unsure if any actions were being taken.

During the evening on level 2 theatres, there was no receptionist available to direct or oversee relatives waiting in the waiting room, or advise when patients would be collected. When we visited the unit there was no indication that reception was closed, and relatives were seen waiting in the waiting room unattended. There was no bell to ring at reception and we could see staff taking their breaks, watching television in the patient’s internal waiting room. In order to speak to a nurse the inspector had to knock on the door and wait for it to be answered. Staff told us there was no receptionist in the evenings, this was not made clear to relatives who potentially could be stood waiting at the desk with no way of gaining a nurses attention.

**Records**

People’s individual care records were not always managed in a way that kept them safe and information stored electronically was not always secure. Information displayed on electronic patient information boards was visible to anyone who entered the ward areas and we were able to read information about patients such as their consultant, specialism and date of birth. These whiteboards were lockable but were left unlocked and could be tampered with.

Paper records were not always stored securely. Wards and areas we visited had lockable notes trolleys, which were left open in high patient flow areas. Staff told us there were staff at or around the nurses’ station at all times which would make it difficult for anyone to access the trolleys without being seen. However, the trolleys were moved outside patient rooms when doctors were doing their rounds and were left unlocked and unattended in the corridors. In two areas we saw record trolleys outside rooms, unlocked and left unattended for extended periods of time. We also saw patient record folders left outside patient rooms in easy view of visitors and others left open on the nursing station with no one in attendance.

Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained. We reviewed six sets of records and all were well completed, legible, timed dated and had the name and grade of the doctor looking after the patient recorded. Each set of records had a diagnosis and management plan documented and regularly updated.

The service ensured that appropriate pre-op assessments were recorded. We checked three sets of records and could see that preoperative assessments were well documented. All patients were assessed using the ASA (American Society of Anaesthesiologists) classification, which was documented in the anaesthetic record sheet. Staff in the pre-admission unit told us that if necessary patients would be referred back to their GP for further follow up and/or treatment. All of this would be documented in the notes.

**Medicines**

The service prescribed, gave, recorded and stored medicines safely. Patients received the right medication at the right dose at the right time. We checked six medicine charts and saw that any missed doses were allocated a score, which explained why the dose had been omitted. All allergies were clearly documented on the front of the chart with the signs and symptoms of the reaction identified. We checked four prescription charts that had antibiotics prescribed; all were signed but only three were fully completed with the clinical indication, dose and duration of treatment. The medication chart, which had the duration missed, was highlighted in green by a pharmacist for correction. Pharmacy staff on the surgical division checked patients’ medicines in line with current national guidance. We checked six sets of records and saw that the pharmacists
had checked patients’ normal medication alongside what they had been prescribed as an inpatient.

Medicines and medicine related stationary were managed, transported and disposed of safely and securely. Staff had access to the hospital’s medicines management policy, which defined the policies and procedures to be followed for the safe management of medicines. This included obtaining, recording, handling, using, safekeeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored. Medicines were stored safely and securely in ward areas and in theatres. Medications were stored in locked cupboards or lockable medicine trolleys all of which were tethered to walls when not in use. We saw the protocol for disposing of empty liquid controlled drug bottles. Both the remaining liquid and bottle was emptied into blue pharmaceutical disposal bins on the ward.

We checked consumables in the ward area and in theatres and all were within date and stored correctly apart from one nutritional supplement, which was out of date. We escalated this and it was removed immediately.

Staff managed controlled drugs in line with the policy, which was available on the intranet for staff to access. A trained nurse signed all orders for controlled drugs (CDs) and all wastage was recorded in the ward CD register. CDs were checked nightly and weekly by two trained nurses.

Medicines for anaesthetic use were prepared in line with the Royal College of Anaesthetist guidelines. Anticipatory medicines were prepared prior to each individual patient’s arrival in the anaesthetic department. All were drawn up and labelled under the supervision of the senior anaesthetist.

The medicines management governance group reviewed the use of unlicensed medications, medication alerts, and latest NMC quality standards and medicines optimisation. The minutes we reviewed gave detail of their discussions around a new court judgement regarding deprivation of liberties and covert administration of medicines.

Medicine refrigerators were available in all ward areas. Monitoring forms were in place and completed daily in line with the medicines policy/procedure. All minimum, maximum and current temperatures recorded were within range and we saw evidence when not in range it had been reported to estates. However, in some areas checking of fridge temperatures was not signed as having been completed. Of four fridges we checked, a total of 21 checks had been missed between July and November 2017.

Staff told us that the pharmacy department were slow collecting expired medicines and or disused controlled drugs. As controlled drugs were all checked daily, staff found that this added time to their daily stock check. On gate 25b, an expired controlled drug had been waiting for collection by pharmacy since 9 September 2017.

Pharmacy cover was provided for each ward we visited. Each ward had a standard service level agreement, which provided a pharmacist service from Monday to Friday; this was not available on weekends. Staff felt the lack of cover on weekends affected the flow out of the wards, as patients could not be discharged unless their medicines were ready to take home. The onsite pharmacy was open on the weekend but at reduced hours, which meant that unless the wards had their medicines requests with the pharmacy by a certain time; they were not screened until the following day.

**Incidents**
Incidents were monitored and learning points used to improve practice although this was not always shared with all areas of the surgical division. Between September 2016 and August 2017, the trust reported three serious incidents (SI’s) classified as never events in surgery. A further never event was reported during the inspection period, in November 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event. All four never events were a surgical/invasive procedure or incident. However, each was of a different never event type and learning varied across the division. The three never events were a retained foreign object post-procedure, a misplaced nasogastric tube and a wrong implant/prosthesis. However, during November 2017 the trust reported a fourth never event during an emergency operation in theatres, which related to wrong site surgery. A SWARM was initiated within 48 hours. This is a process where staff swarm to the site to determine the cause of the event and how it could be corrected. The preliminary issues were identified which focused around missing a ‘Stop’ moment. Changes to practice were identified and implemented for all future surgery and a patient safety message was displayed for staff to see across the theatre departments.

A SWARM had also been carried out following a previous never event to prevent the wrong implant/prosthesis re occurring. All key people who were involved with the never event attended, key lessons learned were discussed and new working patterns identified which resulted in immediate change. This included staff that were not part of the clinical teams such as medical representatives, wearing identifiable hats and badges and updating the standard operating procedure. Implants were to be checked so that all packages for all parts of prosthesis were crosschecked and documented, as done so.

However learning from never events was mixed across the division, some senior staff we spoke with in the theatre department was not aware of all of the never events that had happened. We asked what learning was gained from the retained swab in theatres but no information was provided from staff. Senior ward staff were unaware of the misplaced nasogastric tube never event even though they regularly accessed nasogastric feeding for their patients.

The trust reported and actioned near misses. All staff involved with the near miss and senior teams such as governance teams and the division leads would meet or SWARM as soon as was possible to discuss what happened, what went wrong what learning could be achieved and plan for this not to be repeated. A recent near miss, which occurred in theatres, was identified and again a SWARM took place. From this rapid response, actions were identified and the patient was fully informed verbally and written to in line with hospitals policy on the duty of candour.

Managers told us they investigated incidents and shared lessons learned with teams and the wider service. We saw how information was cascaded from senior levels through to teams on the wards by newsletters and minutes of governance and departmental meetings. Safety briefings were held in theatres, the pre-operative assessment unit and at ward level to identify themes of incidents, share learning and disseminate safety information.

In accordance with the Serious Incident Framework 2015, the trust reported 38 serious incidents (SIs) in Surgery, which met the reporting criteria set by NHS England between September 2016, and August 2017. Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria
- Surgical/invasive procedure incident meeting SI criteria
- Pressure ulcer meeting SI criteria

The complete breakdown by incident type was:

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>11</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>7</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>7</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Medical equipment/devices/disposables incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Screening issues meeting SI criteria</td>
<td>1</td>
</tr>
</tbody>
</table>

There were four separate cases of serious delays in patients receiving cancer treatment, three of them in Urology. The first two were involved patients being lost to ‘follow-up’. We asked senior leads how this had happened and what had been done to reduce the risk of this happening again. They told us that lost to follow up incidents were inherited from patients being transferred from one division to another and these were slowly being identified and resolved. To reduce the risk of this happening again the division were looking at developing an implant register so that those patients who for example had a stent inserted were monitored to ensure that stents were removed on time. A central phone line for follow up patients had been installed so that patients had a dedicated number to ring rather than contacting consultant secretaries.

Two further serious incidents in urology included failure to act on test results. Both failures led to long delays before patients received treatment and probably allowed their cancers to spread further than they would otherwise have done. We asked senior staff how this had happened and what had been done to prevent this from happening again. A full root cause analysis was undertaken and it was decided that a one-stop clinic would be implemented to allow investigations such as biopsies to be taken during the clinic reducing the need for further appointments and complications. We were told that the division were currently waiting to find out if they had received funding for further scoping equipment to streamline the service further and increase accessibility.

Another very serious treatment delay concerned a patient who underwent surgery and was discharged from the intensive care unit to the general surgical and medical ward. The patient deteriorated six days after transfer from the intensive care unit and died after suffering from a cardiac arrest. A presentation was given at the senior nurse’s meeting as this was identified as a serious incident (SI). The root cause analysis results when presented identified system and human errors. Lessons learned were cascaded through to theatre teams and ward teams. The root cause analysis showed evidence of completion of these actions.

There were seven grade three pressure ulcers reported as serious incidents. Three of them occurred on gate 33b, two occurred on gate 26b, the Trauma and orthopaedic surgical assessment unit. We reviewed two pressure injury serious incident reviews from both wards. These clearly identified immediate action, learning points, feedback, teaching to staff and equipment reviews. Work on the reduction of pressure ulcers was seen through the trust’s
pressure injury improvement plan. The trust committed to a continued reduction for all avoidable pressure injuries over a three-year period and was on target to achieve a 50% reduction.

There were two infection control SI’s which both involved pieces of surgical equipment being inadvertently reused on a patient following use on another patient and before they had been properly sterilised. Detail of this was reported within the cleanliness and infection control section of the report.

All staff we spoke to said they felt encouraged to be open and honest and to report incidents. Staff told us how they reported and that they received feedback from incidents they raised via safety briefings, theatres briefings and newsletters.

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. 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 we spoke with from all levels of the organisation had an understanding of duty of candour, when they would use it and the actions they would take. However, we saw an example on the ward when a patient had suffered harm in theatres. This was not recorded as an incident on the divisional electronic incident system, nor reported to the patient under regulation 20, the duty of candour. Due to complications from this surgery and potentially from this incident, the patient was re-admitted to the ASCR division. We could not see, nor were given an explanation as to why the patient had not received an official apology and letter in line with the duty of candour. We raised this with the senior teams during the time of our inspection.

Safety thermometer

The Safety Thermometer was 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 was intended to focus attention on patient harms and their elimination. Data collection takes place one day each month. The surgical wards did not display their entire safety thermometer results. Some data was presented on a board in the ward area and this related to the daily prevalence of falls. However, there was no data relating to the prevalence of pressure ulcers, catheters, urinary tract infections or venous thromboembolisms. Senior staff were unable to tell us why this data was not displayed for staff, patients and visitors to see.

Data from the Patient Safety Thermometer showed that the trust reported 68 new pressure ulcers, eight falls with harm and 15 new urinary tract infections in patients with a catheter between August 2016 and August 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at North Bristol NHS Trust
Is the service effective?

Evidence-based care and treatment

The division had processes to ensure that care and treatment was aligned with current evidence-based practice. The division used enhanced recovery programmes (ERP) to help improve patient outcomes. The division’s ERP programmes for elective hip and knee replacements and bowel surgery started in the pre-operative assessment unit when patients were told that good pre-operative health, such as good nutrition, would help post-operative recovery. Patients were told what to expect post-operatively such as physiotherapy, pain relief, occupational therapy, and discharge planning. Patients who were undergoing hip or knee replacements were entered into the ‘Joint Pathways’ partnership programme. This ERP programme focused on making patients active participants in their care and recovery. Patients received booklets, which covered all aspects of care, and one patient told us they were helpful, easy to read and a ‘good reference to go back to, as there was so much information to take in’.

The trust reported data to the ‘major trauma dashboard’, which was a way of benchmarking outcomes, results or quality of care between major trauma centres in relation to specific measures. Measures 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 July to September 2017, which showed it consistently performed above the national average in all but one measure.

Staff used ‘care bundles’ in line with the Institute for Healthcare Improvement guidance. Staff completed a set of evidence-based practices, or steps which when performed collectively and reliably, have been proven to improve patient outcomes. Wards used the insertion and management of peripheral venous access care bundle and catheter care bundle.

The vascular team were involved in a monthly vascular steering group, which included consultants, vascular scientists, junior doctors, matrons, physiotherapists and occupational therapists. The group discussed performance, shared learning, practice and developments in the
treatment of vascular patients. The meetings followed a set agenda, which included items such as clinic times, complaints, waiting times and developments within the service.

Minutes from the senior nurses meeting and the medicines governance meeting showed how the latest Nursing and Midwifery Council changes to legislation were cascaded to divisional teams. However, the minutes for the divisional cluster meeting did not have legislative or medical updates itemised on the agenda and we could not be sure that information was cascaded across all levels.

**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. As part of the nursing inpatient admission documentation, all patients were screened with a validated nutritional screening tool, which identified patients who were malnourished, or at risk of malnutrition. The board reports for August and September 2017 showed that ASCR were compliant with their malnutrition screening within 48 hours of admission for those patients admitted for 24 hours or more.

Within the ASCR division a monthly newsletter was sent out which highlighted actions and learning from complaints. A number of concerns had been received from upper gastrointestinal patients around the lack of choice of low fat food options on ward menus. This had resulted in patients relying on relatives having to bring in food. It was discussed why this option had been removed from the menu and guidance on how to offer both elective and emergency patients a lower fat choice was explained to staff.

Theatres and the ward areas ensured the effective management of nausea and vomiting. We saw staff enquire about patient’s appetites and offer anti-emetic (anti sickness) medication for patients who reported feeling nauseated. We also saw how staff returned to check the medication had worked and if necessary offer an alternative anti-emetic.

For patients able to take their own fluids, drinks were available on bedside tables and within reach. Patients were advised about appropriate pre-operative fasting in the pre-operative assessment unit. Patients were starved in line with hospital policy and lengths of fasting times reflected where patients were on the day’s theatre list.

Mediroom staff carried out comfort rounds which as explained by the divisional paperwork were aimed at reducing nurse workload, and improving patient satisfaction. Patients comfort and needs were assessed hourly pre-operatively and two hourly post operatively. During the pre-operative checks patients were offered small amounts of water hourly to keep them comfortable whilst they were nil by mouth ahead of their surgery.

**Pain relief**

Staff monitored patient pain levels regularly. The ASCR division had implemented the Faculty of Pain Medicine’s Core Standards for Pain Management to ensure that following surgery patients were given effective pain relief. Guidance on the acute pain analgesic ladder for patients was set out in the day surgery and overnight stay booklets, which offered advice on appropriate analgesics in relation to a patient’s pain score. The referral process was set out and advice on who to call out of hours was clear. We requested information on the audit of pain relief but this was not provided by the trust.

Patients were assessed on the wards pre and post operatively by the Abbey pain score and staff used this for those patients who had dementia. We heard staff asking patients if they had pain and after administering analgesics returned to check if they had been effective.
A new acute lead had been appointed to the pain team and the division had started to provide an out of hour’s pain service, which was staffed by junior and senior consultants and trainee doctors. Comfort rounds were implemented in the medirooms. Patients were assessed for pain hourly pre-operatively and two hourly post operatively.

Information was given to patients pre-operatively to explain what sort of analgesia they could expect to receive during their operation. Booklets given to patients prior to their joint surgery identified that pain which prevented appropriate function such as effective physiotherapy and mobilisation would be prevented. The information went on to explain what certain analgesics were, how they might make a patient feel and how they were administered.

**Patient outcomes**

The service monitored the effectiveness of care and treatment local results with those of other services to learn from them. The ASCR division completed local audits such as hand hygiene audits, complaints, safe staffing and credits for cleaning. The information was collated and discussed at the monthly cluster meeting and fed into the trust board reports.

- Relative risk of readmission

We reviewed the trust’s national data on a patient’s relative risk of re-admission. This indicator measured the percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge from hospital. Between June 2016 and May 2017, across all surgical specialties patients at the trust there was a higher expected risk of readmission for both elective and non-elective admissions when compared to the England average. The risk of readmission was higher than the respective England averages for all of the top three elective specialties based on count of activity. This was especially the case for elective General Surgery.

- Elective Admissions – Trust Level

![Elective Admissions Chart](chart.png)

Non-Elective Admissions – Trust Level

![Non-Elective Admissions Chart](chart.png)

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. *(Source: HES - Readmissions)*

The trust board report stated that detailed analysis was being undertaken to understand if there were any opportunities to avoid readmission. The trust told us that after an internal audit to check the validity of the data, 30% of general surgery re-admissions were true re-admissions. The previous totals had previously included all patients admitted for reviews at the HOT clinic.

- **Hip Fracture Audit**

The trust submitted data to The National Hip Fracture Database, which forms part of the national falls and fragility, fracture audit programme. The trust’s risk-adjusted 30-day mortality rate in the 2017 Hip Fracture Audit was 5.1%, which was within the expected range compared to other hospitals in England. This showed an improvement on the risk-adjusted 30-day mortality rate data reported during 2016 which was 7.3%. The crude overall length of stay was 24.2 days, which again fell within the middle 50% of hospitals in England and Wales. The 2016 figure was 23.4 days.

The proportion of patients having surgery on the day of or day after admission was 83.6%. This was worse than the national aspirational standard of 85% but within the upper quartile of hospitals in England and Wales. This showed an improvement on the data submitted for 2016, which was, was 79.1%.

The crude perioperative medical assessment rate was 95.7%, which was below the national aspirational standard of 100% and fell into the middle 50% of hospitals in England and Wales. This was a slight improvement on 2016 submitted data of 94.4%.

The proportion of patients not developing pressure ulcers was 96.7%, which fell into the middle 50% of hospitals in England and Wales. This was a slight decline since the 2016 data was submitted which was 98.1%. However, the trust remained on target to achieve a 50% reduction of all pressure injuries over the three-year period, in line with the target set at the outset of the national ‘Sign up to Safety’ programme.

*(Source: National Hip Fracture Database 2016)*

- **Bowel Cancer Audit 2016**

The National Bowel Cancer Audit is a high profile, collaborative, national clinical audit for bowel cancer, including colon and rectal cancer. The audit aims to improve the quality of care and survival of patients with bowel cancer, and meets the requirements as set out in the NHS cancer plan, NICE guidelines and the report of the Bristol Royal Infirmary inquiry. The trust’s 2016 Bowel Cancer Audit was better than the national aggregate, as 42.8% of patients undergoing a major resection at the trust had a post-operative length of stay greater than five days. This was less than in 2015 when the post-operative length of stay greater than five days was 47.9%.

The risk-adjusted 30-day unplanned readmission rate was 13.5%, which was within the expected range.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 43.3%, which was within the expected range. The time-period for this metric was April 2011 to March 2014. The 2015 figure showed a decline in numbers of patients and was 38.6%.

The trust’s risk-adjusted 90-day post-operative mortality rate was 2.7%, which was within the expected range and was an improvement on the data submitted in 2015 of 3.3%.

*(Source: National Bowel Cancer Audit)*
The trust’s risk-adjusted two-year post-operative mortality rate was 10.5%, which made the trust a positive outlier in comparison to other trusts in England and Wales. The time-period for this metric was April 2012 to March 2013. The 2015 data showed a decline as the trust’s risk-adjusted two-year post-operative mortality rate figure at 15.7%.

The trust was meeting the 85% target for 62 days of an urgent GP referral during April to June 2017. However, we reviewed the board reports for June to October 2017 and the ASCR division summary showed that only 89.2% patients were seen within two weeks of an urgent GP referral against the national target of 93%. The trust told us it had made significant improvement with its performance against the urgent GP review within 2 weeks of referral. While the rolling 12-month position was still marginally below the national target of 93%, the data in the months between September and December 2017 all passed this target. The trust identified that urology and skin patients in particular had the main pressures within these targets. An action plan had been put into place for urology patients and the division were trialling a nurse led skin biopsy clinic.

The National Vascular Registry (NVR) audits the care provided by NHS vascular units in England and Wales, and reported on the process and outcomes of care for, patients undergoing carotid endarterectomy and abdominal aortic aneurysm (AAA) repairs. In the 2016 NVR audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2% for abdominal aortic aneurysms. This was within the expected range compared to other trusts in the UK.

During the period of January 2013 to December 2015, patients who received a carotid endarterectomy, from symptom to surgery within 11 days, met the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was 3%. This was within the expected range compared to other trusts in England and Wales.

