

# Great Western Hospital NHS Foundation Trust

## Evidence appendix

Marlborough Road  
Swindon  
Wiltshire  
SN3 6BB

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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

Great Western Hospitals NHS Foundation Trust has around 1.2 million patient contacts a year and provides a wide range of acute and community services to the people of Swindon and the surrounding areas. The trust has around 480 beds, numerous outpatient clinics, CT and MRI scanners, maternity services, an Intensive Care Unit, an Urgent Care Centre and a 24/7 Emergency Department. Currently the trust employs approximately 4,500 staff working in the Great Western Hospital, in community healthcare facilities, and people's homes across Swindon.

Since November 2019, the trust has provided primary care services at two main practices in Swindon – Moredon and Abbey Meads, which together serve around 30,000 people.

### Acute hospital sites at the trust

The acute hospital run by Great Western Hospitals NHS Foundation Trust is outlined below.

Name of acute hospital site	Address	Details of any specialist services provided at the site	Geographical area served
Great Western Hospital	Marlborough Rd, Swindon SN3 6BB	Accident and emergency services, anaesthesia, cancer services, cardiology, dementia services, paediatric services, urology,	Swindon, Wiltshire & Surrounding

		gynaecology, dermatology, fracture clinic, endocrinology & diabetology, pre and post-natal services, older persons care, ENT surgery, oral surgery, rheumatology.	
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*(Source: Trust Website / Routine Provider Information Request (RPIR) – Sites tab)*

# Acute services

## Great Western Hospital

Great Western Hospitals NHS Foundation Trust

Marlborough Road

Swindon

Wiltshire

SN3 6BB

Tel: 01793 604020

## Urgent and emergency care

### Facts and data about this service

Great Western Hospital provides urgent and emergency services for people living in Swindon and the surrounding area. The facilities comprise of:

- Majors area with 17 cubicles and an initial assessment area referred to as 'majors chairs for 'fit to sit' patients.
- A minors area (used overnight) with four cubicles and a procedure room.
- Resuscitation area with four bays.
- Observation unit with eight trolley spaces and two mental health assessment rooms.
- A dedicated paediatric (children's) emergency department with a treatment area, four cubicles and a separate waiting area. This was open from 10am to 10pm.
- Urgent care centre co-located within the hospital.

The emergency department does not have a minors treatment area during the day time but refers most walk-in patients to the urgent care centre, which is co-located within the grounds of the hospital.

The emergency department is a level 2 trauma centre, which mean it sees all but the most seriously injured patients, who are stabilised before being transferred to a major trauma centre in another NHS trust.

Attendances to the emergency department (ED) and the urgent care centre (UCC) are approximately 110,000 patients a year, of which approximately 25,200 (28%) are children and young people. The service attendances increase by 6,000 attendances year-on-year for the past five years. There was a 15% increase in attendances in 2019/20 compared within 2017/18, which included a 20% increase in ambulance attendances.

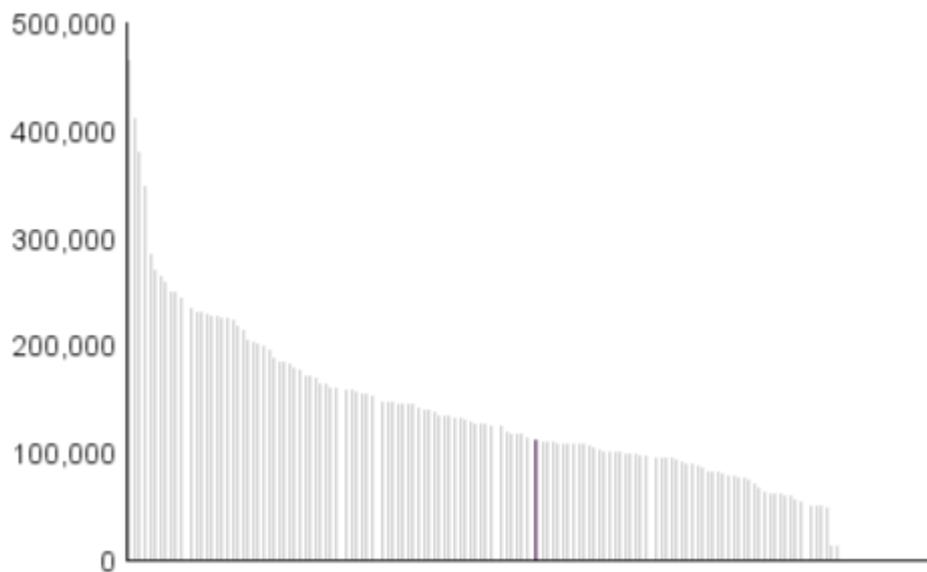
There is a nurse-led urgent care centre (UCC) co-located on the hospital site. UCC is open from 7am to midnight, seven days a week and provides urgent medical care from a team of nurses and

paramedics, providing patients with a same day consultation when they are unable to see their GP.

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

### Activity and patient throughput

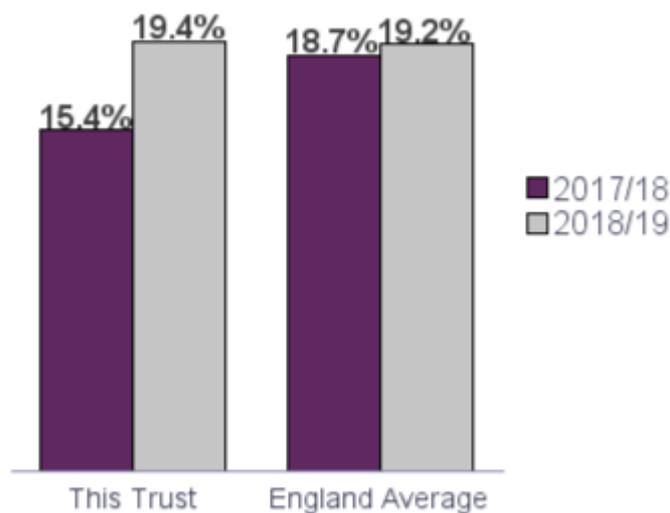
**Total number of urgent and emergency care attendances at Great Western Hospitals NHS Foundation Trust compared to all acute trusts in England, July 2018 to June 2019**



From July 2018 to June 2019, there were 110,553 attendances at the trust's urgent and emergency care services, as indicated in the chart above.

(Source: Hospital Episode Statistics)

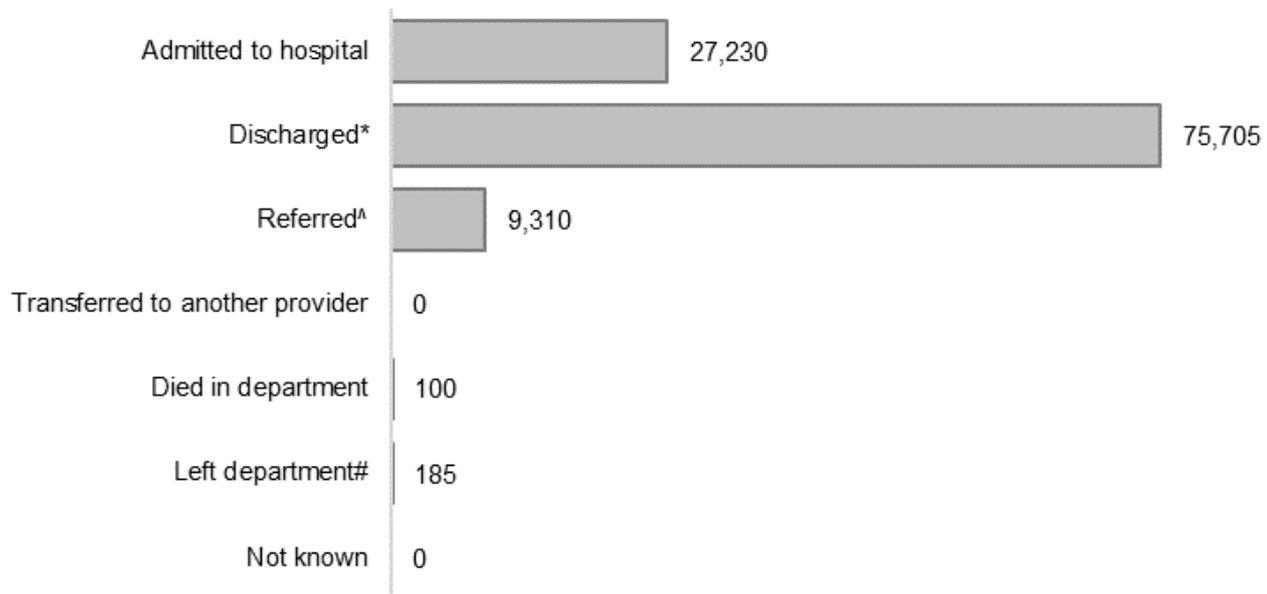
### Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission increased in 2018/2019 compared to 2017/2018.