(Source: National Vascular Registry)

- Oesophago-Gastric Cancer National Audit 2016

The National Oesophago-Gastric Cancer National Audit (NOGCA) covers the quality of care given to patients with Oesophago-Gastric cancer and oesophageal High-grade Glandular Dysplasia. The audit evaluates the process of care and the outcomes of treatment for all Oesophago-Gastric cancer patients, both curative and palliative. In the 2016 NOGCA, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 6.9%. This placed the trust within the middle 50% of all trusts for this measure. The proportion of patients treated with curative intent in the Strategic Clinical Network was 36.7%, similar to the national aggregate. The trust was not eligible for the 90-day post-operative mortality rate metric in either 2015 or 2016. This metric was defined at strategic clinical network level; the network can represent several cancer units and specialist centres. The result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

- National Emergency Laparotomy Audit 2016

In the 2016 National Emergency Laparotomy Audit (NELA), the proportion of the trust’s patients with pre-operative documentation of risk of death was 79%. This narrowly missed the national standard of 80% however; the trust outperformed the national average for England and Wales of 64%.

The proportion of trust patients’ who had access to theatres within clinically appropriate time frames was 85%. This met the national standard of 80% and was better than the England and Wales average of 82%. The trust’s proportion of highest-risk cases admitted to critical care post-
operatively was 90%. This met the national standard of 80% and was better than the England and Wales average of 85%.

The trust’s proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre was 75%. This did not meet the national standard of 80%, but was similar to the England and Wales average of 74%.

The hospital’s risk-adjusted 30-day mortality for the period from December 2013 to November 2015 was 6.6% and was lower (better than) the national average of 11.4%.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures 2016/17

The trust submitted data to the Patient Related Outcome Measures (PROMS), which helped the NHS measure and improve the quality of care patients experienced during and after elective surgery. 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 viewed on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

Patients were asked before and after surgery to allow hospitals to measure the effectiveness of their surgical interventions. The EQ-5D questionnaire is a standardised instrument for measuring generic health status by measuring patients view on five dimensions, their mobility, self-care, usual activities, pain/discomfort and anxiety/depression. The EQ-VAS is a visual analogue scale and is the second part of the questionnaire.

In 2016/17 EQ VAS and the EQ-5D performance on groin hernias was better than the England average.

For varicose veins, performance was worse than the England average according to both the Aberdeen Varicose Vein Questionnaire and EQ VAS. The trust told us that they had not been fully submitting PROMS data.
For hip replacements, performance was slightly worse than the England averages according to both EQ VAS and the EQ-5D index. However according to the Oxford Hip Score, the trust’s performance was similar to the England averages.

For knee replacements, performance was slightly worse than the England averages according to both EQ VAS and the EQ-5D index, but similar to the England averages according to the Oxford knee Score.

(Source: NHS Digital)

Through the Commissioning for Quality and Innovation (CQUIN) payment framework, improvement and innovation goals were agreed between North Bristol NHS Trust and local Clinical Commissioning Groups or NHS England for the provision of NHS services. Ten CQUINs for the financial period of 2016/17 were agreed and the division were on target to achieve their goals for sepsis screening and treatment, review of antibiotic prescriptions, patient discharge summaries, timeliness and completion. However, it was reported in the 2016/17 Account of the Quality of Clinical Services Report, that work was ongoing to achieve targets in the reduction in antibiotic consumption and inter-provider cancer referrals. The report stated that inter provider cancer referrals had been achieved in less than 40% of cases with a reduction in antibiotic consumption partially achieved in 40-79% instances.

Theatres regularly reviewed the effectiveness of care and treatment through local audit of the World Health Organisation’s (WHO) surgical safety checklist. Compliance was a mandatory field in the trust’s operating theatre data bundle and was entered for every patient who has a procedure both elective and non-elective, local or general anaesthetic. The surgical data manager presented weekly to the theatre efficiency group and monthly to the theatre board. The trust told us that good practice was celebrated and poor performance was investigated and any persistently poor performing theatre would undergo a mini-root cause analysis, as had been requested on one poor performing theatre. Board reports showed that in September 2017 staff had been 95.7% compliant with completing the WHO surgical safety checklists and audit data captured between November 2016 to August 2017 reported that ‘Stop Before You Block’ had seen a significant improvement in compliance from 53% to 90%. However, during the inspection period the trust reported a further never event which related to wrong site surgery during an emergency operation. A staff SWARM identified the preliminary issues, which focused around a ‘Stop’ moment that did not happen. Changes to practice were identified and were in the process of being implemented for all future surgery.

Mortality data was reported to a national database. The quarterly statistics for the Summary Hospital-level Mortality Indicator (SHMI), which identified deaths following time in hospital between April 2016 to March 2017, showed the trust was within the parameters for expected deaths. We requested copies of the mortality and morbidity meeting minutes for each speciality and were only sent the minutes for urology. This showed an area for lessons learnt but minimal discussion was documented. The governance report did not show who had attended the meeting so we were not assured that messages were being cascaded across teams.

The surgical division regularly audited their intravenous cannula care bundle for insertion actions and ongoing care. These actions were compared locally at trust level and the surgical division results for September showed that the division’s compliance was higher than the trust wide audit data. However, we were not supplied with a breakdown of this data.

The trust entered all medical devices onto registers such as the national joint register (NJR) which was set up by the Department of Health and Welsh Government in 2002. Information was collected on all replacement operations to monitor,
- The performance of joint replacement implants.
- The effectiveness of different types of surgery.
- The improvement of clinical standards.
- How patients, clinicians and the orthopaedic sector as a whole benefit.

The NJR ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects at national level. It was this process that highlighted an incorrect implant match had been carried out during a replacement operation. This was identified as a never event.

The trust told us they monitored compliance with the use of a national early warning score (NEWS) when recording patients’ vital observations. Early Warning Scores were developed to help staff in the earlier detection of the deteriorating patient by prompting nursing staff to request a medical review at specific trigger points. Board reports highlighted which wards were performing below the trust target and which wards met the threshold for action. The report also highlighted which wards were not submitting data for the audit and tasked senior staff with making sure data was submitted.

The theatre department did not participate in the Anaesthesia Clinical Services Accreditation (ACSA). The scheme was been developed by the Royal College of Anaesthetists, Quality Management of Service Group and the Clinical Quality Division. The ASCS is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review.

**Competent staff**

Patients did not always have their assessed needs, preferences and choices met by staff with the right skills and knowledge. The service provided mandatory training in key skills to all staff however not all areas or staff groups had completed this. This was not picked up during regular appraisals, as the staff did not always receive annual appraisals in line with trust policy. The trust was under its target of 85% between April 2016 and March 2017, as only 55.1% of staff within surgery had received an appraisal. The trust told us, with the exception of medical staff, their target was to reach 100% appraisal completion at the end of the financial year (not including staff on long-term leave). The trust told us that medical appraisals could be delayed by up to three months, and therefore the trust aimed to reach 100% completion in a 15-month period.

A split by staff group can be seen in the graph below.

**Appraisal completion rates within Surgery, April 2016 and March 2017**
The trust had processes in place to review poor or variable staff performance. Ward managers told us they have staff with performance issues such as poor attendance rates they would use the trust policies to review this and discuss issues with their divisional leads. Support and advice was readily available from the human resource department.

The theatre department supported their staff to become competent in their roles. New team members in the theatre department were supported to deliver safe, effective care and treatment. Staff had comprehensive, preceptorship and induction booklets, which had all the information required to learn about the department and the job role. Policies and required reading were identified and these areas had to be signed off by mentors in order to prove compliance and competence. A newly qualified theatre nurse undergoing preceptorship told us that the induction that they had received so far had been good with the support of a good mentor, with allocated times for review meetings. They had met the clinical education team and had a plan of competencies to complete during a supernumerary period.

Staff in the pre-operative assessment unit and the theatre departments had regular governance half days where teaching about specific relevant topics would take place. Recent teaching sessions covered lung function, venous thromboembolism (VTE) and human immunodeficiency virus (HIV).

Theatres recognised how investing in the development of their staff was vital to recruitment and retention. They had developed a new role of a practice development nurse and had recruited a senior nurse into this position.

**Multidisciplinary working**
Staff of different kinds worked together to assess, plan and deliver care and treatment. Doctors, nurses and other healthcare professionals supported each other to provide care. We saw how teams met and discussed patient care from ward handovers to daily meetings with the therapy teams. A daily therapist huddle took place to make sure limited resources were allocated fairly across the departments and provided cross cover across different teams and departments.

We observed how well the theatre department interacted with other specialist services during a procedure, which became unexpectedly more complex. When a procedure required altering at short notice, specialist staff were on hand to offer advice and alter patient pathways. It was identified that recovery time would be altered and therefore the wider multidisciplinary team would require more post-operative involvement.

Staff within the surgical sterilisation unit (SSU) said their relationship with the theatre department staff had improved since changes in processes had been identified and implemented. A process was now in place where the theatre department sent their next day’s equipment list for each theatre to SSU by 5pm the day before. Staff said the process worked well and the theatre department were following it properly. The SSU coordinator would check the list and prioritise the workload to ensure all the equipment was ready for the next day. There was a theatre board meeting every morning and the SSU coordinator would be present and provide an update of the status of the equipment. The SSU were part of the theatre efficiency group and met every month. Staff said this had improved communication and cooperation between the two teams.

Recent serious incident reporting had identified a failing in cross-departmental working in the urology team. The service failed to request certain diagnostic investigations, which had a detrimental effect on the patient. Learning from this lead to the introduction of a one-stop clinic where patients were assessed, investigations completed, and patients left with a plan on that day. Staff told us this worked well because inter-departmental working such as pharmacy and anaesthetic support was effective.

Staff said that access to medical consultants and timely reviews for patients who were accommodated on surgical wards was difficult. We spoke with three members of staff who told us that they had found it difficult to locate the correct medical bleep number for the correct team and this regularly caused frustration and wasted staff time.

However, it was not always clear on the ward areas if learning from recent never events had been shared across departments. We asked senior staff about a recent never event regarding the wrong siting of a naso-gastric tube and staff could not tell us any learning from this or had heard of the event.

**Seven-day services**

The surgical division provided services 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 a limited occupational therapist cover on weekends if patients’ required specific treatment related to mobility aids.

The emergency care and general surgery cluster were involved in the southwest clinical senate, which carried out an audit of the emergency general surgery practice across the southwest. Fourteen trusts within the south west of England were reviewed using a combination of standards from the Royal College of Surgeons (2011) – Emergency Surgery: Standards of Unscheduled Surgical Care, London Health Audit (2013) Quality and Safety programme and NHS Services,
Seven Days a Week Forum (2013). The results of the audit showed the trust had performed well in meeting or partially meeting all 22 standards. The only standards, which were not met fully, were:

- Being unable to provide two consultants ward rounds of all acute admitted patients on the weekend. This meant not all patients were seen within 14 hours of arrival.
- Failure to have a policy for review of all emergency general patients by a consultant, every day, seven days a week, whilst they remained under the care of the emergency team.
- There were no clear protocols for senior speciality review of all general surgery inpatients to include gastrointestinal (GI), vascular, breast and urology every day, seven days a week.
- There were no clear protocols, including a standard of timing, for senior medical speciality review by a physician of emergency general surgical admissions.

**Health promotion**

Staff identified patients and relatives who may need extra support before, during and after their operation. The pre-operative assessment unit supported people to be as fit as possible for surgery. Patients who attended the clinic could be referred to a smoking cessation service.

Patients who had joint operations could attend weekly education groups run by physiotherapists, occupational therapists and nurses. These education groups offered information and teaching on how to prepare pre-operatively. Topics discussed were healthy diet, exercising and reduction in alcohol consumption. Referrals to alcohol liaison teams and smoking cessation sessions could also be achieved from here.

Staff supported patients to maximise their independence following surgery by using the enhanced recovery programmes to enable patients to be actively involved in their recovery. Part of this pathway included encouraging patients to be as healthy as possible before their planned operation. Staff in the pre-assessment unit discussed eating well, exercise, relaxation and the importance of trying not to worry too much about the surgery.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff were aware of consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff had attended mandatory training and the trust reported that as of August 2017, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training had been completed by 87.8% of staff in within Surgery. Therefore, the trust’s 85% target had been met. *(Source: Routine Provider Information Request)*

The registered nursing staff we spoke with were knowledgeable about using the deprivation of liberty standard. During our inspection, patients that had a DoLS in place were handed over on the safety briefing and staff were aware that there was a review date. We reviewed one patient’s DoLS paperwork. The paperwork was a requirement for a standard authorisation and a capacity assessment had been completed on two dates. The form stated that all aspects of care were required to be given and the patient’s family had been informed. An urgent authorisation had been granted for seven days, this was in date during the inspection and due for review in two days’ time. A best interest’s decision had been signed and a family member’s name was added as an advocate.

Staff told us that should a patient be at risk of self-harm than they would have a specialist nurse
to sit with them and a deprivation of liberty standard application would be considered. Wards where patients were admitted with a higher frequency of self-harm regularly employed registered mental health nurses.

Staff acted within the legal framework to obtain patient consent for treatment. Written consent was completed pre-operatively in the outpatient clinic and verbally checked again on admission, as part of the World Health Organisation (WHO) safe site surgery checklist. We observed how staff explained what they were going to do and obtained verbal patient consent for the care and treatment they provided therefore fully involved patients in their care.

Written consent was gained for medical photography and we reviewed consent for a patient who required a photograph of a pressure ulcer. The patient signed this document and a copy was kept in the patient record.

Patients and their relatives/carers living with dementia, learning disabilities, autism or mental health issues were given extra time during the pre-admission process to make sure the correct consent was obtained.

Staff were aware of their responsibilities to patients who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in their record. A full entry was made in the patient's medical notes as soon as a DNACPR order was made. This included the rationale behind the decision, together with a review date and any other relevant comments concerning the patient’s individual circumstances. A copy of the DNACPR order was placed in the front of patient's records. We reviewed three DNACPR forms, all were signed by a consultant, and all areas were completed.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We witnessed how the surgical division supported staff to deal with the number of cognitively impaired patients admitted to their wards. Extra staff were booked over and above their usual funded requirements and was dedicated to care for the safety of these vulnerable patients.

We saw how staff took the time to interact with people who used the services and those close to them in a respectful and considerate way in theatres, the medirooms and on the wards. We observed multiple examples of staff engaging in conversation with patients and relatives. Patients told us staff addressed them by their preferred names and showed interest in what was being discussed, we observed this in patient rooms, bays and on the corridors. Staff introduced themselves by name and explained to patients what their roles were. Staff in theatres took their time with an elderly patient who was slightly confused, forgetful and anxious. The anaesthetist explained everything that would happen several times and took the time to answer all of the patient’s questions and concerns.

Patients were encouraged and supported by staff. We saw staff asking patients if they required assistance on multiple occasions and were very encouraging when patients were struggling. Some patients commented that staff could not have been more helpful. Patients told us they were happy with their care and treatment. We spoke with four patients and all had been complimentary about their treatment. They all said staff at all levels had treated them well and were friendly.

On every department we visited, we saw how hard the staff tried to maintain their patient’s privacy and dignity. Patients in theatres and recovery had their dignity maintained at all times, curtains
were always closed and patient’s that were anaesthetised were covered during any intervention. However, staff told us that during times of escalation an extra bed was slotted into a two-bedded bed space, which compromised patient’s privacy and dignity. Curtains were not available to go around the bed space so a screen was used, which was not big enough to ensure seclusion as patients could be seen over the screen. Ward staff were not happy with the situation and had escalated the issue but had not been told if any changes were going to be made. Staff were unaware if data was collected on the frequency of patients being admitted during escalation.

**Friends and Family test performance**

To capture feedback the hospital used the friends and family test (FFT) which captured near-time feedback and asked if patients would recommend the service to their friends and family. Between August 2017 and July 2017, the Friends and Family Test response rate for Surgery at North Bristol NHS Trust was approximately 26%. This was slightly lower than the England average of approximately 29%.

**Friends and family test response rate at North Bristol NHS Trust, by site.**

![Graph showing Friends and Family Test response rate comparison between North Bristol NHS Trust and England average](image)

**Friends and family test – ward level breakdown**

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Please note that the red, amber and green colour coding above is not a judgement of performance but merely highlights the highest and lowest scores.

Gate 26B reported the lowest overall score of 81% (technically SMD Rosa Burden scored 80% overall but this was based on only one month). Other wards reporting low scores were gate 32B (67% in June 2017) and gate 25A (68% in April) (Source: NHS England).

Friends and Family results were discussed at the surgical senior nurses meeting where highlights and lowlights were shared across the teams.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. We saw how patients had time to ask staff questions during medication rounds and how staff took the time to answer all their questions, offer alternative medications and alleviate concerns.

We saw how staff cared for a terminally ill patient and accommodated the family’s needs to spend time with their relative. Staff made sure the patient was moved into a side room so that his large family could come and go as they pleased without disturbing other patients.

Patients were empowered and supported to manage their own health, care and wellbeing to maximise their independence. Patients were asked for their thoughts and feelings regarding treatment plans and had direct input into setting goals and objectives.

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

Staff involved patients and those close to them in decisions about their care and treatment. Staff told us that relatives of patients living with a diagnosis of dementia, mental health, autism or learning disabilities would always be welcome on the ward if it helped ease the anxieties of the patient.

Staff had access to communication aids to help patients become partners in their care and treatment. For example, we saw a communication booklet, which was used for patients living with dementia and hearing impairments.

Relatives were encouraged to visit their loved ones when appropriate. We saw a relative of a patient on Gate 33b helping their loved one eat and although this was out of the visiting hours, it
had been encouraged. Staff in the pre-operative assessment unit supported patients to understand their relevant treatment options, including benefits, risks and potential consequences. Time was given to all patients to discuss options.

Staff communicated with patients so they understood their care, treatment and condition and any advice given. Patients were able to tell us what treatment they were receiving and were happy that the doctors and nurses kept them up to date with their condition. They said they felt able to ask questions and could raise concerns. For example, we spoke to a patient, with vascular problems. The patient had been admitted to hospital for seven days but the proposed treatment had been postponed. Staff had kept her informed as to why the treatment was delayed and when treatment was likely to be carried out. The patient was happy with the level of information received and felt staff understood the position she was in.

Patients were given the opportunity to reflect on their treatment and condition. Leaflets were available to patients, on the enhanced recovery programme for colorectal surgery, which provided them with a patient progression diary. The diary allowed them to record what they were eating and drinking, their breathing, mobility, pain and nausea as well as their daily goals. However, though available, we did not see any patients using the diaries.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Patients were able to make choices and staff provided care according to these choices wherever possible. Wards had dementia champions and patients who lived with dementia were identified on the wards by blue forget me not magnets and symbols on paper records. Ward packs were developed for those patients who were living with dementia. These packs supported the multidisciplinary team to plan and provide personalised care.

The layout of the wards allowed flexible use of the areas and provided privacy for patients. The high number of individual rooms maintained privacy and dignity and the four-bedded bays could be used for either male or female patients. Bathroom facilities were provided for both.

Average length of stay

Between July 2016 and June 2017, the average length of stay for patients across the division with the exception of general surgery was longer than the England average. However, the trust provided us with statistics, which demonstrated Dr Foster’s data on the trust’s length of stay. This compared the trust data to a peer group of hospitals and showed that the trust was within the expected range for trauma and orthopaedics and performing better than the England average for other specialities.

Elective Average Length of Stay – Trust Level

| This Site | England Avg. |
Discussions about delayed discharges and length of stay could be seen throughout the renal, general surgical cluster meeting minutes, all of which followed the same format. Audits of patients with a length of stay between seven to 14 days across all divisions had taken place and each division had identified their ‘top two’ schemes to reduce lengths of stay. Fortnightly checkpoint meetings were led by the executive team, which reviewed progress against the divisions’ schemes. ASCR 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 social. The ASCR weekly newsletter reported how this had been a focus for staff and the trust had made this a winter priority. October 2017 meeting minutes reported a reduction of 75 to 65 patients across the division.

The executive team had identified across all divisions that some patients chose to delay discharges and this led to a review of the Managing Expectations Protocol. This identified that information should be shared with patients and carers to provide a clear message that when a patient no longer required acute care; they would be expected to leave.

The trust had a contractual standard with the clinical commission groups to have clinic letters typed and ‘turned around’ within ten days. ASCR were outside of this target according to the October 2017 board reports and were due to pilot an outsourcing scheme, where a third party would type and return new clinic letters within 24 hours. This would allow internal staff to focus their efforts on reducing the backlog. The Plastics specialties were reported as having seen an improvement in turnaround time. However, no further details were included in the meeting minutes.