(Source: NHS England)

## Urgent and emergency care attendances by disposal method, from October 2018 to September 2019



\* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

## Is the service safe?

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

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

### Mandatory training

**The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.** Compliance for nursing staff had improved since our last inspection in 2018 but completion rates for medical staff continued to fall below trust targets.

### Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training. Nursing staff we spoke with were aware of and had completed their mandatory training to ensure they received regular training and updates in line with trust policy.

Overall, the trust set a target of 80% for completion of mandatory training, except for Information Governance which was set at 95%.

A breakdown of compliance for mandatory training courses as of February 2020 for registered

nursing staff in urgent and emergency care is shown below:

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Manual Handling - Object	174	179	97.2%	80.0%	Yes
Health, Safety and Welfare	171	179	95.5%	80.0%	Yes
Infection Prevention (Level 1)	171	179	95.5%	80.0%	Yes
Equality and Diversity	170	179	95.0%	80.0%	Yes
Information Governance	170	179	95.0%	95.0%	Yes
Conflict Resolution	169	179	94.4%	80.0%	Yes
Venous Thromboembolism	146	158	92.4%	80.0%	Yes
Duty of Candour	165	179	92.2%	80.0%	Yes
Manual Handling - People	156	172	90.7%	80.0%	Yes
Alcohol Brief Advice	161	179	89.9%	80.0%	Yes
End of Life Care Level 2	152	172	88.4%	80.0%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	157	179	87.7%	80.0%	Yes
Smoking Brief Advice	152	179	84.9%	80.0%	Yes
Adult Basic Life Support	151	179	84.4%	80.0%	Yes
Food and Hygiene Safety Level 1	151	179	84.4%	80.0%	Yes
Learning Disabilities Awareness Level 1	149	179	83.2%	80.0%	Yes
Mental Health Awareness Level 1	149	179	83.2%	80.0%	Yes
Slips, Trips and Falls	149	179	83.2%	80.0%	Yes
Infection Prevention (Level 2)	148	179	82.7%	80.0%	Yes
Learning Disabilities Awareness Level 2	148	179	82.7%	80.0%	Yes
Fire Safety 1 year	147	179	82.1%	80.0%	Yes
Paediatric Basic Life Support	87	108	80.6%	80.0%	Yes
Blood Transfusion	125	158	79.1%	80.0%	No
Medicine management training	141	179	78.8%	80.0%	No

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

In urgent and emergency care the 80% target was met for 22 of the 24 mandatory training modules for which registered nursing staff were eligible. The 95% target was met for Information Governance.

Not all medical staff were up-to-date with all their mandatory training. Compliance was not achieved across all subjects, with compliance in five subjects lower than 70%.

A breakdown of compliance for mandatory training courses as of February 2020 for medical staff in urgent and emergency care is shown below:

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and Diversity	47	53	88.7%	80.0%	Yes
Health, Safety and Welfare	46	53	86.8%	80.0%	Yes
Conflict Resolution	45	53	84.9%	80.0%	Yes
Dementia Awareness (inc	45	53	84.9%	80.0%	Yes

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Privacy & Dignity standards)					
Duty of Candour	45	53	84.9%	80.0%	Yes
Manual Handling - Object	45	53	84.9%	80.0%	Yes
Infection Prevention (Level 1)	44	53	83.0%	80.0%	Yes
Learning Disabilities Awareness Level 1	44	53	83.0%	80.0%	Yes
Learning Disabilities Awareness Level 2	44	53	83.0%	80.0%	Yes
Slips, Trips and Falls	44	53	83.0%	80.0%	Yes
Venous Thromboembolism	44	53	83.0%	80.0%	Yes
Adult Basic Life Support	43	53	81.1%	80.0%	Yes
Blood Transfusion	43	53	81.1%	80.0%	Yes
Information Governance	43	53	81.1%	95.0%	No
End of Life Care Level 2	40	53	75.5%	80.0%	No
Mental Health Awareness Level 1	38	53	71.7%	80.0%	No
Infection Prevention (Level 2)	35	53	66.0%	80.0%	No
Paediatric Basic Life Support	34	53	64.2%	80.0%	No
NEWS (National Early Warning Scoring System)	31	53	58.5%	80.0%	No
Fire Safety 1 year	28	53	52.8%	80.0%	No
Conflict Resolution Advanced	20	53	37.7%	80.0%	No

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

In urgent and emergency care the 80% target was not met for seven of the 21 mandatory training modules for which medical staff were eligible. The 95% target was not met for Information Governance.

The mandatory training was comprehensive and met the needs of patients and staff. Training was mainly delivered as e-learning, but staff were required to attend one face-to-face training day which covered topics such as basic life support, manual handling and infection prevention and control. The e-learning modules included topics such as female genital mutilation, child sexual exploitation, modern slavery and PREVENT (awareness of people drawn into terrorism).

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Training was included in the mandatory training modules all staff were required to complete. In addition, additional training was arranged by a neighbouring mental health care trust to support staff looking after people with mental health needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance data was monitored and held centrally by the trust training centre. Monthly updates sent by the training department highlighted those that were due to complete mandatory training. There was a practice educator who monitored compliance and encouraged staff to book courses in advance before compliance had expired. There was a plan to give staff one day of protected study time to complete mandatory training as it was not realistic for staff to find time to complete their e-learning in working hours. The responsibility for attending and completing training was held jointly by the individual.

## 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. However, completion rates for level 3 safeguarding children training did not meet trust targets or comply with national guidance and had not improved since our last inspection in 2018.

### Safeguarding training completion rates

Staff received training specific for their role on how to recognise and report abuse. However, not all staff had completed the safeguarding training required of their role. Neither nursing nor medical staff completion rates met the trust's completion target for safeguarding children (Level 3) or comply with national guidance: Safeguarding children and young people: Roles and Competencies for Healthcare Staff (2019).

The trust set a target of 90% for completion of child safeguarding training and 80% for adult safeguarding and PREVENT training.

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses 22 November 2018 to 21 November 2019 for registered nursing staff in urgent and emergency care is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	316	338	93.5%	90.0%	Yes
Safeguarding Children (Level 2)	314	336	93.5%	90.0%	Yes
Safeguarding Adults (Level 1)	312	338	92.3%	80.0%	Yes
Preventing Radicalisation - Prevent Awareness - No Specified Renewal	13	15	86.7%	80.0%	Yes
Preventing Radicalisation - Basic Prevent Awareness - 3 Years	139	162	85.8%	80.0%	Yes
Safeguarding Adults (Level 2)	286	338	84.6%	80.0%	Yes
Safeguarding Children (Level 3)	154	206	74.8%	90.0%	No

In urgent and emergency care the safeguarding targets were met for six of the seven safeguarding training modules for which registered nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from 22 November 2018 to 21 November 2019 for medical staff in urgent and emergency care is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	80	90	88.9%	80.0%	Yes
Preventing Radicalisation - Basic Prevent Awareness - 3 Years	38	45	84.4%	80.0%	Yes
Safeguarding Adults (Level 2)	72	90	80.0%	80.0%	Yes

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	78	90	86.7%	90.0%	No
Safeguarding Children (Level 2)	78	90	86.7%	90.0%	No
Safeguarding Children (Level 3)	32	54	59.3%	90.0%	No

In urgent and emergency care the safeguarding targets were met for three of the six safeguarding training modules for which medical staff were eligible.

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

Following the inspection, we asked for more up-to-date training compliance data. This showed compliance with safeguarding children (level 3) was 59.26% (February 2020).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with, knew the signs and symptoms that may indicate a person was being abused and knew how to raise concerns.

Staff were aware of signs and symptoms of abuse in adults, including domestic abuse. Clinicians triaged patients separately from their next of kin so patients could share sensitive information. Staff used specific screening processes in line with national guidance (Domestic Abuse, Stalking and Honour-based Violence (DASH), to identify patients at risk.