**Meeting people’s individual needs**

The service took account of patients’ individual needs. Signage was clear enough to be understood by people who were unfamiliar with the environment. The wards were all accessible by lifts and there were motorised vehicles, which transported patients along the main corridors if they found walking too difficult.
Staff had access to specialist nurses for advice and information when caring for patients with additional needs. This included patients with bariatric needs, living with dementia or with mental health needs. Information regarding fast track bariatric surgery standards were displayed across theatres on level three. Patients and visitors were able to use the handrails fitted to each ward corridor to help them mobilise.

The wards had clear information explaining how many staff were on duty and the nurse in charge. A good variety of leaflets were available including information about avoiding pressure ulcers, deep vein thrombosis and being in hospital, pain relief, delirium and patient transport. There were clear instructions displayed about making complaints or giving compliments, wards displayed thank you cards from patients and their relatives and carers. Boards at the entrance to wards displayed patient safety and quality information, this included dates of the last serious infection, hand hygiene scores and ward cleanliness ratings.

The service took into account people with complex health and social care needs. We observed staff following the trust’s guidance and advice on how staff should provide care and treatment to these patients. Staff demonstrated respectful communication, courtesy, identified themselves, addressed patients by their preferred name, listened, spoke with patients sensitively, and kept patients informed about their condition, treatment and discharge.

The pre-operative assessment unit had a telephone assessment service for those patients who were unable to access clinics easily. Handovers and whiteboard meetings routinely considered the needs of those patients and their carers living with complex mental health conditions and dementia. Whiteboards were updated at ward handovers and the multidisciplinary team worked well together shared information about progress and referrals to other services.

Staff told us that if they had any concerns for a patient’s mental health, they would make a referral to the mental health liaison nurse. The burns unit had 24/7 mental health support for their patients and this was typically available within two hours of referral. Staff on other wards could access psychiatric support via a referral process and staff told us that the service was responsive.

Staff provided good treatment and care for patients living with dementia. All staff were required to complete dementia awareness training as part of the trust’s mandatory training programme. All patients over the age of 75 years were screened for dementia. If it were suspected the patient had dementia, staff would complete a cognitive care bundle, which included the completion of the ‘this is me’ booklet. This booklet explained specific aspects of their day-to-day living, likes and dislikes. The cognitive care bundle prompted staff to add the information into the discharge summary for GP follow up. Staff ensured they knew who to contact and had details relating to power of attorney, associated documentation, lead professional and the carer’s details. Carers were also provided with a leaflet giving information on what would happen during admission. Patients who lived with dementia were identified on the wards by blue forget me not magnets and stickers on their notes. During safety briefs, patients living with dementia were discussed, along with their additional needs so all staff were aware of how to ensure that patients received appropriate and safe care. On one ward, staff provided film and popcorn entertainment sessions and had digital reminiscence therapy on an interactive television. Staff told us that patients could attend a memory café, which was held weekly and that they could contact the dementia lead for the division for advice.

From 1st August 2016 onwards, all organisations that provided NHS care or adult social care were legally required to follow the Accessible Information Standard. The standard aimed to make sure that people who had a disability, impairment or sensory loss were provided with information that they could easily read or understand and with support, communicate effectively. Tools were used
by staff when patients had difficulty communicating such as picture aids and advice and guidance on sign language. The pictures could be used by staff to identify when a patient needed to use the toilet, their degree of pain and symptoms experienced, body parts and personal care.

Arrangements for people who needed translation services could be booked through the hospital switchboard. If patients were elective admissions, booking staff would organise this prior to pre-admission appointments. The service available was delivered by telephone or in person. Staff would use them whenever patients required assistance with understanding their condition and treatment. They also said they would try to use gestures when communicating with patients whose understanding of English was limited.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Between September 2016 and August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery showed a trend of improvement. In September 2016, 65% of patients were treated within 18 weeks versus the England average of 71%. In August 2017, 76% of patients were treated within 18 weeks versus the England average of 70%.

![Graph showing referral to treatment (percentage within 18 weeks) - admitted performance](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Patients who required plastic surgery, urology and general surgery could access the service when they needed it. A breakdown of referral to treatment rates for surgery separated by specialty is below. The trust performed better than England overall for the three specialties below:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>89.7%</td>
<td>82.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>86.8%</td>
<td>77.3%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>76.3%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

However, the trust performed worse than England overall for the two specialties below:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>55.3%</td>
<td>70.2%</td>
</tr>
</tbody>
</table>
Referral to treatment times were discussed at cluster meetings for all departments and remedial action plans were put in place to help divisions reach national targets. The board reports for October 2017 reported that trauma and Orthopaedics had achieved their recovery trajectory for the first time since May 2017.

Access and flow to services within the ASCR division was varied and patients could not always access the right care and treatment at the right time. The ASCR division had developed a Hot Clinic on the surgical admissions (SAU) unit for patients with general surgery or urology problems who might not require admission to hospital. The SAU Hot clinic was developed so that staff and patients had timely access to initial assessment, test results, diagnosis and treatment.

### Referral to treatment times for 52 week waits

In September 2017, there was a trust total of 96 patients who had waited over 52 weeks from referral to treatment time, three of which were in neurosurgery and 85 others were from across the trust. The reasons consisted of patient choice, lack of hospital bed capacity and pathway delays. The number of patients who had chosen to wait greater than 52 weeks for their treatment was identified as a particular challenge and we were told a root cause analyses had been completed, with dates for patients’ operations being agreed at the earliest opportunity and in line with the patient’s choice.

### Cancer waiting times

Patients with more urgent needs had their care and treatment prioritised. The trust met the 85% target of 62 days for an urgent GP referral during April to June 2017.

However, some patient waiting times were below national targets. We reviewed the board reports for June to October 2017 and the ASCR divisional summary, which showed 89.2% patients were seen within two weeks of an urgent GP referral against the national target of 93%. The trust told us it had made significant improvement with its performance against the urgent GP review within 2 weeks of referral. Whilst the rolling 12-month position was still marginally below the national target of 93% the months between September and December 2017 all passed this target.

The trust identified that urology and skin patients in particular had the main pressures with these targets. An action plan had been put into place for urology patients and the division were trialling a nurse led skin biopsy clinic. The failure of the trust to reach the 62-day cancer target for urology cases was identified on the ASCR divisional risk register, this was rated as amber. The trust explained that it received referrals from other trusts for urology, skin and sarcoma services and these may be late referrals. The trust gave an example that during the period of July to October 2017 out of 37 urology patients transferred to the trust, 23 were beyond the 62-day limit. The trust provided further data where compliance with the 62-day standard was 86.4% at the end of October 2017, against the national target of 85%.

### Cancelled operations

The service monitored its rate of cancelled surgeries and compared them to previous local and national data. A last-minute cancellation is a cancellation for non-clinical reasons on the day a patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient had not been treated within 28 days of a last-minute cancellation then this was recorded as a breach of the standard and the patient should be offered treatment at the time and hospital...
of their choice.

Between quarter three 2015/16 and quarter one 2017/18, the proportion of patients whose operations were cancelled and were not treated within 28 days was consistently lower (better) than the England proportion. In quarter one 2017/18, this trust cancelled 223 operations. 0.4% of these patients were not treated within 28 days of cancellation. According to the board reports, one cancellation was due to a lack of anaesthetist availability and the other was due to emergency pressures on the day.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - North Bristol NHS Trust**

The number of cancelled operations more than doubled as a percentage of elective admissions in quarter four, 2015/16 compared to the previous quarter, from 1.2% to 2.5%. However by quarter four 2016/17 the proportion had fallen to 1.3%. The trust proportion was consistently higher (worse) than the England proportion.

**Cancelled Operations as a percentage of elective admissions - North Bristol NHS Trust**

(Source: NHS England)

September cancellation rates were 1.46% in comparison to the national target of 0.8%. The trust identified this as being due to theatre timing issues and equipment failures. The theatre board were looking at cancellations and told us they were overseeing a delivery plan to address productivity and scheduling. Meeting minutes of the theatre board reported that they had sourced extra consultants to access un-utilised lists. Two new theatres were due to be completed by January 2018, this had been delayed and the board report stated a mitigation plan was about to be put in place.

The surgical sterilisation unit collected data on cancelled surgeries relating to issues with surgical instruments. The SSU had also created a dashboard, which highlighted the performance of the unit, including the cleaning production of the unit per month and the type of production e.g. tray sets, scopes and instrument packs. The dashboard could also highlight individual staff member performance.
Theatre utilisation data from March 2017 through to August 2017 showed that overall utilisation was insufficient. This situation was amber rated (a medium risk) apart from two weeks in the period, which were red rated (a high risk). Data showed that theatre sessions during this six-month period all started over 15 minutes of the booked start time and were all red rated. The trust told us that a theatre improvement plan had been running over the last 18 months, and this had shown an improvement in utilisation from 65 to 80%.

Caring for medical patients on surgical wards (outliers) sometimes created difficulties for staff and delays for surgical patient admissions. During the time of our inspection, there were eight medical patients admitted to the urology ward, which meant there were fewer beds for urology patients.

The facilities and premises were not always appropriate for patients accessing outlying beds. During times of escalation, an extra bed was slotted into a two bedded bed space. We reviewed the standard operating procedure (SOP) regarding the practice of escalating patients to four bedded bays. The SOP said that patients and their families/carers were to be informed of the decision to transfer a patient to a four-bedded bay and the reasons why. It also outlined the surgical wards which were not suitable for escalation of patients, which included 6b (neurosurgery), 25a (neurology/neurosurgery) and 33a (burns and plastics). The process for transferring patients and the measures taken to ensure they received safe care and treatment was detailed in the SOP. The process involved making sure the patient was in an area outlined in the SOP and the following was available or carried out:

- Oxygen.
- Portable suction.
- Escalated patient notes.
- Nursing staff informing clinical staff of additional patient.
- Storing escalated patients’ medicines in the ward stock cupboard.
- Bed side table made available for the patient.
- Clinical trolley used as temporary storage for patient’s belongings.
- Operations team informed of the escalated patient and include of flow screen.

During the time of our inspection, there was a lack of surgical beds and some patients were admitted as outlying inpatients to the interventional radiology unit. This unit was purpose-built 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 identify the number of patients admitted to the unit and assess if a patient was safe to be accommodated on this unit. As discussed in the medical report, the environment in the interventional radiology department was not designed for overnight patients. There were female and male toilet facilities but only one shower room, which also had a toilet. Inspectors observed this being used by a staff member. The shower room was along a corridor, which meant if staff accompanied a patient, they would be temporarily away from the unit. There were emergency call bells in the shower room, however due to its location away from the ward, response times from staff may have been delayed.

At the time of our inspection, two surgical patients had been admitted to this unit.

The trust recognised in times of escalation that ideally patients needed to stay within the surgical division rather than be housed within a different speciality. The trust managed day surgery patients in medirooms and had a dedicated area for those patients who required an overnight stay or were able to be discharged later that day. The mediroom model allowed day case or overnight patients to remain in the surgical division and be cared for by surgical nurses. However, in times of bed pressures and to maintain patient flow through the wards some short stay inpatients were cared
for in these medirooms. This was not ideal because there were limited bathroom facilities and no shower rooms.

We visited the discharge lounge, which provided care for those patients who were clinically fit for discharge but were waiting for transport to go home. The unit opened from 7.30 to 19.30 Monday to Friday and provided care for up to 15 patients. Staff worked with pharmacy and ward staff to make sure that patients were safely transported to the unit, had the correct medicines and were discharged safely home. Staff told us that this was a good service and that it provided its own porters to collect patients from the wards, which eased the nurses’ workload. If a patient’s transport failed to arrive staff told us they would escalate this to the clinical bed team and the patient would be transferred to a ward.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously and investigated them thoroughly; there was evidence of shared learning across the division. The NHS constitution gives the people the right to have complaints dealt with efficiently and be investigated, know the outcome of the investigation, take their complaint to an independent Parliamentary and Health Service Ombudsman and receive compensation if they have been harmed. Information about how to complain was accessible across the division in easy to read leaflets.

**Summary of complaints**

The trust told us they carried out 37,000 operations per annum, which led to a significant number of patient interactions. The trust took an average of 39.4 working days to investigate and close complaints. The trust policy stated that complaints should be closed within 35 working days or, if the complaint was complex “45 plus working days”. By the 14 August 2017, 159 of these complaints had been closed in line with trust policy.

The outcomes were:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld - Resolved</td>
<td>124</td>
</tr>
<tr>
<td>Partially Upheld</td>
<td>13</td>
</tr>
<tr>
<td>Not Upheld</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>14</td>
</tr>
<tr>
<td>Blank</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>159</strong></td>
</tr>
</tbody>
</table>

Apart from “all aspects of clinical treatment”, the most common subjects were “communication/information” (49), “delay/cancellation inpatient” (18), and staff attitude (17). The complete breakdown by subject was:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Page 130
All Aspects Of Clinical Treatment | 76
---|---
Communication/Information | 49
Delay/Cancellation Inpatient | 18
Attitude Of Staff | 17
Admission/discharge/transfer | 15
Delay/Cancellation Outpatient | 3
Patients’ Property/Expenses | 2
Other | 2
Complaints Handling | 2
Patients’ Privacy/Dignity | 2
Transport (Ambulance & Others) | 1
Nursing/ward staffing shortage | 1
**Total** | **188**

There were five themes mentioned across numerous complaints:

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and treatment</td>
<td>76</td>
</tr>
<tr>
<td>Communication</td>
<td>32</td>
</tr>
<tr>
<td>Discharge issues</td>
<td>15</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>14</td>
</tr>
<tr>
<td>Waiting times/process</td>
<td>10</td>
</tr>
</tbody>
</table>

Of the 15 complaints relating to discharge, three clearly alleged a premature discharge. These related to the medirooms and the trauma and orthopaedic surgical assessment unit. Other complaints may have alleged to premature discharge, but this was unclear because the information provided by the division was too short a description (for example “discharge concerns”).

The breakdown by ward or unit for all reporting units in Surgery with three or more complaints is shown below, together with the approximate percentage of closed complaints about that area that were upheld or partially upheld in each case.
<table>
<thead>
<tr>
<th>Ward and specialty</th>
<th>Total</th>
<th>% upheld*</th>
</tr>
</thead>
<tbody>
<tr>
<td>G26b (Trauma &amp; Orthopaedics, Surgical Assessment Unit, General Surgery)</td>
<td>29</td>
<td>90%</td>
</tr>
<tr>
<td>G6b (Neurosurgery)</td>
<td>19</td>
<td>87%</td>
</tr>
<tr>
<td>General Surgery SMD</td>
<td>17</td>
<td>75%</td>
</tr>
<tr>
<td>Gynaecology SMD</td>
<td>16</td>
<td>83%</td>
</tr>
<tr>
<td>G26a (Elective Orthopaedics)</td>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td>G34b (Urology)</td>
<td>11</td>
<td>75%</td>
</tr>
<tr>
<td>G33b (Vascular Surgery)</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>G33a (Burns, Plastics)</td>
<td>10</td>
<td>88%</td>
</tr>
<tr>
<td>G25b (Trauma &amp; Orthopaedics)</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>G25a (Neurology, Neurosurgery)</td>
<td>7</td>
<td>83%</td>
</tr>
<tr>
<td>G34a (General Surgery, General Medical)</td>
<td>7</td>
<td>83%</td>
</tr>
<tr>
<td>G32b (Surgical Assessment Unit - Gastroenterology, Infectious Diseases, Haematology)</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>G21 Orthopaedic Theatres</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>5</td>
<td>75%</td>
</tr>
<tr>
<td>G7b (Elective Orthopaedics, Neuro Monitoring)</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Urology Department SMD</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Orthopaedics SMD</td>
<td>3</td>
<td>67%</td>
</tr>
<tr>
<td>G21 Medirooms</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>G32b SAU</td>
<td>3</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Overall (including wards with fewer than three complaints)</strong></td>
<td><strong>188</strong></td>
<td><strong>87%</strong></td>
</tr>
</tbody>
</table>

*Percentage of closed complaints that were upheld or partially upheld.
In all 60 complaints concerned orthopaedics. This was nearly a third of all complaints about Surgery over 12 months. These were broken down into:

- 37 concerning two trauma and orthopaedic wards, Gate 26b and Gate 25b.
- 15 complaints about two elective orthopaedic wards, Gate26a and Gate7b
- Five complaints about orthopaedic theatres.

Seven of the complaints about orthopaedics concerned staff attitude (across Surgery there were 17 such complaints), four concerned delays in receiving treatment, and one a delay in receiving a radiology report. Another four concerned waiting times, while three concerned cancelled operations. The latter group of complaints included one described as “Cancelled op x 3”. It should be noted that between August 2016 and July 2017, only 36.1% of elective trauma and orthopaedic patients were admitted to the trust within 18 weeks of referral (see previous section). Both elective and non-elective trauma and orthopaedic patients also had longer lengths of stay compared to the respective England averages (see previous section).

July 2017 saw the largest number of complaints about orthopaedics of any month over the whole 12-month period. There were 11 such complaints in that month: more than one in six of the 60 complaints about orthopaedics over the whole 12 months. A higher percentage of the complaints about orthopaedics, 92%, were upheld compared to the 87% of upheld complaints about Surgery overall.

The cluster meeting for each area and the senior nurses meeting minutes included an update on the progress of divisional complaints. The meetings identified how many complaints were outstanding, what was being done to address them and how they should be cascaded through to the division. A monthly newsletter was sent out to the whole division with actions and learning from complaints.

Senior staff told us they were addressing the issues highlighted in complaint themes and trends. For example, the neuro, musculoskeletal (NMSK) division were looking at ways in which delays in patient surgery or appointments could be reduced. They planned to review consultant patient lists to look at why some consultants were taking longer than others to see patients. Data matrices were going to be produced to look at the length of patient wait per consultant so this could be reviewed periodically. The service was also looking at whether patients could be transferred to alternative consultant lists to reduce the wait for surgery. This would be done with the consent of the patient. The service was also increasing the involvement of consultants in the scheduling process to understand why waiting times were not reducing. Consultants were also involved in discussions regarding the possibility of additional operating lists so patients could be seen more promptly.

**Is the service well-led?**

**Leadership**

Leaders had the skills, knowledge, experience and integrity they needed to fulfil their roles. Local nursing leaders at ward level were experienced and were knowledgeable about the needs of the patients they treated. Most had worked for the trust and on their respective wards for a number of years.

Leaders were visible and approachable. Staff were complimentary about their ward coordinators and ward managers. They said they were supportive and would try to address any problems highlighted by staff and/or escalate them to matrons when appropriate. All staff said the ward
matrons were always available to speak to and were seen on the wards regularly. They felt able to escalate concerns to the matrons and were confident the concerns would be addressed.

The theatres had a clear development programme for staff that were new in their roles and recognised how investing in their staff’s education encouraged recruitment and retention.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action. The trust had a vision of realising the great potential of their organisation by empowering their staff to deliver high quality, financially sustainable services in modern facilities. They wanted their clinical outcomes to be excellent and where a spirit of openness and candour ensured an outstanding experience for their patients.

The values of the trust were to work well together, putting patients first, recognising the person and striving for excellence. Staff were unable to tell us exactly what the values of the trust were but did tell us they were about putting patients first and trying to be the best.

The vision for the ASCR division was to be the number one choice for specialist services within England, which was to be achieved by supporting education and innovation.

**Culture**

Nursing managers promoted a positive culture that supported and valued staff, which created a sense of common purpose based on shared values. The theatre department used a tool for boosting morale and identified that continuous learning and staff engagement was key. The skills matrix, which was used in theatres, identified specific skill sets for roles and specialities and set out learning pathways. This was so successful that other trusts were planning to take this approach forward.

The culture was centred on the needs and experience of people who used the services. Staff of all levels showed patient care and treatment was a priority and told us they wanted to provide the best possible service. Staff felt positive and proud to work for the trust the majority of which said the best thing about it was the facilities.

The ASCR weekly newsletter reported the division were lowest in the performance table of responses to the staff satisfaction survey. The newsletter informed staff that if the division could increase the response rates then an iPad would be rewarded to a random member of staff.

However, medical staff told us that there was not always an emphasis on the safety and well-being of their staff. They told us that they were not encouraged to report on exceptions, for example some medical staff told us that they frequently worked over their hours and they were discouraged to log this an in incident/exception report. This was echoed at senior level as we were told that there were minimal exception reports. We asked staff if they would report this to their ‘Guardian for safe Working’ and staff told us that they were unaware of who this was.

**Governance**

There were structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. However, there were identifiable gaps, which were acknowledged by senior staff. Within the surgical core service, there were two divisions, one for anaesthesia, surgery, critical care and renal (ASCR) and neuroscience and musculoskeletal (NMSK). Each division had a separate governance system but each followed the same structure. For each division there was a senior management team consisting of a general manager, a clinical director and a head of nursing. Underneath each senior management team were surgical
specialities/clusters within the division. Overseeing each surgical speciality/cluster was a service manager/assistant general manager (AGM), lead nurse/matron and a speciality 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.
- Elective care and emergency care.