All children presenting to the emergency department (ED) were checked against the National Child Protection Register, and staff were alerted if concerns had been raised previously. Reception staff highlighted this on the electronic patient record. It was also highlighted if a child had social worker involvement and meant a health visitor or school nurse referral would be made.

There was a senior nurse who was the lead for children's safeguarding; however, they only had one day a month to carry out the additional duties and tasks associated with this role, including support and training of staff. Staff had access to a paediatrician with safeguarding expertise 24 hours a day. Staff could contact a registrar or paediatric consultant in the children's unit if required. There were processes to escalate safeguarding concerns if parents left the children's emergency department without their child being seen by a medical professional.

The emergency department had seen an increase in young people who had suffered injury related to 'county lines' incidents (a term used to describe when drug gangs from big cities expand their operations to smaller towns). Additional training had been given to staff to raise awareness. This meant when young people with suspicious injuries were admitted, additional questions were asked to help protect and safeguard these young people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding referrals were made on an electronic system and ensured all internal and external partners were aware of the referral. All referrals were logged to enable an audit of safeguarding referrals made. If staff recognised or suspected incidents of female genital mutilation (FGM), this was incident reported and reported to the trust's safeguarding team.

Staff followed safe procedures for children visiting the department. For example, children waited in a separate waiting area and there was a rule that hot drinks were not allowed to be consumed in the children's department.

## Cleanliness, infection control and hygiene

**The service did not control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean, but records did not always provide assurance of this.**

All areas of the emergency department were visibly clean and had suitable furnishings which were clean and well-maintained. The service recognised crowding in the department could impact on cleaning and had added this to the departmental risk register. We checked for dust in high to reach areas and found these were dust free. In the resuscitation bay, boxes were stored directly on the floor, meaning it was difficult to ensure effective cleaning of floor areas. This was because of insufficient storage facilities. However, we looked at a displayed cleaning audit in the majors area from February to December 2019 and found cleanliness was scored at 97% to 99%. These results were based on 55 audits of which two audits had failed to meet standards. Cleaning was outsourced to an external company and the emergency department had two cleaners in the department during daytime hours every day. Overnight the cleaning responsibilities fell on nursing staff although they could call a cleaning team if deep cleaning was required.

The hospital generally performed well for cleanliness. In a patient-led assessment of the care environment (PLACE) audit 2019, the trust scored 94.4% for cleanliness, although this was below the national average of 98.6%. It was not possible to see audits results broken down into individual departments.

Staff mostly cleaned equipment after patient contact but did not always label equipment to show when it was last cleaned. The turnover of patients was sometimes so high that cleaning of cubicles in the resuscitation bay was not always completed before the next patient was admitted. This was a recognised risk and added to the department's risk register (risk ID 2042) in January 2018. The risk had been regularly reviewed. However, we saw staff cleaned equipment used to obtain vital signs most of the time.

Cleaning records were up-to-date and demonstrated that some areas were cleaned regularly. However, cleaning records were not consistently displayed in patient toilets, which meant the public could not be assured the toilet facilities were cleaned regularly. Most patient/public toilets we checked looked clean, but some had paper and litter on the floor. We checked two commodes in the sluice in majors, which were both clean. However, there was inconsistent use of green "I am clean" stickers to demonstrate equipment had been cleaned, which included commodes.

Most staff followed infection control principles, including the use of personal protective equipment (PPE). Most staff were bare below the elbows in line with national guidelines, but we noted one doctor wearing a cardigan with rolled up sleeves while delivering patient care and treatment and one staff member wore nail varnish while on duty. This was not in line with trust policy (Dress and Personal Appearance policy). We observed most staff washing their hands in line with national guidance. However, we saw both medical and nursing staff leave a patient cubicle without decontaminating or washing their hands. In the resuscitation bay, access to one of the hand washing basins was obstructed by chairs and equipment, making it difficult for staff to wash their hands following care and treatment interventions, as required in line with national guidance.