Under the NMSK division the surgical services/clusters were:

- Neurology.
- Neurosurgery.
- Orthopaedics and trauma.

As part of the governance process within ASCR, divisional meetings were held monthly. At the meetings, all the cluster leads attended. The meetings followed a set agenda, which included discussions on quality and safety performance across the division. The attendees also discussed risk, staffing, complaints and strategy. The clinical director, head of nursing and general manager attended the meetings.

In addition, cluster clinical governance meetings took place every six weeks within ASCR and NMSK. Meetings followed a similar agenda to that of the division governance meetings where overall performance, workforce, finances, governance, safety, complaints and strategy were discussed. The meetings were used as a forum to escalate information, issues and concerns from ward level and to disseminate information from divisional meetings. We were told the cluster meetings within the NMSK division were recent and they had only had three at the time of our inspection. The meetings were minuted and circulated by email. If there were associated learning from incidents, clinical audits or performance data, it was disseminated to staff at these meetings.

Senior staff had identified a gap in cascading information from the emergency care division to staff who worked within the surgical admissions unit. It had been identified that there had been no formal arrangements for governance meetings between lead nurses/matrions and ward managers across these two areas. We were told information was discussed on an ad hoc basis. For example, incidents reported using the trust’s electronic incident reporting system was looked at on a daily basis by the senior nurse/AGM but not discussed on a monthly basis unless there were significant concerns or themes. Plans to put governance processes in place, similar to those outlined above were underway during our inspection.

Every month there was a senior nurse meeting with all ward managers and department leads in attendance. The meetings had an agenda but the content would not always be the same. For example, the attendees would discuss issues or concerns which were relevant at the time. We were told at the most recent meeting, the attendees discussed a recent coroner’s report and the associated learning and this was corroborated within the minutes.

There was a weekly ward sister meeting across the emergency care cluster. Ward sisters from each ward within the cluster would meet to discuss performance across and any issues with safety.

On gate 34b, the band six registered nurses attended monthly meetings. During the meetings, attendees discussed ward issues, improvements, staffing and performance. The meetings were
documented and emailed to staff. The ward also held monthly ward meetings to disseminate information discussed at governance meetings but there was variable attendance due to lack of staff capacity.

On gate 33b ward, meetings were arranged bimonthly or quarterly but could not always take place, as staff were not always available. The staff relied on the morning and evening safety brief to obtain the information related to ward. This did not ensure all staff had access to all relevant information related to the performance of the ward.

Staff at all levels were clear about their roles and understood what they were accountable for. Staff were able to tell us what their role was and what they were responsible for. Ward coordinators had defined roles and could tell us what their daily, weekly and monthly responsibilities were.

**Management of risk, issues and performance**

There were processes for managing current and future performance. The ASCR division had a monthly process called ‘back to the floor’ where senior nursing staff, including the head of nursing, lead nurses and matrons, would work on a ward for a morning. This was to review staff performance relating to a particular issue, for example, the care of patients with diabetes. This was linked to the division’s safety thermometer day. Senior nurses would work with ward staff to monitor how they performed and discussed specific aspects of patient treatment with them. A lunchtime meeting was then held to provide feedback to staff regarding any issues identified or good performance and an update on their recent safety thermometer data. This process was seen as a good way to monitor performance and address developing risks within the division. Staff were also able to provide feedback to senior nurses during the lunchtime meetings. The process gave senior nurses the opportunity to review practice and address issues directly and to gather feedback from ward staff on why issues may have been occurring.

The trust had an effective oversight on performance of antimicrobial prescribing and antibiotic stewardship which was a Commissioning for Quality and Innovation (CQUIN) national goal for the division for 2016/17 and 2017/2018. The medicines governance group meeting minutes discussed how a point prevalence study had demonstrated that the trust had not met the standards for antibiotic prescribing as described in “Start Smart then Focus”. Initiatives were put in place to work more closely with divisions to improve prescribing practice and a review of antibiotics at 72 hours. The newly designed prescription chart focused the prescriber, pharmacist and nurse on a 72 antibiotic review. Antimicrobial stewardship was included in foundation year one and two, core medical training alongside a teaching and e-learning package. With increased audit work, the medical governance committee had reported overall antibiotic usage had started to decrease.

A small reduction in long-term sickness and a small increase in short term sickness meant that the level of sickness in May remained unchanged. Anxiety/Stress/Depression remained as the number one reason for long-term sickness. The largest increase in short term sickness was Anxiety/Stress/Depression and Cough, Cold & Influenza which resulted in 40% more full time equivalent days lost in May 17 than the same time last year. A core focus of the staff health and wellbeing plan was around mental health wellbeing and resilience. Stress had been highlighted in the staff survey and sick leave as a consequence of stress had been added onto the divisional risk registers. Stress audit tools were conducted for ‘hot spots’, listening events and monthly workforce reviews were part of the actions identified.

The trust had a divisional risk register for ASCR and local departmental risk registers. We reviewed the ASCR divisional risk register, which contained all risks across the division. For each entry, the level of current risk was clearly identified, with controls and gaps in controls documented. Action plans were identified which contained the target score. There was an
alignment with serious incidents and risk at divisional level. Incidents with urological patients and plans to address these were identified, the ASCR risk register highlighted root cause analysis and action plans to investigate those patients who had been lost to follow up.

There was an alignment between what people told us was on their ‘worry list’ and recorded on the departmental risk registers for example theatres told us that they had concerns that not all doors had vision panels. This had been highlighted during our previous inspection and had been added to the theatre risk register. The register showed how the risk was active, but no score was visible on the paperwork that we had been provided with.

**Information management**

The division collected, analysed, managed and used electronic information to support activities; the divisions had secure electronic systems with security safeguards in place but did not always use them correctly.

All trust staff had their own email account and received regular updates on training courses they could attend and when their mandatory training that had expired. Senior staff also received updates for their team members expired mandatory training. Staff could access the trust’s intranet system and told us there were enough computers for their needs. Staff showed us how they accessed policies and documents on the intranet and searched for guidance on medication issues.

Staff used an electronic system to update risk assessments on admission and throughout a patient’s stay. An electronic staffing safe care tool was used by the trust to analyse staffing ratios against the acuity of patients. This information was collected twice daily at the point of care, to monitor, manage and report on safety.

Staff from the pre-admission clinic through to staff admitting patients on to wards as an emergency told us how to request/book interpreters. However, some members of staff told us that they would use family members to help in translation services. Staff told us that they recognised when this was not appropriate for example, when important information needed to be given to patients.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The service worked with local commissioners and divisional leads met with other stakeholders on ‘Away Days’. Discussions around staffing had been one of the topics discussed on a previous session.

Staff were actively engaged so their views were reflected in the planning and delivery of the services. Work had been undertaken to improve retention of staff such as the introduction of the HappyApp, which allowed the staff to express their thoughts and feelings in real time. Staff told us that this worked well and they liked how responsive senior staff had been in addressing issues. Managers told us how the App allowed them to identify trends and ongoing concerns such as skill mix concerns. Managers also told us that recent issues were less about patient safety as issues had been addressed and they saw this as a positive result.

The majority of staff felt supported, respected and valued. Staff told us their colleagues and supervisors supported them. They believed the work they did was appreciated and valued by the trust. Since our last inspection, theatres had increased locker numbers and we saw staff were provided with hydration stations across the department.
As described above, in the management of risk, issues and performance section of the report, staff were able to feedback directly to senior nurses during lunchtime feedback sessions during ‘back to the floor’ days.

The board reports stated that work had been undertaken to fund initiatives to support staff staying in work and shortening their absence period. This included extending and increasing the resource for a staff physiotherapist service to help staff with muscular-skeletal problems, to continue the wellbeing courses offered by the psychology team and provide training for managers to support them around the mental health and wellbeing of their staff.

**Learning, continuous improvement and innovation**

The trust committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. Leaders and staff in theatres worked towards continuous learning, improvement and innovation. Ward staff worked hard to ensure that for all patients the first discharge consideration was to return home. Training and support was given to teams to enable them to evaluate whether a patient would be safe to go home with no care, on a restarted existing care package, return to a care home or home on a Discharge to Assess Pathway. The multi-disciplinary teams worked closely with patients and carers to ensure the early assessment of needs and ensure discharge plans were developed as soon as possible. A single point referral form had been developed over the year that could be accessed via the electronic patient record system. This would electronically refer patients for discharge to health and social care community teams, care homes and other providers. This partnership model had been in place for over a year and had progressed further with improved systems and processes implemented to develop more efficient and effective discharge

The surgical assessment unit was nominated for an exceptional healthcare award within the trust.
End of life care

Facts and data about this service

We inspected Southmead Hospital on an unannounced visit as part of the new phase of our inspection methodology. During the inspection of end of life care, we did not visit any community locations.

The trust provides end of life care at Southmead Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and to families and relatives following a patient’s death. It may be given on any ward or within any service in the trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support, and mortuary services. Between July 2016 and June 2017, the trust had 1,731 deaths, 40% of whom were seen by the specialist palliative care team. Between April 2016 and March 2017, 1,643 referrals were made to the Specialist Palliative Care Team. Of these referrals, 51% were for patients with malignant disease.

The Specialist Palliative Care Team comprised of 2.65 whole time equivalent (WTE) consultants, one specialty registrar on rotation and six WTE clinical nurse specialists. They provided an advisory role and had a model of shared care with all clinical teams within the hospital. They worked closely with colleagues in acute oncology and liaised with many other site-specific groups via multidisciplinary teams and oncology outpatient clinics.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

During the inspection visit, the inspection team:

- Talked with eight patients and those close to them.
- Observed staff giving care.
- Reviewed 34 sets of patient records, including care records, treatments 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 58 members of staff at different grades including doctors, nurses, healthcare assistants, non-clinical staff, ward managers and mortuary staff.
- Met with consultants and board leads for end of life care within the trust.

End of life care was rated as requires improvement overall during our previous inspection in 2016, with caring and responsive rated good. The end of life service was issued with three recommendations for service improvement, and we looked at the changes the service had made to address these during this inspection. During this inspection, we inspected all five domains to determine whether end of life care was safe, effective, caring, responsive and well-led.

Is the service safe?

Mandatory training

Staff were not always compliant with training and regular updates in the systems and processes, which helped keep people safe. The hospital provided a programme of mandatory training and updates for staff. This included resuscitation, falls, health and safety and information governance. The trust’s mandatory training target was 85%. The palliative care nursing team and the nursing staff within the palliative care service achieved slightly under the trust target compliance for
mandatory training at 78%. For medical staff, compliance was 100%. There were four modules out of a total of 10 where the trust had met the 85% target.

The lowest compliance rate was for venous thromboembolism (VTE) training at 38%.

<table>
<thead>
<tr>
<th>Mandatory training completion rate (registered nursing staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Completion (%)</strong></td>
</tr>
<tr>
<td>Equality and Diversity - 3 Year expiry</td>
</tr>
<tr>
<td>Information Governance - 1 year expiry</td>
</tr>
<tr>
<td>Waste Management (Clinical) - 3 year expiry</td>
</tr>
<tr>
<td>Resuscitation - 2 year expiry</td>
</tr>
<tr>
<td>Conflict Resolution - 3 year expiry</td>
</tr>
<tr>
<td>Falls - 5 year expiry</td>
</tr>
<tr>
<td>Health and Safety - 3 year expiry</td>
</tr>
<tr>
<td>Infection Prevention and Control - 2 year expiry</td>
</tr>
<tr>
<td>Dementia Level 2 - 3 year expiry</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE) - 3 year expiry</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Within the specialist palliative care team, staff told us they were given the time needed to attend training required for their role. There was both face to face and electronic learning available in relation to mandatory training. Managers were able to access training records for their staff to ensure they had oversight of completion levels.

End of life training was offered to all staff upon induction, and as part of their mandatory annual update training. However, some staff felt this was very brief and did not fully equip them to provide end of life care. They told us the skills they developed to provide end of life care were often learnt in informal training provided on wards.

**Safeguarding**

There were systems, processes and practices to keep both adults and children safe from abuse. Staff had good knowledge of the trust’s safeguarding policy and the contact information for the safeguarding leads within the trust and local safeguarding service.

Safeguarding had three levels of training. Level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. Training records for the specialist palliative care team showed nursing and midwifery staff had not met the 90% target set by the clinical commissioning group for two safeguarding modules that were relevant for them. For medical staff this figure was 100%.

A breakdown of compliance for safeguarding courses rolling data as of August 2017 for nursing/midwifery staff in the specialist palliative care team is shown below:
There were policies, systems and processes for reporting and recording abuse. Staff we spoke with were able to demonstrate a good understanding of their responsibilities and the process involved in raising a safeguarding concern. Staff were also aware how their responsibilities extended to the relatives of patients. Whilst on inspection, we saw a documented example of a safeguarding referral being made in relation to care prior to admission. Staff ensured the local authority safeguarding teams were informed and appropriate action was taken.

Staff also demonstrated knowledge of different types of abuse such as physical, emotional, sexual and neglect.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.

Standards of cleanliness and hygiene were well maintained in the work carried out by the mortuary. There were clear guidelines and processes for mortuary staff to follow, and a ready supply of personal protective equipment such as gloves and aprons, which we saw in use. There were clear protocols for the staff to follow for cleaning the premises and equipment.

There were reliable systems in place to prevent and protect people from infection. We saw the mortuary used a form to record where deceased patients had infectious diseases. This enabled them to inform funeral directors or others who may come into contact with the body, and for recommendations to be recorded about the handling of such patients.

Other areas we visited, such as the sanctuary and the wards, were visibly clean and well maintained. We observed staff following infection control guidance, and observing the trust policy of being bare below the elbow to ensure handwashing techniques were thorough to reduce the spread of infection.

**Environment and equipment**

All wards we visited during our inspection had controlled access in place to ensure the safety of patients. The design of ward areas encompassed a large number of side rooms, which were used...
for care of the dying. Staff told us patients with palliative care needs were placed in a side room unless there was a risk of falls or there was a preference expressed by the patient.

The maintenance and use of equipment kept people safe. Equipment required on the ward for the appropriate treatment of patients was available to ensure patients’ needs were met. Staff told us there was an adequate supply of pressure relieving equipment and this was all provided promptly when requested. Staff told us there was a sufficient supply of syringe drivers and could describe the process for accessing further equipment for times of high demand. During our inspection, we found syringe drivers were available on all wards we visited, alongside a copy for the protocol for safe use.

We visited the mortuary and found it to be visibly clean and tidy. Viewing rooms and waiting rooms were tastefully decorated providing a comfortable environment for visitors. The main refrigerators were connected to a trust-wide system that monitored their temperature and alerted staff if temperatures fell outside a pre-determined range. There had been no breaches of this in the year prior to our visit. Staff tested this system by warming up vacant refrigerators systematically and making sure the alarms sounded.

However, the design of facilities did not always keep people safe. Refrigerators used when the main mortuary was full, and those used for perinatal deaths, were not connected to the monitoring system. These were checked daily. Records showed these had not fallen outside of range. The mortuary was unmanned between 4.30pm and 7.30am. If refrigerators were to fail during this time, there was no system to raise an alert this had happened.

Assessing and responding to patient risk

Patients at the end of their life were identified and comprehensive risk assessments were carried out for people who were using services. We found staff were able to recognise patients requiring end of life care. We observed multidisciplinary meetings which identified end of life care needs and referred to the specialist palliative team. We found the rationale and decisions regarding care were clearly documented in the patient record. On wards we visited, we saw resources to support the transition to end of life care. Staff had easy access to specific care of the dying documentation including guidance for assessment and care of symptoms.

Patients who received end of life care in the hospital were assessed regularly by ward staff and the specialist palliative care team. A symptom observation chart was used to assess care needs, which included pain, nausea and vomiting, agitation, respiratory secretions, and mouth condition. A separate skin assessment was undertaken. The patients’ symptoms were colour-coded, which prompted staff to take either immediate, prompt or no further actions. We saw risks to nutrition and hydration were regularly assessed, and where identified had mitigating actions put in place. For patients at risk of developing pressure sores, specialist equipment was put in place. In all of the records we looked at, the risk of venous thromboembolism was assessed. We spoke with staff involved in decisions regarding feeding at the end of life who described a risk-based approach to the assessment of swallowing, which also took into account the wishes of the patient.

Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, and medical emergencies. This helped ensure patients were kept safe.

We saw discussions about the point at which interventions were increased or decreased were also completed, in relation to the clinical needs and wishes of patients. We saw an example where a patient being treated at end of life deteriorated during the course of the day. The palliative care doctor ensured there was a clear plan of care to be followed out of hours when there was no palliative care presence at the hospital. This detailed the type of pain relief to be offered, as well
as other actions to relieve potential symptoms, which were expected as time developed. As a result of this, ward staff said they felt confident they would be able to meet this patient’s needs during the overnight period.

Staff were able to seek support from senior staff. Ward staff we spoke with said senior staff, including the members of the palliative care team, responded promptly to requests for input and advice. Information was available on the wards about the arrangements for advice around palliative care during evenings and weekends.

**Nurse staffing**

The palliative care service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and, abuse, and to provide the right care and treatment. At ward level, each ward had a link nurse for end of life care who received additional training and support from the Specialist Palliative Care Team. This meant at a local level, nursing staff were available with the knowledge and skills required to support colleagues to deliver end of life care.

The trust reported their staffing numbers below for the period April 2017 and July 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Life Care Pathway</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Palliative Care Specialist Nurses</td>
<td>10.1</td>
<td>9.9</td>
</tr>
<tr>
<td>Palliative Care Specialist Nurses</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12.1</strong></td>
<td><strong>11.5</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Nurse staffing within the specialist palliative care team was stable with no turnover in the year from August 2016 to July 2017. There were also no nursing vacancies within this service in the same time period, although one palliative care nurse was on maternity leave at the time of our inspection.

Sickness levels within the specialist palliative care team were at 3.8% between August 2016 and July 2017. This was close to the trust average of 3.3%.

The palliative care service did not report any use of bank or agency staff at the trust.

There was an induction programme for new or temporary staff. All staff were expected to complete this programme and new staff were inducted into the areas they worked to ensure they had a good knowledge of the important aspects of working there.

**Medical staffing**

The palliative care team did not have any vacancies for medical staff. Work was allocated to the doctors within the team during the morning of each day, being split between a triage and an ongoing delivery level.
Junior doctors we spoke with on wards said they felt well supported by the palliative care consultants, and they were approachable and happy to be contacted.

**Records**

People’s individual care records were written and managed in a way which kept people safe. We looked at a variety of patient records, including care plans, medical notes and specific end of life care documentation. Records were clearly written and demonstrated regular patient reviews. They were signed clearly with the name of the person completing them and were clearly legible. At the time of our inspection, the trust used both electronic and paper records to document patient care. Daily records of patient care were completed in paper records. In addition, a large amount of patient information, including the results of investigations, was available electronically to staff.

Processes were in place to enable communication about the patient’s condition with community-based healthcare colleagues either prior to or at the time of the patient’s discharge. This also included letters to be sent to GPs where the patient was not expected to leave hospital.

For patients approaching the end of their life who were discharged home or to a care home, a community prescription chart was completed. The chart was completed by medical staff or non-medical prescribers. This meant professionals providing care to end of life patients in the community were able to access these medicines in a timely manner.

For patients identified as being at end of life, the hospital had specific documentation known as “Caring for Patients at the End of Life”. This document aimed to hold all current information about a patient’s care in one place. Its content was based upon best practice principles for end of life care, and prompted those using it to consider these principles when delivering care. We looked at 16 of these documents and saw these records were initiated in a timely way once a patient had been identified as end of life. The most recent audit of records for patients treated at end of life, completed in November 2016, showed, on average, patients recognised at being end of life had the appropriate documentation started on the same day. This audit sampled 122 sets of notes of patients who had died between December 2015 and November 2016. Within this number, there were 54 sets of notes where the patients had specific end of life care documentation in place. The document contained a notification to inform the patient’s GP that a care of the dying plan was in place. However, we found this was not consistently completed. The audit showed this occurred in only 54% of cases.

The same audit identified 68% of medical reviews were completed, but only 47% of nursing reviews were completed. In the care plans we looked at we saw medical reviews were consistently completed, as were nursing reviews. However, within the end of life documentation we looked at, personal care was rarely documented in any great detail.

In the records we reviewed, patients’ spiritual needs were recorded consistently. We saw records were used well to enable all professionals involved with a patient to have a complete picture of their care. This was an improvement to that identified in the records audit from November 2016, which showed only 28% of patients’ spiritual and cultural preferences were assessed and recorded in their end of life care documentation.