We observed staff wearing gloves when they were engaged with care or treatment procedures where this was required. The service audited compliance with use of personal protective equipment and data showed 100% compliance between June and December 2019. However, we did not observe many staff use an apron unless care interventional procedures were carried out, such as catheterisation. The use of aprons protects health care workers against contamination from patients and to reduce the risk of spreading infections.

Following the inspection, we asked for hand hygiene audits to review compliance. The service carried out hand hygiene audits and the audits for the urgent care centre (January 2020) and for the emergency department (February 2020) were shared with us. However, the results of audits did not form part of the quality dashboard or the 'matron's audit'. We were therefore not assured of effective oversight of hand hygiene compliance.

There were not always effective processes to manage infection risks for patients who presented with known or suspected communicable diseases. The emergency department had one isolation room. However, processes to identify patients with infectious conditions were not always adequate. We observed one patient who had confirmed influenza, who was nursed in the majors area on a trolley in the corridor. The patient was transferred to the medical expected unit without highlighting the infection risk. When we spoke with staff about the processes, they stated there had been a breakdown in communication between nursing and medical staff on this occasion, as nursing staff were not aware the patient had confirmed influenza before transferring them to the ward. We reviewed minutes of a band 7 nurse meeting from January 2020, and found a similar episode was raised for discussion. We were not therefore assured effective actions had been taken to address the concerns raised.

The emergency department had implemented national guidance for possible outbreak of a high-profile infection. Policies and procedures were implemented to reduce the risk of possible spread of infection by minimising the contact, advising people to 'self-quarantine' and processing samples in line with national guidance. Staff were informed of updates daily and/or if the advice changed.

## **Environment and equipment**

**The design and use of facilities did not keep people safe. The emergency department was not big enough and was not designed to meet the increased number of attendances. However, facilities and equipment were well maintained, and staff managed clinical waste well.**

The design of the environment was largely in line with national guidance, Health Building Note: 15-01 (2013), although demand had outgrown the size of the department. It was recognised the department was not big enough to accommodate increasing attendance. Some of the national standards were not met. For example, 'grab boards' (a board at the head of patient trolleys which has emergency airway equipment for easy reach in emergencies) did not have 'shadows' of small items of equipment in line with national guidance. There was a plan to build new facilities and senior staff had been involved with the design of the new department. The building work was scheduled to be completed by 2023.

The area used for 'fit to sit' patients referred to as 'majors chairs' had not been modified since it was introduced in November 2019. The area used to be part of the waiting area for all self-presenting patients. There was direct access from outside and it also included the receptionist area. It meant the environment was cold and draughty and there was little confidentiality of initial assessments.

There was a separate entrance designated for ambulance arrivals, which ensured easy access to the majors area and the resuscitation bay. This was protected from rain by a canopy for offloading patients from ambulances. There was a helipad to enable air ambulances to land for transfer of seriously ill patients to the emergency department.

There was a fully equipped four bed resuscitation area, with a designated paediatric bay. Equipment was suitable for patients, including children. None of the cubicles in the majors department were identified as a 'step down' area, enabling close monitoring of patients that had been transferred from the resuscitation area and in the event of the resuscitation area being full.

There was a separate children's emergency department (ED) with a separate waiting room for children and their parents. When the child was booked in at the main reception, they entered the children's waiting room through a secure door with only swipe card access. There was no receptionist dedicated to this area and children were not under constant observation by staff. There was one security (CCTV) camera which was managed by the security team in the hospital. It was recognised there was a blind spot which could not be seen unless staff were in the waiting room. Staff were aware of this and checked the waiting room regularly. This had been entered onto the department's risk register. In mitigation, there was a door bell parents could ring if they were concerned about their child while they were waiting, if no staff were available or present in the waiting area.

Staff had access to most equipment needed to look after sick children. We noted there was no weighing equipment to weigh babies' nappies to gain information about sick babies' urine output.

In the urgent care centre (UCC), there were nine cubicles for patient assessment, which were uncluttered and appeared visibly clean and dust-free. There was one waiting room with a small children's play area in one corner, but this was not separated from the main waiting room.

The observation unit was geographically separated from the emergency department and could only be accessed through the surgical assessment unit. Patients with mental health needs were taken to the observation unit for assessment as this was where the mental health assessment rooms were located. Staff were keen to stress the observation unit was not solely for patients experiencing mental health crisis. It was also used for patients who were not acutely ill but were awaiting blood results or needing further observation before it was safe to discharge them. The ratio of patients with mental health needs and other patients was about 50/50.