The specialist palliative care team used an electronic system, which contained referral information, prioritisation, and further assessments which included physical and psycho/social aspects of care. The electronic record was also used for handover between the specialist palliative care team and discharge planning, and supplied information for assurance monitoring.

Electronic records were held securely through password protection. The main body of the paper patient record was held in lockable cabinets in a non-patient area with additional observation.
records held on the entry to the patient’s room. However, information was also held on an electronic board on the entrance to the ward. This displayed patient information, such as their full name, and speciality of their care, which was not protected from view. We observed staff and relatives using the board to locate patients, meaning the service could not be assured private information about patients was being held securely.

**Medicines**

The service prescribed, gave, recorded and stored medicines well. Patients received the right medicine and the right dose at the right time. We looked at medicine records for patients at end of life. Anticipatory medicines were prescribed based on the symptoms of each patient, in a timely manner. This meant any delay in receiving these medicines was kept to a minimum. In the records we reviewed, we found medicines were prescribed to meet the needs of this patient group. When symptoms were reviewed, the effect of current medicines was considered. The documentation in patients’ records showed clear rationale for changes in medicines, which were reflected on the medicine chart.

Wards had supplies of the most commonly used medicines needed in end of life care, which were stored in locked cupboards. The stock levels were checked by the pharmacy team to ensure a sufficient supply. Staff told us of arrangements in place to source further stock if required. If issues arose out of hours an online check of stock in other wards was undertaken before escalation to the clinical site manager, and an out of hours pharmacist was available if additional supply was required. Hospital pharmacists also provided support to staff on wards. We saw checks of prescription charts and their presence on the wards to provide advice and support when needed.

One of the specialist palliative care nurses was a non-medical prescriber, meaning they were able to prescribe medicines for patients when they needed them. Two other members of the team were completing modules, which would enable them to become non-medical prescribers in the near future. We saw positive relationships between the palliative care nurses and ward-based medical staff. This meant they were able to work together to ensure patients had the necessary medicines prescribed.

We witnessed numerous conversations between doctors and/or nurses and patients about medicines being prescribed. Staff took the time to discuss medicines, side effects and combinations with patients or their families/carers. This enabled patients or those close to them to make informed decisions about medicines.

**Incidents**

Between September 2016 and August 2017, the trust reported no incidents classified as never events within end of life care. 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: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in end of life care, which met the reporting criteria set by NHS England between September 2016 and August 2017.

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

We were not assured systems and processes used to identify or review end of life incidents were always robust. Staff we spoke with could not describe a type of incident that may be specific to
end of life care. For example, we heard of an incident whereby a patient’s syringe driver was not replaced when it was due, leaving the patient without pain relief. We were told this was not reported because it was remedied when it was noticed 20 minutes later, and the patient and family were apologised to.

Additionally, the system used to report incidents did not have a category for staff to easily choose end of life as the service it related to. The system relied on a free text box for this information to be added. Leaders told us they could not be confident they had a truly accurate picture of the number or type of end of life related incidents. The trust was moving to a different system in the month following our inspection, and it was hoped this would improve reporting processes for end of life care. We were told the new system would have a category for end of life specific incidents.

Due to the apparent lack of end of life specific reporting, it was not possible for learning to be taken from these incidents. It was also not possible for leaders to confidently identify themes of incidents relating to end of life care. An end of life strategy group discussed incidents that had been reported during quarterly meetings. However, when we looked at the minutes of these meetings, it was not clear in what capacity incidents were discussed. There were no examples of thematic reviews of incidents or learning taken from them.

Staff working in the mortuary were able to give clear examples of the type of incidents they would report. Additionally, they kept clear records of these and were able to access their own reports that gave them an indication of the times, types and seriousness of incidents reported. The manager of the mortuary discussed learning from incidents with the end of life strategy group.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and reviewed evidence of its effectiveness. Documentation used to provide end of life care was based upon national guidance for best practice, including the “Five Priorities of Care”. These priorities recognised the dying person, and those identified as important to them should be involved in decisions about treatment and care.

The palliative care team were actively involved in both local and national strategic initiatives. Promoting best practice and sharing the evidence base was seen as an essential part of their role. The team had a major role in the implementation of the end of life care strategy both in everyday clinical practice and through membership of local and regional working parties.

The team was a key part of the trust’s End of Life Strategy Group, which was helping to promote delivery of high quality end of life care to all dying patients in the trust.

Additionally, 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.” The Ambitions framework was developed through partnership with national organisations across the statutory and voluntary sectors. It set out a vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.

The team also worked as part of a Bristol, North Somerset and South Gloucestershire (BNSSG) network to undertake audits, develop guidelines and promote best practice in palliative and end of life care across the network.

**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 preferences.

We saw for patients at the very end of life, the provision of food and fluids and the monitoring of the function of their organs were modified to meet differing needs. For example, where decisions had been made to stop actively treating a patient, monitoring of kidney function was ceased.

Nutrition and hydration requirements were clearly recorded in patient notes. This meant nursing and medical staff could clearly find this information and use it to inform assessments of a patient’s condition. We saw evidence patients received care from dietitians regarding swallowing assessments. This enabled food and drink to be safely given in the last days of life. We were told speech and language therapists were also involved in assessing patients’ ability to swallow safely.

**Pain relief**

Patients’ pain was monitored, assessed and managed effectively. Pain relieving medicines were prescribed in an anticipatory manner, meaning patients had timely access to pain relief and were not left without medicine. Within prescriptions, we saw consideration for break through pain relief in addition to more routine medicine. We heard examples of staff adjusting pain relief to accommodate diagnostic procedures for palliative patients.

Assessments carried out by the palliative care team and ward based doctors demonstrated how pain was often discussed as a matter of priority, before assessing other symptoms.

Nursing staff on wards administered pain relief at timely intervals, and patients and those close to them told us their pain was managed well. Patients and those close to them demonstrated they understood the medicine being administered, and told us their side effects had been explained clearly. We observed staff adjusting the route of medicine to be the least invasive. Staff also accounted for the time taken for medicine to take effect to ensure continuous effect during personal care activities.

**Patient outcomes**

The trust participated in the end of life care audit: ‘Dying in Hospital’ (2016) and performed better than the England average for three of the five clinical indicators. The trust scored particularly well for indicator three ‘Is there documented evidence that the patient was given an opportunity to have concerns listened to?’ For this indicator the trust scored 98% compared to the 84% national average.

*(Source: Royal College of Physicians)*

Information from the trust showed between April 2016 and March 2017, of the patients seen and discharged by the palliative care team, 49% returned home, 37% were discharged back to the ward following interventions or advice, 5% to a hospice, 3% to a care home and 2% to other hospitals.

Whilst 60% of patients who died at the hospital were not referred to the specialist palliative care team, the trust audited outcomes in relation to end of life care across a sample of all patient deaths in hospital. This was achieved through the National Care of the Dying Audit of Hospitals, which looked at quality parameters for all deaths (sample of 52 cases) and an internal audit conducted in November 2016, which reviewed 122 sets of notes of all deaths in the trust. In addition, the trust took part in end of life CQUIN schemes in the two years preceding our inspection, which involved the scrutiny of outcomes for patients at end of life during this time.

**Competent staff**
Most people had their needs assessed and choices met by staff with the right skills and knowledge. The trust had initiated a strategic education programme. At the time of inspection, we were told 4,000 staff (approximately 50%) had received training. All new staff received an introduction to end of life care during corporate induction. This was supplemented by e-learning training, which was available to all staff, and face-to-face teaching, which varied dependent upon profession and specialist role. Medical staff gained knowledge and skills through their induction process, which was accompanied by consultant-led sessions. Ward based nurses attended study days following the completion of induction or preceptorship periods. For healthcare assistants, bespoke training was available and also part of the care certificate. When we spoke with staff who had received training, they felt well equipped to recognise and care for those at the end of life. However, not all staff we spoke with understood the relevant education to their role, or could confirm what level of training they had received.

The role of the Palliative Care Link Nurses was to support the educational needs of the ward-based staff. We spoke to link nurses who felt well trained in their role through study days and quarterly development meetings. Staff spoke highly of the palliative care link nurse. They found them to be a useful resource and felt supported to deliver care at the end of life. Within some ward areas, we found competencies regarding end of life care had been incorporated into local induction training. This was overseen by the palliative care nurse and the ward manager. The trust had recently introduced new infusion catheters for syringe drivers, and training was delivered in the ward area by designated staff. We saw evidence of training records for syringe drivers and were told medical devices formed part of the appraisals process.

We asked what training staff had received in advance care planning, but none of the staff we spoke with had received any training in this subject matter. Staff told us they felt unprepared for patient conversations about advance care planning. We followed this up with the clinical lead for end of life care who felt that advance care planning was more of a priority for community-based end of life care. The rationale behind this was that by the time patients were receiving end of life care in hospital, the opportunity for such conversations had often passed. The discharge manager had received specific fast track discharge training from Bristol and South Gloucester local authorities, which aimed to support them deliver an useful discharge service for patients at end of life.

Porters taking patients to the mortuary completed competency assessments in order to carry out this part of their role, and were not allowed to do so until they completed this assessment. This assessment covered all aspects of a porter’s role, including dignity in death, when transferring patients from the hospital to the mortuary, and equipped them to manage this task.

Mortuary staff completed competency assessments to enable them to carry out their role. We were told they felt it equipped them to complete all aspects of their role. Mortuary staff we spoke with were clearly competent in their role.

Volunteers recruited within the chaplaincy service had received comprehensive training to carry out their roles. This had involved six teaching sessions covering all areas of their work, including subjects such as inter-faith working, listening skills, dignity and respect and equality training. It was felt the training had equipped them well for the voluntary work they carried out.

**Specialist Palliative Care Team**

The specialist palliative care service made sure staff were competent for their roles. A major remit of the team was providing education to all grades of staff within the trust. The team also undertook formal national and local lectures. This included ward-based teaching and running a successful palliative care link nurse programme. It also accommodated regular educational attachments to
the team for nurses, doctors and allied health care professionals in the form of placements. Managers appraised work performance and held supervision meetings with staff to provide support and monitor the effectiveness of the service. All members of the specialist palliative care team received regular clinical supervision.

Staff had appropriate training to meet their learning needs. Two members of the palliative care team were completing masters’ modules to add to their qualifications. The aim of this was to eventually complete training to become non-medical prescribers. Staff told us they felt supported to continue learning in their roles within the palliative care team. However, we were told time pressures on the team meant time for learning was often limited, with study time compromised by operational pressures.

Between April 2016 and March 2017, 86% of nursing staff within the palliative care team at the trust had received an appraisal compared to a trust target of 100%. This was equivalent to six of the seven nurses within the palliative care team.

Medical staff within the palliative care team received appraisals from within directorates they were closely aligned to.

Those working within, but not employed by the palliative care team, did not always have access to specialist training. The specialist palliative care team included occupational therapists that were allocated from the trust’s therapies service. Training in end of life care had been accessed, including communication skills and internal study days. There was a link to a professional specialist interest group and associated conferences, but funding was not always available to enable them to attend.

**Multidisciplinary working**

Staff, teams and services within and across the trust worked well together to deliver effective care and treatment. Multidisciplinary working was truly embedded with all necessary staff, including those in different teams involved in assessing, planning and delivering care and treatment. There were daily multidisciplinary meetings where all patients referred to the palliative care team were discussed. This meeting was also attended by cancer nurse specialists who worked closely with the palliative care team to deliver end of life care.

The multidisciplinary meetings provided a platform for a holistic review of patients’ care, where actions were allocated to the appropriate professional. Being a daily occurrence meant these patients were reviewed regularly and plans amended when they were needed without delay.

The palliative care team provided daily advice and support to ward based staff and answered questions about patients in these areas. Staff told us this input helped them to feel competent and confident when delivering end of life care. Junior doctors said the advice and support given to them during the working hours of the palliative care team gave them the confidence to be able to provide good out of hours end of life care.

We observed a multidisciplinary review on the ward following a joint consultation. This collaborative working considered the appropriateness of interventional procedures, and the wishes of the patients and those close to them. There was clear thought given to advanced care planning, including preferred place of care. We also saw the same level of teamwork during multidisciplinary ward ‘huddles’. We were told the huddle took place during each shift to identify concerns and ensure tasks had been completed. We saw the team identified those at the end of life and ensured a referral to the palliative care team was in place. There was collective discussion regarding current care plans and the safe discharge of patients, with all members of the team providing input and their professional prospective.
We saw an appreciation for multidisciplinary working both within the ward-based team and other staff who supported patient care. For example, we saw how a hearing therapist was recognised for improving a patient’s ability to express their wishes. We saw the palliative care team involved other professionals within the trust to improve care of patients. Psychology input was available for patients with motor neurone disease, and we saw this was also called upon to support relatives of patients with the condition.

The hospital based palliative care team liaised with local hospices and community services routinely to provide joined up care for patients at end of life.

Within the specific end of life documentation, there were clear sections to be completed for patients whose care was to be continued by community services. GP letters were completed and forwarded in a timely manner.

**Seven-day services**

Specialist palliative care provision within the trust was not available in accordance with the recommendations of the Royal College of Physicians. The palliative care service within the hospital was provided between the hours of 9am and 5pm, Monday to Friday. Outside of these times, staff had access to an on call service provided by a local hospice. Contact details were placed within patient records to encourage prompt communication. Staff spoke highly of the service provided by the hospice. They told us the hospice was accessible and advice was appropriate. However, this contract was due to finish six weeks after our inspection. The trust was looking at how it could provide an on call service after this time. At the time of our inspection, the need for an extra consultant to provide this service had been agreed, but the decisions about how this would be funded had not been made. Following our inspection, we received confirmation that this funding had been agreed, and the provision of an on call service provided by the trust’s team would begin when the previous contract ended.

We were told there were plans to look at providing a seven-day palliative care service in the future, but the priority was to ensure the on call provision was secured before other options were explored. Staff told us the night call practitioner was available to support patient care out of hours, including additional pain relief or a review of care. This was part of an escalation process to reduce delays in care when outside of working hours. Doctors were also available and staff felt confident to call on them when needed.

There was evidence that many patients admitted to hospital between Friday afternoon and Monday morning had unmet needs or died before they had any access to specialist palliative care team. Of the 48 patients referred to the team after 5pm on Friday (August 2016 to March 2017), 90% died before the team had an opportunity to assess them on Monday due to the lack of a seven day a week service provision.

The mortuary was staffed between 7.30am and 4pm, Monday to Friday. Outside of these hours, mortuary staff were available on an on-call basis. Porters were trained to be able to safely deliver deceased patients to the mortuary out of hours and this was monitored by the manager.

The chaplaincy service was structured so it could provide a seven day a week service to patients. Additionally, volunteers were divided into those providing regular visits and those available on holy days.

To support the timely discharge of patients over the weekend, the occupational therapy team described how they identified patients who would be safe to go home. This enabled the occupational therapist working at the weekend to support safe and timely discharge.

**Health promotion**
Patients who were identified as being at the end of their lives were identified and extra support was offered. We saw for one patient, who had recently been diagnosed with an untreatable cancer, sympathetic support was offered by the palliative care nurses. This involved detailed discussions about pain relief, how discharge could be arranged safely, caring for the patient’s next of kin as well as allowing time for the patient to discuss their concerns.

There was a clear focus on enabling patients to make choices about their care, and decide for themselves where possible, the direction of their treatment. This included where active treatment was to be withdrawn, as well as where limits to treatment were agreed.

Patients who smoked were offered nicotine replacement therapy whilst in hospital, and given advice about stopping upon discharge.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

We were not assured all staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

The trust had a policy around the assessment and recording of a patient’s capacity and a document to be completed when this was assessed. Assessment of capacity for patients receiving end of life was not audited and this meant that it was an area that had not been scrutinised. The trust could not therefore be assured the mental capacity to consent to treatment was being assessed or recorded for end of life patients in its care.

We were told by leaders they were aware there was room for improvement around the area of recording capacity and consent. This had been raised as a recommendation of our previous inspection, and featured in the trust’s action plan following that visit.

The trust reported that rolling data up to August 2017 identified mental capacity and Deprivation of Liberty Safeguards training had been completed by 87.5% of staff within the specialist palliative care team.

**Is the service caring?**

**Compassionate care**

Staff clearly understood and respected the personal, cultural, social and religious needs of people. They also demonstrated an understanding of how this related to care needs and took this into account when delivering services. There was a clear process for recording and sharing this information.

Patients and relatives told us they felt listened to and cared for during their stay in hospital. We saw as much care was taken of those close to patients as to patients themselves. Despite the situations, patients and those close to them were in, they were keen to talk to us to tell us how pleased they were with how they were cared for. We saw compliments from families describing “excellent care”, and “the staff were kind”. The people important to the dying person were listened to and their needs respected. Care was tailored to the individual and delivered with compassion, with an individual care plan in place.

Staff involved in caring for patients, from the most senior consultants, to nurses, healthcare assistants, porters, cleaners, and mortuary staff, took time to interact with people who used services and those close to them in a considerate and thoughtful way. We saw when patients were in pain this took priority over any other tasks, and was dealt with first. Patients who were unsettled
were cared for in an unhurried and caring manner until they were calm, regardless of the time this took.

Single occupancy rooms accounted for 75% of beds within the trust. This meant patients requiring privacy at end of life were able to be accommodated in these rooms, and were not required to share bays with other patients.

After death, the ward had a clear process in place to respectfully care for the deceased and their family. A checklist prompted the nursing staff to ensure all needs were met, information was given to the family, property was gathered, and documentation was completed. Staff told us they had introduced a white ribbon which was placed on the door to notify others of a deceased patient. Staff commented this prevented unwanted intrusion and gave the family uninterrupted time with their loved one.

Deceased patients in the mortuary were cared for respectfully by mortuary staff. Within the training given to porters, behaviour was emphasised as a crucial part of their competency assessment. The mortuary reported if deceased patients were not in good condition when they arrived in the mortuary as incidents. This could include whether they were suitably dressed, or were not prepared properly.

The mortuary had facilities to be able to offer the provision of ritual cleansing after death for patients of faiths where this was needed.

The bereavement service offered support to relatives in a caring way. Recent changes in the system for collecting death certificates had driven improvements in this service. As a result, delays in being able to collect death certificates had been kept to a minimum. The chaplaincy service was able to offer support to patients and those close to them. Chaplains from a variety of faiths were available. Chaplaincy services were also offered to patients and those close to them of no faith.

**Emotional support**

Staff clearly understood the impact a person’s care, treatment and condition had on their wellbeing and on those close to them, and responded to this. We saw an example where staff had supported a patient’s grandchildren to leave mementos of their visit. This took the form of a plaster imprint of their hands, which was made into a plaque to be displayed in the patient’s room on the ward.

Mortuary staff told us they regularly came into the mortuary outside of their hours to facilitate visits from bereaved relatives. This could involve visits every evening for a week for parents of a baby who had died in the hospital. This was not seen as over and above their role, but was an embedded practice.

The manager of the bereavement service had worked hard to smooth the process for collecting death certificates. A registrar was available at the hospital, and the bereavement team aimed to have death certificates available within three days of a patient death, minimising the length of time, or number of visits, required by bereaved relatives.

The chaplaincy service provided bespoke support to patients and those close to them in whatever faith was required or no faith at all. We saw a chaplain arrive to see a patient within 30 minutes of a call to the service from the ward. The palliative care team identified end of life patients to the chaplaincy team. We were told how the chaplain offered support to patients, families, and staff members.

The trust had processes to support the family and relatives for patients who were identified as being at the end of life. For example, they were able to reduce the cost of car parking. Relatives were issued with passes to enable them to have access to the staff restaurant so they could
purchase hot meals and drinks throughout day and night. Staff on wards often went over and above what was required, providing food and drink for families directly.

When patients died in the intensive care unit, there was a clear process staff followed to offer emotional support to those close to them. Memory boxes were made, and relatives were offered the opportunity to meet with staff who had cared for their loved ones in the days following death. Six weeks after death, the unit sent bereavement cards to families, and once a year a memorial service was held in the sanctuary area for relatives who had lost someone that year to attend.

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

Staff communicated with people so they understood their care and treatment, and any advice given. We saw nursing and medical staff spoke with patients and those close to them in an unhurried way and gave them time to ask questions and clarify understanding. This included where patients refused treatments recommended to them.

Staff were knowledgeable about services on offer to patients at end of life, both within the hospital and in the community. This enabled them to answer questions and make provisions for patients who wanted to go home, or be discharged to their preferred place of care. We observed conversations with patients and those close to them to find out what the patient imagined their needs to be.

Patients and those close to them were involved in making decisions about their care and treatment. One patient told us their wishes and preferences had been supported by staff. They also told us they felt supported in their decisions regarding their care needs now and in the future. We saw numerous patients with treatment escalation plans, and these had been discussed with them. We also noted documented discussions with family members. The staff had explained the management plan, signs of death and pain management. There was an open discussion regarding prognosis and the family members were offered support from the team.

Patients we spoke with and those close to them told us they felt involved in making decisions about their care. We heard options were given to them and they were treated in a non-judgemental way. We consistently found documented evidence that patients and those close to them were able to review their care plans. We consistently observed the multidisciplinary team considering the impact of changes to care on the patient and those close to them. We saw relatives being promptly contacted to communicate changes. We also observed staff organising consultations at a time when family members could attend.

Information was available for patients and those close to them to enable them to understand what options were available to them. Other resources were available to support staff to offer support and advice.

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people. There were no designated palliative care beds, but 75% of the beds in the hospital were in single rooms. This meant patients at end of life and those close to them could be cared for in private and with dignity. There was also a supply of temporary beds available for relatives who wished to stay with their family members overnight. We saw these were provided for a patient during our visit, and single rooms had enough space for these to be accommodated.
The trust served a population of multiple faiths, and the chaplaincy was able to accommodate these requirements. Chaplains of a number of faiths were available to patients requesting them. Additionally, the chaplaincy and bereavement manager had secured additional support from an Imam to provide support to a growing Muslim population in the area served by the trust.

The palliative care team provided a service between Monday and Friday each week, excluding bank holidays, and during this time were reported to be very responsive to requests for support from wards. We saw this team ensured they were available to patients when they were needed, even if this meant they worked over hours. Outside of hours, patients and staff were supported by phone support from a local hospice.

Between April 2016 and March 2017, the palliative care team received an increase of 21% more referrals. Referrals for patients with a diagnosis of dementia had increased significantly in recent years. An increase of 42% from 2014/2015 to 2016/2017 and 294% from 2012/2013 to 2016/2017. This increase was in line with other hospital specialist palliative care teams.

Where people’s needs and choices were not being met in relation to patients achieving their preferred place of care, there were no systems in place to enable the service to capture this information. We were told this was a piece of work was planned to be undertaken with the integrated discharge team by modifying the system used to capture information.

**Meeting people’s individual needs**

The staffing level of the palliative care team was not sufficient to provide seven-day access to specialist palliative care. Specialist palliative medical care did not always meet the needs of people receiving end of life care, when this fell outside of their operational hours. The level of palliative care medical cover met the needs of patients in the hospital between the hours of 9am and 5pm on weekdays. Outside of working hours, the local hospice provided a remote advisory service which staff were confident to access. Although staff told us they were pleased with the advisory service, they felt face-to-face provision would better meet the patients’ needs.

People’s spiritual, religious, psychological and social needs were taken into account when care was provided. We witnessed numerous discussions with patients and those close to them which were about the whole person, rather than just their illness. For example, a patient who had untreatable cancer was supported to express concerns about the impact on their spouse. This was listened to carefully and suggestions put forward about how this could be managed. People’s needs were clearly documented in the records we looked at.

The mortuary had clear processes in place to deal with deaths of those from a variety of faiths and cultures. The staff told us they had good links with funeral directors in the local area, including ones dedicated to specific faiths.

The design of the hospital and individual wards meant people with disabilities could access it in its entirety. This included access to toilets, and wide doorways.

The needs of people with mental health conditions were identified by ward staff and support and advice was provided by staff based in the hospital. The mental health of patients and those close to them was always taken into consideration in the care we observed. This ranged from emotional support for patients who were upset, to referrals to psychologists when necessary.

Identifying patients who had entered the last stage of their life happened effectively within the trust. During our visit we witnessed the palliative care teamwork with other doctors and nurses to determine where patients were likely to require end of life care. Most nurses we spoke with said they felt confident to hold discussions with doctors on the ward about identifying patients at end of
life. Doctors told us the support they received from the palliative care team meant they were confident about identifying such patients when the palliative care team were not available.

The Specialist Palliative Care Team accepted electronic referrals from ward areas but proactively attended forums where additional patients could be identified.

The trust used an individualised end of life care plan. This utilised the five key priorities for care, drawn from the national “One chance to get it right report” written by the Leadership Alliance for the Care of Dying People. The individual needs and personal choices of patients were recorded in these plans. We saw these records were used well to record both nursing and medical care, as well as the needs and wishes of the patient.

Advance care planning took the form of treatment escalation decision documents for the patients we saw in the hospital. This document made provision for the recording of decisions and preferences about treatment of patients at end of life. However, when we spoke with staff we found there was little awareness about the process of advance care planning, and staff could not clearly describe what this entailed.

Staff handled difficult conversations with sensitivity and tact. When decisions were made to stop actively treating patients at the very end of their lives, they and those close to them were given the opportunity to ask questions, and make requests so patients could experience comfortable and dignified deaths. Family members told us they felt listened to, and their relative had been treated in the way they wished at the end of their life.

**Access and flow**

People could access the service when they needed it. Data produced by the trust showed the specialist palliative care team saw 94% of referrals within two working days.

We observed a daily multidisciplinary review of medical patients within emergency care and the admissions unit. Each patient was reviewed with an overview of their previous medical history, current care provision, the tests which had been order and the results of investigations. The meeting facilitated access to the specialist palliative care team for patients who were awaiting admission or admitted overnight. The daily multidisciplinary meeting facilitated effective tracking of patients through the hospital.

The discharge process aimed to fast track discharges for patients at end of life who wanted to leave the hospital. When considering discharge from hospital, patient safety reviews were conducted to establish whether the patient was stabilised and their pain was under control. This was discussed with both family and patient, with their preferences identified to the specialist palliative care team. Dedicated palliative care occupational therapists undertook environmental assessments and arranged equipment. This often meant liaising with community colleagues to secure funding for packages of care to be delivered at home or in the preferred place of care. We saw this worked well for patients at end of life by enabling timely discharge when community provision was available.

However, we heard of examples where patients did not manage to go home and receive care in their preferred place due to lack of availability of care packages in the community. Not all local authorities the trust worked with had efficient systems in place to facilitate fast track discharges. This meant decisions about funding for packages of care could be delayed, and patients remained in hospital rather than their preferred place of care. We saw evidence that the trust was working proactively to address this and that for the period April to December 2017 an improvement of 1.5 days in the average time patients spent on the Leaving Hospital Database had been seen compared to the similar period for 2016.
Only 5% of patient discharges between April 2016 and March 2017 were to local hospices. This figure was significantly below the national average of hospital discharges to hospice care, which in 2014 was 13.5%. The local hospice was overstretched and had reduced their bed numbers. This meant it was often unable to fulfil requests to transfer patients with complex needs at the end of their life. The number of transfers was likely to decrease further as the hospice temporarily relocated to the outskirts of Bristol, rather than based as now close to the hospital. The trust was seeking to input into and influence decisions around hospice care, but its influence in these decisions was limited.

In order to highlight patients which would benefit from transfer to the local hospice, the palliative care team took part in a telephone conference each morning. The aim of this meeting was to ensure effective liaison and timely transfers of patients to the hospice from the hospital.

An outpatient service was provided by the palliative care team. Referrals to the clinic included patients recently discharged from hospital so symptoms could be reviewed and further psychosocial support continued. Patients could also be referred by their GP from the local catchment area or by another hospital consultant for specialist palliative care assessment, symptom management and advance care planning. The palliative care team aimed to see patients within one to two weeks of referral, but the primary health care team remained the key workers, supported by the specialist team.

**Learning from complaints and concerns**

Patients we spoke with said they knew how to make a complaint if they needed to, and information about how to do this was available to them. Complaints received about end of life care were investigated by the appropriate leader within the directorate they occurred. Complaints relating to the palliative care team would be investigated by leaders from that service.

Between October 2016 and October 2017 the trust reported there were eight complaints related to end of life care. The times of these are detailed in the graph below.

![Number of complaints involving end of life, palliative care and death](image)

Of these complaints, two related to attitude, two related to discharge arrangements, one related to communication of decisions, one related to medical treatment, one related to nursing treatment, and one related to transport arrangements. Following investigation, five of these complaints were upheld, and all complainants received an apology.

Managers told us complaints were reviewed quarterly at the end of life strategy group meeting. This was a cross-directorate group with responsibility for communicating messages back from the group to services. We reviewed the minutes of this meeting and whilst complaints were noted,
there was no information about discussions that surrounded them, or learning being identified to be disseminated. Staff we spoke with on wards were unable to describe any examples of learning from complaints.

At a leadership level, we heard how changes had been made to the way in which community medicine charts were completed following incidents where patients did not have timely access to medicines.

Is the service well-led?

Leadership

Leaders had the skills, knowledge, experience and integrity they needed within end of life. The director of nursing was also the board representative for end of life care at the trust, and worked with the clinical lead for end of life care. The trust also had a non-executive director for end of life care. As well as attending monthly board meetings, the non-executive director for end of life care also participated in “walkabouts” within the trust. This was to ensure they were up to date with how end of life care was being delivered in the hospital.

The executive and clinical leads for end of life care had a clear understanding of the challenges to quality and sustainability of the service and were working together to address them. For example, the ending of the contract with the local hospice meant a solution needed to be found for this provision to be continued. Both leads were working together to mitigate the risks posed by the impending change.

Staff were aware of the trust leaders involved with end of life care. Managers in the services told us they were well supported and engaged with the work being done to develop and improve end of life care across the hospital. Staff were engaged and motivated to provide a high quality service, which they were proud of.

At a local level, we saw high quality dynamic leadership from the bereavement and chaplaincy service, as well as within the mortuary and palliative care teams. Managers were truly visible to their teams, and took the time to support them in their roles. Staff told us they felt encouraged to offer their views, and empowered to make decisions.

Vision and strategy

The end of life service had a clear vision and strategy which spanned the provision across the whole trust. This was based upon the national “Ambitions for Palliative and End of Life Care” framework. Leaders spoke passionately about how the strategy aimed to improve end of life care at the trust. End of life link nurses we spoke with on wards were aware of the strategy and plans for the changes it would bring.

As part of putting the strategy into action, a quality improvement project had been started which aimed to improve end of life care by improving staff confidence, knowledge and approach. This project involved a structured process to gain feedback and information about the existing status of end of life care at the trust.

At the time of our inspection an updated version of the end of life care documentation was being trialled as part of the strategy. Some ward link nurses were aware of how this was progressing and were keen for it to be adopted in all areas. A plan to launch an improved approach to end of life care was planned for the month following our visit. Arrangements had been made for a varying specialities and levels of seniority to be able to attend this launch event.
Audits undertaken had demonstrated the need for, and informed the development of, improved documentation for end of life care. It was anticipated the launch of this would provide a clear pathway to improved and sustainable end of life care at the trust.

The development of the strategy, and monitoring of its progress, was the responsibility of the end of life strategy group. Observations, comments and input was welcomed and discussed. The end of life strategy sat within the trust’s priorities for 2017.

**Culture**

Staff felt supported, respected and valued. The culture of end of life care centred on the needs and experiences of people who used services. Staff we spoke with talked confidently about their responsibilities in relation to being open. We heard an example where the palliative care team apologised to a patient who had received poor care from a doctor from a different service which had caused distress.

Staff felt end of life care was important and was treated as a priority. We saw staff were supported to offer good quality end of life care, and staff also told us this was the case. Additionally, the end of life strategy group was attended by leads from the full variety of directorates within the trust.

Decisions that were made about end of life care delivery were done so on the basis of input from all of these directorates and made for a more rounded delivery. For example, an audit had been completed which looked at end of life care for patients with dementia. The outcome of this showed junior doctors did not always identify where a patient may be suitable for end of life care.

Therefore, the consultants for end of life care within the group looked at how training could be amended to address this issue.

Within the palliative care team, each staff member rated their emotional wellbeing at the start of the day as either red, amber or green. For staff who may be having a tougher day, this was taken into consideration when their work was allocated in the morning. This was a very simple, but effective, way of ensuring the team felt able to undertake the work required by their role.

The palliative care team were highly regarded throughout the organisation. We were told numerous times they were accessible, helpful and worked very hard to support ward based staff to deliver high quality end of life care.

**Governance**

Organisationally, the specialist palliative care team and end of life care sat within the division of medicine. We saw evidence of board level reporting which was led by the Director of Nursing and Clinical Lead.

There was strategic oversight of how end of life care was being delivered through the End of Life Strategy Group which met quarterly. End of Life care outcomes were audited for a sample of all end of life care patients including those not referred to the specialist palliative care team. The trust was taking a proactive approach to care improvement and had recently launched the ‘Purple Butterfly Quality Improvement project to further enhance and embed the monitoring of end of life care as a core standard within the trust. In the year April 2016 to March 2017, only 40% of people who died at the trust were referred to the palliative care team. The remaining patients were cared for within their respective directorates, and quality measures for these patients in terms of end of life care were not collated in any formal manner.

The end of life strategy group comprised leaders from across the different specialities of the trust and met regularly. An action log was attached to the minutes of these meetings which was a live document to track and monitor the progress of agreed actions. We saw this worked well as a process, with many outcomes achieved.
Staff we spoke with were clear about management structures within end of life care at the trust, who they were accountable to and the responsibilities that lay within their roles. The services had regular team meetings and there were daily opportunities for staff to speak to their managers. Staff told us they could raise concerns and ideas and these would be discussed and listened to. Staff told us they received relevant and up-to-date information through their staff meetings.

The trust used a systematic approach to continually improving the quality of its services. There were systems to report information gained from auditing and improvement action plans.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks were identified, monitored and appropriate actions recorded. There was an end of life care risk register, which detailed three risks to the service:

- The impending loss of the out of hours advice line for palliative care.
- The issues around delayed discharges caused by a lack of community provision
- Concerns caused by poor experiences of bereaved relatives, particularly in regards to the collection of certificates.

The risk around the bereavement team was removed from the register during the week of our inspection due to the vastly improved provision following the work of the bereavement team manager.

We were not assured data from sources such as incidents or complaints was effectively captured or scrutinised to establish threats to the service. We saw evidence of corporate risk review when we reviewed the minutes of the strategy meeting. However, the relationship to divisional level governance was not clear.

There was a system for collecting information in relation to palliative care which ensured care and treatment outcomes were being monitored, and required improvements identified. The data was collected through audits completed on the wards, and from the specialist palliative care team. A range of data was collected and collated. This included the total number of deaths that month, and the percentage of total deaths with a treatment escalation decision form.

We were not assured there was sufficient oversight of incidents that related specifically to end of life care. The system in use at the time of our inspection did not prompt users to choose end of life as a category, but relied on this information being added in a free text box. We were told a new system was to be implemented in the weeks following our visit that would facilitate this, and it was hoped this would improve reporting processes. Incidents were a standing agenda item on the end of life strategy group meeting. However, when we looked at the minutes of this meeting it was difficult to see how any thematic review of incidents or learning from them was identified or shared. This echoed what we heard on the wards when staff were unable to discuss with us any incidents that had resulted in changes to practice. Leaders told us they were not confident they had full knowledge of incidents that occurred in the trust and there was a chance some got missed.

The mortuary had capacity to hold 54 deceased adults in refrigerators, including nine bariatric spaces, and four spaces in freezers. Additionally, there were spaces for 12 deceased perinatal patients. To add capacity, there were a further 30 adult refrigerators outside of the main mortuary building which could be used if the main area was full. We were told this overflow facility was more often in use than not, and capacity was felt to be an issue. As an additional contingency plan, the mortuary could access additional space in the mortuary of another local trust approximately five miles away. This had not been necessary in the year prior to our visit.
Information management

There were arrangements and processes to ensure all relevant staff had access to information required to deliver safe care and treatment. Staff had access to up-to-date, accurate and comprehensive information.

Staff completed up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system which they could all update. Staff had access to the information they required to provide good patient care. 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.

Engagement

The trust had effectively engaged with staff in informing them of the changes and improvements that were being made in relation to end of life care. This had been through focus groups, questionnaires, and staff themselves promoting and explaining the changes. This had been done through the specialist palliative care team, and by the end of life link nurses who worked on the individual wards. Staff told us their views were considered in the planning of services and developments that were planned. For example, the bereavement team had been fully involved in the planning and reorganising of their service.

The leadership team for end of life care engaged with others to help shape and develop the service provided. The end of life Link nurses provided a connection between ward-based staff and the leadership team. The link nurses we spoke with were highly engaged in their role, discussed end of life care with their colleagues, and felt part of improvement work as they provided feedback on tools. We were told of a public engagement project called ‘100 days to live’. The purpose was to encourage conversations with staff, public and patients around palliative care and part of the dying matters week.

The bereavement team had been working on a questionnaire to be handed to those close to patients to obtain feedback on their performance. The aim of this was to better capture the experiences of relatives and friends of patients and use this information to improve services. This had been shared with the end of life care group with plans of how this could be rolled out most effectively. However, at the time of our inspection, feedback from bereaved friends and relatives was not routinely collected.

Learning, continuous improvement and innovation

For patients where discharge to their preferred place of death was possible, the palliative care team were involved in the development and implementation of a Bristol Palliative Care Collaborative Community Palliative Care Drug Chart in July 2016. This aimed to support a safe and well organised discharge. The prescription chart could be completed in hospital by a doctor or independent nurse prescriber, authorising the use of anticipatory medicines for end of life care in a community setting. When patients were discharged into a community setting with their anticipatory medications for end of life care, community and care home nursing staff could administer these medicines immediately, without having to obtain authorisation charts from the patient’s GP. This development had a significant positive impact on patient care and reduced the amount of time community and care home staff spent in obtaining medicines authorisation charts.
North Bristol NHS Trust outpatient services for adults are predominantly provided at Southmead Hospital, with further appointments held at Cossham Hospital, Yate Health Centre, and Bath Outpatient Clinic. Outpatient services were provided at Frenchay Hospital until April 2017.

At Southmead Hospital, we visited various outpatient areas in the Brunel Building (known as gates) as well as the breast care unit and the Bristol brain centre, which were also located on site. We did not visit Cossham Hospital, Yate Health Centre or Bath Outpatient Clinic as part of this inspection.

In October 2016, the trust reorganised itself into five clinical divisions. During this inspection the majority of outpatient services sat within the ‘Core Clinical Services’ division. However, some sat within the ‘Anaesthesia, Surgery, Critical Care and Renal’ division.

Clinics we visited included renal, vascular, haematology, phlebotomy, pain clinic, dermatology, vascular, rheumatology, the fracture clinic, the therapies department, and the pre-operation service.

During this inspection, we spoke with 45 staff, including managers, doctors, therapists, nurses, health care assistants, cleaners and volunteers. We spoke with 17 patients and four relatives. We observed interactions of care between staff and patients and looked at 15 patient records. We looked at patient waiting areas and clinic environments, policies and procedures.

**Total number of appointments compared to other trusts**

The trust had 541,816 first and follow-up outpatient appointments between July 2016 and June 2017. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

**Number of appointments by site**

The following table shows the number of outpatient appointments by site, a total for the trust and
the total for England, between July 2016 and June 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southmead Hospital</td>
<td>666,460</td>
</tr>
<tr>
<td>Cossham Hospital</td>
<td>39,541</td>
</tr>
<tr>
<td>Frenchay Hospital</td>
<td>8,990</td>
</tr>
<tr>
<td>Yate Health Centre</td>
<td>6,416</td>
</tr>
<tr>
<td>Bath Outpatient Clinic</td>
<td>5,197</td>
</tr>
<tr>
<td>This Trust</td>
<td>789,552</td>
</tr>
<tr>
<td>England</td>
<td>104,275,113</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments between July 2016 and June 2017. The percentage of these appointments by type can be found in the chart below:

Number of appointments at North Bristol NHS Trust between July 2016 - June 2017 by site and type of appointment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Most staff received effective training in safety systems, processes and practices. Compliance with updating mandatory training was generally good but was below the trust target of 85% for some modules.
As of August 2017, medical staff had met the trust target for seven of the ten training modules. For two of the modules (infection prevention and control and resuscitation) training levels fell just below the trust target with compliance rates of 84% and 83% respectively.

A breakdown of compliance for mandatory courses rolling up to August 2017 for medical staff in outpatients is shown below:

As of August 2017, nursing staff had met the trust target for seven of the eleven training modules. Infection prevention and control and resuscitation were only slightly below the trust target at 84% and 83% respectively.

Conflict resolution training compliance was below the trust target, as only 74% of registered nursing staff had updated their training. This increased the risk of harm to patients, staff and visitors if an aggressive situation were to occur.

A breakdown of compliance for mandatory courses rolling up to August 2017 for nursing staff in outpatients is shown below:
For healthcare assistants and support staff working in outpatients, compliance rates were less positive. These staff were compliant against the trust target for six out of eleven modules. Information governance and falls training were below the trust target, but only slightly. Training in resuscitation and information governance were below the trust target with compliance rates of 82% and 56% respectively.