There were two mental health assessment rooms located in the observation unit, which were used to conduct mental health assessments. These were arranged and furnished to meet national safety standards recommended by the Psychiatric Liaison Accreditation Network (PLAN). There were no blind spots or ligature points. The rooms had viewing panels and were well lit. There was no alarm call point in the assessment room, as recommended by the PLAN. However, staff told us they carried personal alarms with them at all times. The room was minimally furnished and had one long heavy chair which could not be picked up and used as a missile or barricade. The room had two doors which opened outwards, as recommended by PLAN. There was only one security camera in the observation unit, but staff told us they had a close working relationship with security staff who visited the unit regularly and responded quickly to personal alarm calls.

Patients could reach call bells and staff responded quickly when called. Patients in cubicles had call bells if they needed assistance or if they felt they were deteriorating or in pain. There was an electronic sign above the nurses' station which alerted staff to which cubicle the call bell was ringing from. This was an effective visual aid to promote patient safety and to ensure call bells were answered in a timely manner. However, patients on trolleys did not have call bells and had to rely on the ability to catch someone's attention.

Staff mostly carried out daily safety checks of specialist equipment but the records to demonstrate checks had taken place were not consistent and did not provide assurance that

equipment was accessible and fit for purpose. We raised this as a concern at our last inspection in 2018 and served a requirement notice. During this inspection we found the emergency equipment, including defibrillators in the resuscitation area, had not been checked daily. Records showed daily checks had not been completed on seven days between 28 December 2019 and 11 February 2020. The checklist they used did not provide effective assurance essential equipment was checked daily. We raised this with the ward manager during our inspection, who changed the processes to be consistent with other areas of the department. This meant the checklist was more concise. The service audited compliance with checking of the resuscitation trolley daily checks but this was not consistently completed. The matrons audit demonstrated 100% in August, September and November 2019 but compliance was not audited in June, July and December 2019.

The service had enough suitable equipment to help them to safely care for patients. There was an equipment department within the trust which managed medical equipment. Electronic databases held records of all equipment assets held by the equipment department. The data base set out records of maintenance programmes for all equipment. However, we found not all equipment displayed when it was last serviced. We checked five electronic pieces of equipment and found two of these were not labelled to show a service date. Staff were aware of actions to take if equipment was not working as it was intended. These actions included taking the piece of equipment out of action, labelling it and informing the equipment department.

We checked randomly picked consumables in all areas and found these were in date and in sealed packaging. Staff told us they had enough medical devices to provide treatment.

Staff disposed of clinical waste safely. Staff separated waste in accordance with trust policies. Sharp bins were not over filled and were closed when not in use.

## **Assessing and responding to patient risk**

**The service did not meet national targets in respect of ambulance handover or time to initial assessment.** However, staff identified and quickly acted upon patients at risk of deterioration. We observed unwell patients were quickly identified and received prompt attention.

There was a standard operating procedure (Initial Triage and investigations (SOP) v1.3 December 2019) which set out roles and responsibilities when patients presented to the emergency department, either self-presenting or brought by ambulance.

All self-presenting patients had an initial assessment, risks were prioritised, and actions taken. Self-presenting patients arrived at a reception desk in a main waiting room. Once patients' basic details had been entered on a computer system, patients were either asked to go to the urgent treatment centre (UCC) or asked to take a seat in what was known as 'majors chairs'. This concept, referred to as reverse streaming, was introduced in November 2019.

It was not clear who had the authority to make the decision to re-direct patients to UCC and there was no standard operating procedure/guidance to support staff. We observed receptionists re-directing patients and asked what criteria they used to make these decisions. They told us there was a list of presenting symptoms which prompted them to ask patients to remain in the emergency department. We asked for the list, but the document provided was not dated and staff were not certain it was not the most up-to-date list. The list included some medical jargon, which receptionists were unable to explain when asked. This was not in line with the emergency department's SOP (December 2019) or national guidance (Royal College of Emergency Medicine: Initial assessment of emergency department patients, 2017), which states "streaming should always be performed by a trained clinician" to ensure patients are directed to the correct

service and the correct person to manage their clinical needs. However, receptionists told us they asked the triage nurse allocated to the area to review patients if they were in doubt.