A breakdown of compliance for mandatory courses rolling up to August 2017 for healthcare assistants and support staff in outpatients is shown below:

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Not all medical staff, registered nursing staff, healthcare assistants and support staff were trained in the management of dementia. Only 75% to 77% of staff were trained across all staff groups. This meant some staff were not up to date with meeting the potential needs of people living with dementia.

Despite this, training rates for medical staff, nursing staff and healthcare assistants and support workers was better than trust average.

Staff working in outpatients did not receive additional training to make them aware of the potential needs of patients living with mental health conditions, learning disabilities or autism.

Generally, staff were positive about the quality of mandatory training they received.

**Safeguarding**

Staff at all levels in all outpatients understood, and were able to describe, their responsibilities to adhere to safeguarding policies and procedures. They were able to identify and give examples of adults and children at risk of harm, and how they would escalate their concerns to the trust’s safeguarding team.

We were given an example of safeguarding where staff were concerned about a patient. They recognised neglect and contacted the safeguarding team and the patient’s GP. An investigation was carried out and actions were taken as a result to protect the patient from abuse.

Safety was promoted throughout the recruitment process. All new staff appointed to a role would be subject to a Disclosure and Barring Service check. Additionally, if there was regular contact with children as part of their role, an additional enhanced check was completed.

The clinical commissioning group set a target of 90% for completion of safeguarding training. Based on information provided by the trust, medical staff and nursing staff and healthcare assistants and support staff were not meeting the 90% target for safeguarding children and adults level two modules.

A breakdown of compliance for safeguarding courses (rolling data as of August 2017) for medical, nursing and healthcare assistant and support staff in outpatients is shown below:

![Safeguarding training completion rate (medical staff)](image-url)
Cleanliness, infection control and hygiene

There were clear processes to prevent the risk of spreading infection. All staff we saw in outpatient departments were bare below the elbow, in line with trust policy. This was to enable more effective hand washing and prevent long sleeves from coming into contact with patients, to reduce the spread of infection.

We observed all staff either washing or decontaminating their hands immediately before and after every episode of direct contact or care with a patient. This was in line with the National Institute of Health and Care Excellence quality standard 61, statement three.

Trust policy required all outpatient areas to have infection prevention and control audits every two weeks, with a compliance minimum score of 95%. We saw a sample of infection control and hand hygiene audit results, all of which were 100%. Audits were completed by cleaning staff supervisors, and the trust lead for domestic staff.

In some areas we found notice boards which displayed reminders for staff to flush oxygen, suction and glucose machines. There were clear lists of cleaning tasks displayed with responsibilities for different staff groups. We were shown completed cleaning lists evidencing that processes were being completed.

All clinical areas within the Brunel building we visited were compliant with the Department of Health Building Note 00-19 (infection control in the built environment) for flooring and sinks, which maintained high standards of infection prevention and control.

In one clinic we found a utility room with a door propped open. Within this room we found several urine samples kept in plastic bowls which had no lid on them. This was an infection control risk to patients and staff.

Environment and equipment

The maintenance and use of facilities and equipment mostly kept people safe.

In the vascular and renal clinic, we found, in an unlocked sluice room, a container of chlorine tablets in an unlocked cupboard. This was accessible to members of the public and if ingested could cause burning, vomiting and stomach pain. This was raised at the time of the inspection and

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
was immediately removed. Staff we spoke with were aware the contained should have been locked away.

Most sharp instruments were managed safely. However, in two clinics we found there were two sharps bins unlabelled (including date and a named person identified who assembled the bin). We also found sharps bins which had the temporary lids left open. This increases the risks of spreading infection, and staff or a member of the public, having a needle stick or other sharp instrument injury.

We checked a selection of resuscitation trolleys and found they were fully stocked, used tamper evident tags, and had their checks completed daily.

We looked at a variety of equipment in various clinics and found all had been checked and correctly labelled. There was clear guidance for all staff responsible for cleaning the equipment.

**Assessing and responding to patient risk**

Patient risk assessments were comprehensive and were in line with national guidance.

Of the 15 sets of patient records we looked in we found recognition of mental health needs and additional support required as part of risk assessments. This included for patients who were at risk of self-harm.

All reception staff were aware of what to do if a patient’s health deteriorated in the waiting area. They said they would call for a nurse or phone for the emergency response team. Staff we spoke with were able to give examples of having done this the previous week, and described how they were fully supported by the nursing staff.

Staff we spoke with in outpatients were trained in line with the National Institute of Health and Care Excellence guideline 51 on sepsis recognition, diagnosis and early management. The trust was running an initiative at the time of the inspection “to train 600 staff in 60 days” on this guideline.

Staff described having good access to a mental health liaison team who were able to attend patients’ appointments if staff requested it. This allowed the staff to provide a safer service to patients suffering from mental health conditions.

**Nurse staffing**

Staffing rates in outpatients were generally good. However, there were occasions where understaffing occurred as a result staff rotor systems and processes.

Each morning senior nursing staff in outpatients met to discuss staffing levels. This was a forum to discuss the staffing levels for the day and to move staff around the service to ensure clinics had the right level of staff where possible.

**Vacancy rates**

Vacancy rates in the outpatients service were low. Between July 2016 and June 2017, the trust reported an average vacancy rate of 6.9% in outpatients. These were entirely attributed to Southmead Hospital.

*Source: Routine Provider Information Request (RPIR) P17 Vacancies*

During the inspection the outpatient service had a 0.6 whole time equivalent vacancy which was out to advert. The trust reported 0% vacancies at Cossham hospital and the South Bristol Satellite Centre.

**Turnover rates**
Turnover rates in the outpatients service were low. Between July 2016 and June 2017, the trust reported a turnover rate of 9.7% in outpatients:

- Southmead Hospital: 5.6%
- Cossham Hospital: 11.2%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
Sickness rates in the outpatients service were low. Between July 2016 and June 2017, the trust reported a sickness rate of 6.2% in outpatients:

- Southmead Hospital: 7.2%
- Cossham Hospital: 31.4%

Sickness percentage rates for Cossham hospital were high, however there were a small number of staff employed therefor impact of this was reduced.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 1% in outpatients:

- Southmead Hospital: 1,079 shifts were covered by bank staff out of a total of 1,358 which meant 316 (23%) shifts were not fully staffed in outpatients.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Staffing rosters were not always fit for purpose. They did not display annual leave, which meant the band six nurses at each gate were unable to see annual leave for their staff. This could make authorising leave, and avoiding having too many nurses off at a time, difficult. Inspectors were told about two recent occasions where there was understaffing of nurses due to too much annual leave being authorised.

Medical staffing
Medical staffing rates in outpatient services was good with turnover rates and sickness rates having no detrimental impact on the service.

Vacancy rates
Vacancy rates for outpatient services were generally good. However, some specialties had more vacancies than others.

Between July 2016 and June 2017, the trust reported an average vacancy rate of 17.8% in outpatients. Of this 14.9% was attributable to Southmead Hospital.

The laser centre had no medical vacancies. However, the symptomatic breast centre had 21% vacancies and the HIV outpatients’ service had 12% vacancies.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Sickness rates
Sickness rates among the medical staff were insignificant. Between July 2016 and June 2017, the trust reported a sickness rate of 0.7% in outpatients:
• Southmead Hospital: 1.0%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

There was minimal use of bank and locum medical staff. Between July 2016 and June 2017, the trust reported a bank and locum usage rate of less than 1% in outpatients.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records

All records we saw were accurate, complete, legible and up to date.

During the inspection we looked in 15 patient records and found them to be managed in a way that kept patients safe.

Access to patient records had improved significantly since the last inspection. During the 2016 inspection, 20% of patient records were unavailable to clinicians for outpatient appointments. This meant clinicians were potentially not always fully informed when making decisions on care and treatment for these patients. During this inspection we found only 9% of patients were seen in outpatients without their full records being available.

Temporary records were created when medical records were not available, which contained at the very least, the patient’s referral letters. However, other important information, such as test results, were readily available on computer systems, so these could be referred to at a patient’s appointment.

We were told as more patient records were becoming electronic (with less paper records in the hospital) staff were finding missing records were becoming less frequent. This was due to the additional time available to find them and ensure they were at clinics.

Patient records in outpatients were audited. Elements of data quality in outpatients were presented in the ‘Account of the Quality of Clinical Services 2016/2017’ document. This recognised the completeness of a patient’s NHS number and General Medical Practice code had improved over time. Of the records audited 99.2% of NHS numbers and 100% for General Medical Practice codes had been completed.

Not all patient records or information was being stored to protect their confidentiality and security. We found in most outpatient areas there were still patients paper records being stored insecurely with record trolleys being unlocked, with more patient records stored on top of them. However, these were always stored in areas where members of the public would not have access, unless accompanied by staff. Staff told inspectors the storage of notes has been an issue since 2014 when they moved into the Brunel building, as the building was not designed to store paper records.

The concerns around the safe storage of patient paper records would be resolved with the introduction of electronic records, which was ongoing during the inspection. This was a phased rollout with specialties and locations adopting the service in turn. During the inspection we found the breast care centre had already adopted this system and consequently there were no paper records in the unit. A week following the inspection, a further 30% of outpatients (including haematology and renal) was going to be using electronic records. Paper notes in this area would be removed, scanned to the electronic record and then securely destroyed.
Areas already using electronic patient records were positive about the change. This was due to the increase of space in their clinics, the decreased risk of notes being unsecured, and more information being available to them.

In the vascular clinic we found patient attendance lists were left on show which compromised patient confidentiality. In the renal clinic we found a computer had been left unlocked and unattended with a patient list left on it.

**Medicines**

Medicines were safely managed.

We checked a selection of controlled drugs in the outpatients' service. We found they were all stored securely, accounted for, and saw evidence of daily checking. All drugs stored were accurately documented in a separate logbook for controlled drugs. The computers used to print prescription forms were also secure.

**Incidents**

Staff told us they had a good understanding of incidents and felt confident to report them. They all understood their responsibility to raise concerns, report patient safety incidents and near misses. We saw evidence incidents had been investigated and learning identified. However, staff said although they received general feedback, they did not always have individual feedback from incidents they had reported.

Themes on incidents included: transport issues, booking of appointments not being correct, and clinic issues where outpatients’ staff were not informed of when they were cancelled. They also included clinics taking place without patient results, delays for appointments, and staffing levels.

**Never Events**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

Between August 2016 and July 2017, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England between August 2016 and July 2017.

(Source: Strategic Executive Information System (STEIS))

However, inspectors were informed of one serious incident which was relatively recent at the time of the inspection. This was where transport failed to arrive leaving a patient in the atrium of the hospital until 11:30pm. There was a subsequent investigation and learning was identified and shared with the staff in the outpatient teams, and with ambulance service providers. As a result, there was clearer guidance being issued if there were concerns with a patient being collected. The investigation report was discussed at a monthly outpatients team meetings.
Duty of candour is a regulatory duty related 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. This duty requires staff to be open, transparent and candid with patients and relatives when things go wrong.

Staff were trained in duty of candour as part of their induction, which included a face-to-face presentation as well as online tools. Key staff were also required to complete a duty of candour module as part of risk management and root cause analysis training programmes. We found no examples in incidents where the duty of candour required application. However, noted that all staff were able to describe how they would be open and honest with patients if something went wrong.

### Is the service effective?

#### Evidence-based care and treatment

The outpatient service provided care and treatment in line with National Institute for Health and Care Excellence guidance, and evidence-based guidance. There were some services, such as outpatient uro-dynamics which was best practice, which provided services across the South West.

The therapies department had a band seven leadership team which had responsibility for ensuring the department was identifying, implementing, and following evidence based practice and guidance. As part of this role, they facilitated a rolling programme of clinical governance projects which looked at different sub specialties (such as upper limb, lower limb, and spinal) individually.

Staff we spoke with in the therapies department were supported to read and evaluate research, literature reviews, case reviews and feedback to encourage best practice and innovation in line with guidelines.

Technology and equipment was used to enhance the delivery of effective care and supported independence. This included the use of telemedicine when medically appropriate, which enabled telephone appointments rather than a face-to-face appointment in urology. This meant patients did not have to travel, and clinics could be run in the evenings.

Patients were given appropriate information in their outpatients appointments to ensure they were fully informed of what to do when requiring further help or if their condition deteriorated.

#### Nutrition and hydration

We saw evidence new patients attending outpatients were nutritionally risk assessed in line with the NICE QS15 (Statement 10, physical and psychological needs) and results acted upon.

Patients who were waiting a long time for appointments were offered drinks of water, tea and coffee.

#### Pain relief

Patients were not routinely assessed for pain in outpatients, as this was not generally a clinical risk. However, staff discussed simple oral analgesia with patients and its use at home, and gave advice about when to seek further support.

#### Patient outcomes

There were no routine outcomes collected in outpatients as many outcomes assessed the surgical and medical elements of the patient’s treatment.
Staff in the therapies department were responsible for developing patient pathways to ensure best practice and guidelines were implemented to improve patient outcomes. There were examples where the department had influenced the community services patient pathway as well as the acute pathway. These included back support classes, and the introduction of a rapid access service within the local community.

**Competent staff**

Arrangements to support staff to deliver effective care and treatment had not always been effective within outpatients. Appraisal rates were not meeting the trust’s target. However, due to recent changes in the divisional structure there was more support available to increase appraisal rates. This included the introduction of seven new team leaders to support staff complete appraisals. This change was recent, and therefore not reflected in the information provided by the trust.

**Appraisal Rates**

Between April 2017 and August 2017, 47.3% of staff within outpatients at the trust had received an appraisal compared to a trust target of 100%. This meant the trust was not assured its staff were competent to carry out their roles, and identify any training or developmental needs.

A split by staff group can be seen in the graph below:

![Appraisal completion graph](image)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Nursing Revalidation**

Despite not meeting appraisal targets for nursing staff, during the course of 2016/17, all nurses working in outpatients submitted their revalidation successfully.

Revalidation is a process introduced in April 2016 by the Nursing and Midwifery Council to demonstrate nurses are compliant to the nursing code. All nurses are required to revalidate every three years. Revalidation was managed through computer-based systems and generated alerts for managers and individual staff members when they were due for renewal. A revalidation support manager produced a report on a monthly basis for heads of nursing and matrons to show which staff required revalidation within the following two months.

Nurses had access to various resources to support revalidation. There was an intranet page containing necessary information and links to the Nursing Midwifery Council. There was an e-learning module available as well a portfolio to store evidence and records of continual...
professional development. All processes were supported by a revalidation policy and user guidance.

The outpatient service had developed a skills framework for all staff. This identified additional learning needs and training to ensure development and competency in their roles. An example of this was all health care assistants being trained in the management of blood tests. They were being given an opportunity to gain a gold standard certificate in spironomy (used in the diagnosis of chronic obstructive pulmonary disease).

When starting in outpatients, staff completed a trust corporate induction and were given an orientation booklet. New staff to outpatients got induction over half a day, and then worked as supernumerary (so not counted in the staff numbers to enable them to gain experience) for a month.

Appraisals and revalidation of medical staff would be considered as part of their speciality work under medicine and surgery.

**Multidisciplinary working**

Staff of different grades and skills worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw evidence of multidisciplinary working within different speciality outpatients.

There were good processes in the therapies department to ensure patients with mental health conditions or patients living with dementia, received bespoke care tailored to their needs. Staff discussed how they had access to a dementia link nurse within the trust who was able to attend appointments if necessary. They also discussed strong links they had with the mental health physiotherapists in another acute trust, who they were able to refer patients to. This meant patients living with mental health conditions were seen by the most appropriate professional in the most appropriate place.

**Seven-day services**

Key services such as the fracture clinic and the plaster clinic were available seven days a week and were only closed on Christmas day. This meant patients attending the emergency department or diagnostic imaging had access to these facilities seven days a week.

There were no other clinics regularly run on a Saturday or Sunday apart from cardiology clinics. Managers in outpatients said the use of clinics at weekends was completely at the discretion of the clinicians within their specialties. However, staff in outpatients told us they were willing to work on weekend shifts if they were required.

**Health promotion**

Staff were active in encouraging health promotion to patients. We saw examples of leaflets available for patients to take away which encouraged a healthier lifestyle. We also observed a consultation between a consultant and a patient where the patient quitting smoking was discussed.

In the pre-operation service, staff had worked with patients to develop better information to encourage a healthier lifestyle to prepare for operations. This led to patients then being able to be discharged more quickly after an operation.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent was sought and provided in line with legislation and guidance.
Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff discussed with inspectors how they would support patients experiencing mental ill health and those who lacked the mental capacity to make decisions about their care. Staff also had a good understanding of best interest decision making. They knew how to seek advice when patients were not able to give valid informed consent, due to a lack of mental capacity.

The trust reported as at August 2017, mental capacity and Deprivation of Liberty Safeguards training had been completed by 87% of staff within outpatients. This was better than the trust’s target of 85%.

![Mental Capacity and DoLS (outpatient staff)](chart)

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.

We spoke with 15 patients and four relatives in various outpatient clinics and feedback received was consistently positive. One patient said they were “Very impressed…excellent I cannot fault it”. Another patient said, “Staff are lovely, always very kind and patient.”

We observed staff introducing themselves to patients and relatives in a positive, respectful and compassionate way. This was in line with National Institute for Health and Care Excellence QS15 (Statement 1, patient experience in adult NHS services). This was followed on with reassuring conversation with the patient to ensure they were in the right place and if there was anything they wanted (for example, a drink).

We also observed staff going the extra mile. On several occasions we saw cleaners who were working in outpatient waiting areas stop and talk to patients. One cleaner recognised a patient had been waiting for a long period of time and offered to get them a drink.

The staff on reception kept patients updated when clinics ran late, and spoke to patients in a kind manner.

NHS Friends and Family Tests collect information from patients receiving outpatient care on the quality of the service received. Although the questions are generalised, they can establish themes on the care received. In September 2017, 93% of patients said they would recommend the service...
to someone else. This was a slightly higher percentage when compared to the average of the South West of England, and only a slightly lower percentage when compared to the England average. This was also a higher percentage of patients recommending the service than the other services provided by the trust.

There were a large number of positive comments received about staff being caring compared to negative ones. In September 2017, there were 400 positive comments compared to less than 50 negative comments around staff attitude. There were also 50 positive comments about communication compared to 15 negative ones.

**Emotional support**

All patients had the opportunity to have a chaperone at any time. Sometimes there was a slight delay for the appointment, whilst an appropriate member of staff was identified. On occasion, female patients requested to see a female doctor only. Staff did their best to accommodate this, and this was never a problem if the patient had requested this in advance. However, there had been a couple of occasions when a patient who had not requested this before their appointment had to have their consultation rebooked.

There was emotional support available to patients who had received a diagnosis of cancer. Certain clinics had support for patients from a specialist cancer nurse, who could speak to the patient straight away if they wished. In addition, all patients were invited to attend a health and wellbeing education event as part of their care following diagnosis and a significant number of patients were offered a holistic needs assessment and care plan.

The trust has a MacMillan Wellbeing Centre, which could be accessed by any patient, relative or carer from the Bristol and South Glos area. The Centre provided advice, information and support to cancer patients as well as offering free complimentary therapies and a range of activities from external agencies such as citizens’ advice bureau, dieticians, and psychologists. The Centre was run by specialist nurses, cancer support workers and volunteers. The Centre provided face-to-face support for 30-40 patients per day and also averages 15 telephone appointments per day.

The nursing staff were very positive about this, and said patients often took advantage of this opportunity and were provided with compassionate and understanding advice at a difficult time.

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

The outpatient service was routinely involving patients and those close to them in planning, and shared decision-making about their care and treatment. The service had trialled a Commissioning for Quality and Innovation (CQUIN) initiative called ‘Ask three questions’.

Patients attending outpatient appointments were given an ‘Ask three questions’ leaflet to encourage involvement in consultations. A video was also shown in the waiting areas to reinforce the message. Questionnaires were then carried out to assess shared decision making.

The results from this initiative showed an increase (from 83% to 96%) of patients feeling they received the right amount of information; an increase (from 94% to 100%) in patients feeling involved in their decisions; and an increase (from 81% to 88%) in patients feeling better equipped to manage their condition or treatment better.

However, the initiative recognised, despite the improvements, patients were still feeling as if they were not asked what was important to them. This was being addressed through a revision of staff training and further embedding of involvement of patients in practice.
The brain centre had a patient garden, which was managed by the patients working alongside staff. It also had a café, which was run by patient volunteers. Two patients also provided domestic services within the brain centre.

Is the service responsive?

Service delivery to meet the needs of local people

Services provided by outpatients reflected the needs of the local population. Staff were finding different ways to manage patient care to improve the efficiency of clinics and service lines. This included:

- Patient initiated follow ups, which allowed patients to initiate a hospital follow up appointment ‘as required’, rather than with the traditional clinician-initiated follow up.
- An advice and guidance service which allowed GPs in the community to call clinicians to discuss a referral or a treatment pathway, without the patient needing to attend for an outpatient appointment.
- In dermatology, patients who would traditionally have had to attend an outpatient appointment were periodically sending clinician’s photos of their skin conditions, rather than attending an appointment. The clinician would then contact them to discuss progress and any changes to their treatment.

The outpatient service was utilising allied healthcare professionals (such as radiographers and physiotherapists) to create patient pathways, which reduced waiting lists and improved the efficiency of care. These included:

- A joint physiotherapy and pharmacist respiratory clinic, which had successfully reduced waiting list times.
- Pathways for prostate patients, who would attend a clinic appointment and have their diagnostic magnetic resonance imaging and computed tomography scan on one day.

We observed a number of one-stop clinics. These ensured that patient could attend multiple appointments in one day. Patients asked to attend a one-stop service were fully informed of the processes before attending, and were told of potential waits during the clinic process. One patient we spoke with was very positive about the service. They told us they were “very stressed and anxious” but the staff had been supportive and made them “feel comfortable” as they expected to be there for at least a couple of hours. We observed the clinic was well organised and efficiently run.

Environments for outpatients were appropriate and patient centred. There was suitable and comfortable seating, with access to toilet facilities and drinks machines. On our inspection, these areas were not overcrowded and there was enough seating for patients.

There were no separate waiting areas for patients who found busy waiting areas distressing. However, there were procedures to ensure those patients were seen quickly to minimise the time they were in the department.

Patients we spoke with said there was sufficient car parking available.

Patients were provided with an appointment letter before attending the hospital. This had a barcode which needed to be scanned when arriving to inform patients of where in the hospital they needed to go. Patients we spoke with found this was a good way of directing patients in such a large hospital.
There were volunteers readily available by the scanning machines, to support patients to get to their appointments. There was also an electronic buggy available to take patients who had difficulty walking to the correct gates.

In the pre-operative clinic, staff were organising a survey of patients to find out if they received adequate information about certain procedures. As part of this, staff were working with certain specialties to provide better information leaflets for patients.

Information on public transport was available on the trust’s website, and buses from various areas regularly came to the hospital. There were arrangements which enabled staff to arrange transport for patients if they were unwell after a procedure or if the patient was unable to travel home alone.

Information regarding clinics was displayed on computer screens in the waiting areas. This displayed the patient name, the clinic they would be attending, and information on any delays.

**Clinic utilisation**

The outpatient service had a responsibility for 130 individual clinic rooms. The service was working with the specialties to streamline and standardise processes for managing appointments. This had included the introduction of a new booking system to allow oversight, accountability and reporting of clinic capacity. Inspectors were told how prior to this system being used, rooms were regularly double booked. They were also being booked despite no clinic being run, and clinicians attending clinics without booking rooms.

The new system had reduced the frequency of this happening. However, there were still examples of rooms being booked with no clinic scheduled. There was a team of administration staff with oversight of this system who were working to address this and increase clinic utilisation.

Clinics were mostly being used in a way that met the needs of local people. Of the 130 clinic rooms within the outpatient service, utilisation was constantly around 80% which meant there were enough clinics available to meet people’s needs. Nurse led clinics accounted for 30% of use, with clinician led clinics making up the other 50%. Many specialties ran evening clinics. However, the booking system had identified there were 50 rooms booked in the five weeks following the inspection where a clinic had been cancelled. This meant the rooms could not be booked for other clinics.

**Cancelled appointments**

The service had recognised on their risk register some patients were attending appointments that had been cancelled. Inspectors were told this was due to a computer software issue which they were working to resolve.

During the inspection one patient who had travelled over 100 miles to attend a clinic found it had been cancelled. Staff in the service worked to ensure that, despite the patient’s clinician being unavailable, they were still seen by another clinician that same day.

Senior managers said this was happening less frequently the more patients were being managed through the trust’s e-referral system. This was an electronic referral system which was being introduced at the time of the inspection. At the time of the inspection, 60% of patients were managed through e-referral while the remaining 40% would be using e-referral by June 2018.

**Processing of appointments and call handling**

As a result of the introduction of e-referrals, the processing of paperwork associated with the outpatient service had become quicker. Standard (non-urgent) referrals were being processed and appointments being offered within five days of receiving a referral. Urgent referrals were being processed and appointments being offered within two hours of receiving a referral.
There was an effective system to manage incoming calls about outpatient appointments. There was a team to take calls, with processes to manage busy periods. During the inspection, we found calls were managed well, being answered quickly with the average wait being only 43 seconds.

**Did not attend rates**

Between July 2016 and June 2017,

- the ‘did not attend’ rate for Bath Outpatient Clinic and Cossham Hospital were higher than the England average.
- the ‘did not attend’ rate for Southmead Hospital and Yate Health Centre were lower than the England average.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, North Bristol NHS Trust.**

![Proportion of patients who did not attend appointment, North Bristol NHS Trust.](chart.png)

*(Source: Hospital Episode Statistics)*

The outpatient service was introducing systems to encourage patients to attend appointments. This included booking with six weeks’ notice (so the patient was less likely to forget about their appointment) and by sending text message reminders.

In urology, staff were flexible and compassionate about do not attend rates. Staff recognised the difficulties of cancer diagnosis and the nature of some of the conditions they were managing.

**Meeting people’s individual needs**

The service went some way to identify and meet the information and communication needs of people living with a disability.

There were several dementia champions within outpatients. All had received specialist training from the Alzheimer’s society. As part of this it was their responsibility to cascade learning on this subject to other staff. One member of staff gave an example where a patient living with dementia had been identified in a GP letter. The staff were then aware of the person’s needs and ensured they were managed appropriately and seen quickly. When asked, all staff said they would ensure patients living with dementia were seen quickly in a clinic. Staff we spoke with were aware of the memory café in the atrium of the hospital provided by volunteers and nurse specialists which was available for patients and their carers.
Training on support people with learning disabilities was delivered through safeguarding training. Staff did not receive specific training on the management of autism. However, staff gave examples where they had cared for patients with autism and how their needs had been met. One example was a patient who regularly attended a clinic. The staff were consistent with their approach to the patient and their relatives, to increase familiarity with the surroundings. Staff could also contact the trust’s learning disability link nurse for support and guidance if there were any other concerns.

We were given an example of the management of a patient with Tourette’s syndrome, and a patient with Down’s syndrome. Staff found a spare room for the patient to wait, as the usual waiting area was very busy, and the patient was very anxious. Staff did their best to get the patient through the clinic as soon as possible, ensured they had a cup of tea, and a member of staff nearby to support them.

In the therapies department, staff were able to discuss with inspectors what they would do to meet the individual needs of patients with mental health conditions and learning difficulties. This included having quiet rooms available for anyone suffering with anxiety, and longer appointment times if necessary, to allow them to fully support the patients.

There was a pain clinic available for patients living with chronic pain, which managed patients’ needs effectively. This service had access to support services, such as psychology, to manage the mental effect of chronic pain as well as the physical effects. There was a nurse led acupuncture clinic available for patients, as well as a nurse led spinal cord stimulation service.

We were provided with an example of meeting patient’s needs. In the pain service a patient who was not ‘opening up’ during a psychological group session was offered regular one to one sessions with a psychologist, which improved the effectiveness of their treatment.

There were processes to manage chronic pain associated with female genital mutilation. As part of this service, the trust referred the patient to a local Wellbeing Service to help improve their quality of life.

There were processes to protect patients who were having thoughts of suicide due to their chronic pain. We were given examples where patients were given additional support and supervision (for example in the waiting rooms) to actively manage the risk to the patient. We were also given examples of some patients who were discussed at a multidisciplinary team meeting to discuss their suicidal thoughts and how best to protect them from harm.

**Access and flow**

People could access the service when they needed it. Waiting times for appointments and treatment were mixed.

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

Between August 2016 and July 2017, the trust’s referral to treatment time for incomplete pathways had been worse than the England overall performance. Referral to treatment incomplete pathways are patients waiting to start treatment. In the outpatients setting this could be patients waiting to see a doctor before they are considered for further intervention (such as surgery).

More patients were waiting longer than 18 weeks for an initial appointment in this trust than the England average. In outpatients, 86% of patients were treated within 18 weeks in August 2016 whereas in July 2017, the number treated was similar with 87%. This showed a worse performance compared to 90% nationally as well as the 92% national standard.

A breakdown of referral to treatment rates (percentage within 18 weeks) for incomplete pathways,
North Bristol NHS Trust is shown below:

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Ten specialties were above or in line with the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>99.8%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>99.0%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>98.8%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>98.0%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>96.1%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.0%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.4%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>93.2%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>91.7%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Other</td>
<td>91.5%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Seven specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks). However, all but three of these were only slightly below the England average. The worst performer was Trauma and Orthopaedics (69% compared to an England average of 85%).

Patients who were waiting longer than 18 weeks were reported as being part of a backlog.

The trust looked at backlogs at their monthly board meetings in the integrated performance report. Specialties which failed to meet their targets were gastroenterology, respiratory medicine and
neurosurgery, all of which had remedial action plans. However, cardiology and general surgery exceeded their planned reduction in patients waiting.

Some services were finding it difficult to meet the demand required of them. However, there were plans to rectify this. For example, in gastroenterology and general medicine clinics, there had been an improvement in recruitment of key staff. In the neurology clinic, capacity had been increased through extended clinic days.

Validation is the process to check patients waiting to ensure the highest risk patients were seen first. This was ongoing in some specialties. Managers told inspectors about the high number of patients which had been discharged from the service as a result of validation, particularly in the gastroenterology service.

However, inspectors were provided with limited evidence that patients were being seen on a risk basis (so with the patients at highest risk being seen first). This meant patients who may be in greatest need of care were not identified or treated first.

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust was performing worse than the 93% operational standard and the England average for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), North Bristol NHS Trust**

(Source: NHS England – Cancer Waits)

The trust had identified this in the integrated performance report which was discussed monthly at the board meeting. In the most recent data (for July 2017) the trust’s performance was 91.6%. The trust received 2,045 urgent referrals in July and had 171 breaches in this standard. Of these breaches, 83 were for skin, 25 for colorectal and 20 for breast cancers.

The September 2017 board report highlighted this was worsening since August 2017 with a performance of 89.7%. Out of the 1,946 referrals received in July (which this report was based on) there were 198 breaches. Of these breaches, 108 were skin, 30 were colorectal and 22 were breast cancers. The same report stated a majority of the breaches were due to patient choice (with patients being unable to attend when offered an appointment within two weeks). The skin service was understaffed and an increased level of referrals resulting in breaches.

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust had continually passed the 96% operational standard for patients waiting less than 31
days before receiving their first treatment following a diagnosis of cancer. It was performing better than the national average until quarter four 2016/17 where it declined slightly below the England average. The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

Cancer operational standards were discussed at the monthly board meeting. The integrated performance report stated the trust had once again exceeded the national target with 98% of patients waiting less than 31 days in July 2017.

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust was consistently performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral between Q3 and Q4 2016/2017. However, this dropped slightly below the standard in Q1 2016/17. The data shows that the trust has performed better than the England average for the previous 12 months. The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

The integrated performance report stated in July 2017 the trust had exceeded this target with 91% of patients waiting less than 62 days for their first definitive treatment. Within this, some specialties (including colorectal, haematology, sarcoma and upper gastrointestinal) were achieving 100%. Gynaecology and lung specialties were achieving 80% and 69% respectively.

**Follow-up to new rates**

Follow-up to new rates indicate the ratio of new to follow up patients. If a service is seeing a high percentage of follow up patients they will be reduced capacity to see new patients. Between July 2016 and June 2017, the follow-up to new rates for Yate Health Centre, Bath Outpatient Clinic and Cossham Hospital were found to be similar to the England average. The follow-up to new rate for Southmead Hospital and Frenchay Hospital were worse than the England average. This reduced capacity to see new patients, however ensured follow-up patients were seen.
A breakdown of follow-up to new rates at the trust compared to the England average is shown below:

(Source: Hospital Episode Statistics)

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Patients and visitors we spoke with knew how to complain and said they would feel comfortable approaching staff if they had a concern.

In the therapies department, concerns and complaints were used as an opportunity to learn and drive improvement. Every six months the therapies department (which included physiotherapy, occupational therapy, speech and language therapy and dietetics) met to discuss the previous six months’ data to share lessons learnt and actions taken as a result of complaints.

The trust had a Patient Advice and Liaison Service. However, inspectors found very little information available for patients to contact them and raise a complaint.

Staff we spoke with were knowledgeable about learning from complaints. Staff were also aware of themes arising in complaints and concerns. Some staff we spoke with could describe in detail the main themes (including patient transport and appointment issues) and were able to discuss actions from these.

**Summary of complaints**

Between August 2016 and July 2017, there were 173 complaints about outpatients. This is the second largest core service for complaints accounting for 30% of the trust’s total (584). However, this large percentage was to be expected due to the size of the service.

Complaints were reported for each month between August 2016 and July 2017, ranging between 10 and 25 per month. The number of complaints was higher at the end of last year from September 2016 with a peak in January 2017. Most recently since June 2017 there has been a decline in reported complaints.

The trust took an average of 36 days to investigate and close complaints. This was in line with its complaints policy, which stated complaints should be completed within 35 days or 45 days for more complex complaints.

Of the complaints 70 were around the communication/information followed by 25 complaints about all aspects of clinical treatment.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
Is the service well-led?

Leadership

Leaders within outpatients had the skills, knowledge, experience, and integrity to lead effectively. During interviews, managers at all levels demonstrated they fully understood the outpatient service and worked well together as a leadership team. Leaders described positive and proactive relationships amongst peers.

All managers we spoke with understood the challenges to quality and sustainability. They could clearly demonstrate an in-depth understanding of actions and progress with safety and quality projects. This understanding was corroborated with documentation which reflected progress.

As part of the divisional restructuring, additional leaders had been appointed to improve support for staff and improve compliance rates for appraisals and training. This included the introduction of a separate booking manager, with four team leaders supporting a team of booking clerks and call handlers. There was a receptionist manager with three team leaders supporting a team of 45 receptionists. Staff we spoke with commented how they had felt a benefit from the additional support and which felt they would be listened too. This had also seen an improvement in patient waiting lists, and overdue follow up appointments due to increased efficiency of the teams.

With this additional leadership, there was greater stability for the support staff. Previously receptionists were regularly changed between gates, depending on the service demand, which staff found challenging. However, as a result of the improvements in management they rarely moved.

Staff we spoke with felt the new management structure for outpatients was showing improvements and could look ahead with confidence that further improvements would be made.

Due to the fact the service had recently been reorganised there were no plans at the time of the inspection for the development of a leadership strategy or succession planning.

Vision and strategy

The outpatients service worked with the trust’s overarching vision and values to develop the service. This allowed the department to set its own objectives. All managers we spoke with were able to discuss the trust’s strategy and objectives, how they fitted into outpatients, and how they were taking actions to meet them.

This included the objective to ‘change how services are delivered to generate affordable capacity to meet the demands of the future’. The service was ensuring meeting demand was one of the top priorities, and were able to demonstrate how they were constantly seeing more patients than they were contracted. Alongside this, they were able to demonstrate they also provided a safe as well as responsive service.

Another priority was the introduction of electronic records in the outpatient service. This was in line with the trust’s objective to ‘maximise the use of technology so the right information is available for the key decisions’. This had already been introduced in some outpatient areas (such as breast care) and was being introduced to a further third of the outpatient service the week following the core service inspection. There were plans to remove all paper-based records by May 2018.

Culture

Staff we spoke with at all levels discussed an improving culture within the outpatient service. In 2016, nursing staff within outpatients went through a nursing staff consultation and staffing levels
reduced from 19 staff to 11 staff. However, since that point it had been recognised improvements were being made to ensure a positive working culture.

Alongside this, due to financial restrictions as a result of the trust being in financial special measures, there was a period, which had ended at the time of the inspection, where there was no additional training available to staff to allow them to develop in their roles. At the time of the inspection a training needs analysis had been completed to ensure staff received the training they needed to progress and develop in their role. This included all healthcare assistants being training in spironomy (a diagnostic tool for the diagnosis of chronic obstructive pulmonary disease).

There were many positive comments received by inspectors which highlighted a positive staff wellbeing and job satisfaction. Comments included “I love my job. We go above and beyond for patients, spending as much time with the patients as we need.” Another said “It feels great being part of the outpatients team.” One member of staff commented they had worked for the hospital for many years and were very proud of the department. We were also informed of a member of staff who returned to work after retirement because they missed working for the service.

Cleaning staff we spoke with said they had a good relationship with the outpatient service and felt part of the team. They were positive about all aspects of working with outpatients and were supported by the managers.

**Governance, risk management and quality management**

The outpatients service had an innovative governance structure with clear processes and systems of accountability. In October 2016, the trust reorganised itself into five clinical divisions. During the inspection a majority of outpatient services sat within the ‘Core Clinical Services’ division. However, some sat within the ‘Anaesthesia, Surgery, Critical Care and Renal’ division.

**Outpatients in the Core Clinical Services Division**

Core Clinical Services outpatient services were considered its own ‘speciality’ and were managed by a service manager, outpatients manager and outpatients matron under a clinical director and divisional manager.

The structure for outpatients was only introduced six weeks prior to the inspection. In that time the management team had developed a risk register, processes for escalation from the staff to the board, and an action log.

The risk register was in its first version and identified all of the risks to the service. It clearly recognised risk owners, risk scores and review dates for actions. Through the course of the inspection CQC inspectors did not identify any further risks to the outpatient service which were not already recognised.

An action log supported the risk register. This document logged 24 actions which were ongoing including the development of a business continuity plan and a patient experience plan.

There were five risks which were graded as high risk. These included patients not receiving cancellation letters, lack of e-referrals and patient notes, capacity in respiratory clinics, and a follow-up appointment backlog. All senior staff we spoke with understood the issues fully and were able to describe actions to reduce the risks.

There were several meetings to ensure information was cascaded and escalated effectively to staff. There was a weekly management meeting which involved the senior managers, team leaders and supervisors. In this forum the outpatients’ transformation log was discussed. This group then reported into the outpatient board, which was chaired by a board director. Additionally
to this there was a bi-monthly outpatient governance meeting which reported to the core clinical services divisional meeting.

On a monthly basis, the clinical director and the divisional manager submitted a report to the trust board to share activity and receive challenge on the service provided. This report identified key activities, risks and their mitigations for the previous month to provide the board with assurance they were safe and providing high quality care.

**Outpatients in the Anaesthesia, Surgery, Critical Care and Renal division**

Outpatient services for general surgery (such as the pre-operation department), the breast service, urology and renal specialties sat within the Anaesthesia, Surgery, Critical Care and Renal division. These were managed well with clear processes of accountability. As part of this, a weekly bulletin was released to these services called ‘five plus two’. This highlighted five things which went well in the previous week and two things that were in their power to resolve. This was positively received by staff and encouraged learning and engagement in quality improvement.

The outpatient teams working within Anaesthesia, Surgery Critical Care and Renal had regular talks from other specialties over the last 12 months. This included lung function, needs of Jehovah’s Witness patients, and an enhanced recovery project.

The outpatient service had a clinical governance day every six to eight weeks. As part of this, all clinics closed to ensure staff could attend. It was an opportunity for staff to present issues, learning and concerns from their department.

**Public and staff engagement**

Patients’ views and experiences were acted on and shaped improvement of the service and the culture. NHS Friends and Family Test results were collected within outpatients and were discussed monthly in the integrated performance report at the trust board. From there, themes were identified and used to develop improvement actions.

Response rates from patients for outpatients were good and continually exceeded regional and national average response rates. Between May 2016 and May 2017, response rates averaged between 14% and 22%. This was against a local target of a 6% response rate.

Managers within outpatients recognised the NHS Friends and Family Test did not work effectively for outpatients. They explained how the questions gave no distinction between the clinicians and the outpatient service. They had decided to develop a bespoke outpatients’ questionnaire.

In order to engage further with the public, plans were for the service to hold regular patient experience groups. This would enable feedback to be more detailed and give patients time to express themselves further. Managers said they would be approaching patients who had chronic conditions and who were regular attenders to the clinic. The first one had been booked for January 2018.

The outpatient service managers informed inspectors they planned to hold regular clinician user groups to gain detailed feedback on the service the outpatient staff were providing. The first of these was booked for January 2018.

**Learning, continuous improvement and innovation**

The outpatient service had a transformation plan which had been developed several weeks prior to the inspection. This was designed through the use of several ‘outpatient transformation workshops’. Within these workshops, senior managers and nursing managers identified what the
objectives of an outpatients department should be and the direction in which they want to be developed. Further workshops had been booked.

One member of staff in the pain service had been recognised by their service for an award as they had introduced a service for staff with back pain to receive treatment.