Staff completed risk assessments for each patient on arrival, using nationally recognised tools to identify deteriorating patients of all ages including children. Patients were seen by a triage nurse who carried out an initial review promptly once referred to the 'majors chairs. They took their vital observations and a brief outline of the symptoms that had brought them to the department. They arranged further tests such as electrocardiogram (ECG) and blood tests and prioritised the order in which patients were seen by a doctor, based on their presenting symptoms. Some patients received treatment, such as intravenous fluids or antibiotics while in this area. During week days a consultant was assigned to manage 'fit to sit' patients. During weekends, the emergency physician in charge (EPIC) had overall responsibility for clinical decisions made about 'fit to sit' patients.

Patients who were referred to the urgent care centre (UCC) were triaged promptly by a nurse. If staff felt patients were not safe to be seen in UCC they would refer them back to majors. Patients who needed an x-ray also had to go back to the ED for x-ray before returning to UCC for ongoing treatment. Staff told us UCC had not received any complaints about patients moving between UCC and the ED. We were told safety standards and practices to meet Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) had just been agreed and emergency nurse practitioners were in the process of completing IR(ME)R training. At the time of our inspection there were no IT facilities to review x-rays using a picture archiving system (PAC's), in UCC.

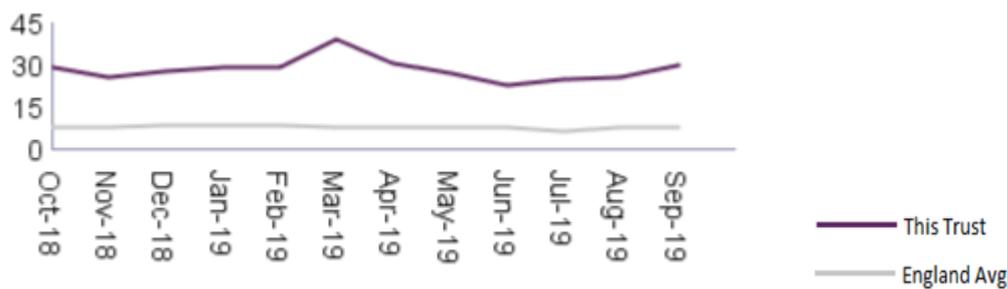
Staff recognised and acted when patients deteriorated suddenly. We observed a patient admitted to the resuscitation bay who appeared to have deteriorated. Staff took immediate action to monitor, assess and treat possible causes.

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

The trust monitored the time from the patient's arrival to initial assessment against the national standard of 15 minutes. The median time from arrival to initial assessment was worse than the overall England median from October 2018 to September 2019. Following our last inspection, we served a requirement notice to ensure patients received initial assessment within 15 minutes. However, this data related to a period prior to the implementation of 'reverse streaming' of patients in November 2019, to reduce the operational pressure on the emergency department. Following the implementation of reverse streaming, time to initial assessment had improved from 28% of patients receiving an initial assessment within 15 minutes (March 2019) to 82% in the week commencing 19 January 2020.

Following our inspection, we asked for data to demonstrate the difference the actions taken had made to ensure the national target was met. Data shared by the trust demonstrated an average of 32% of patients were assessed within 15 minutes between April and December 2019. However, in January and February 2020, this had increased to 70.15% and 76.15% respectively. This data demonstrated an improvement from our last inspection where the median time from arrival to initial assessment within 15 minutes was 48% to 60%.

### **Ambulance – Time to initial assessment from October 2018 to September 2019**



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

Patients arriving by ambulance were not always handed over to hospital staff within national target times. There is a national government standard which requires that emergency department staff should always accept handover of ambulance-borne patients within 15 minutes of arrival. The time to assessment for patients queueing in all corridor areas was mostly managed, with delays to handovers caused by the volume of patients. If patients were queueing in corridors and there were delays in handing over patients to hospital staff, the ambulance service provided a hospital ambulance liaison officer (known as a HALO) who would maintain clinical supremacy for ambulance patients even though they had been booked in.

Ambulance staff we spoke with, were positive about the patient handover process to emergency department staff and told us staff were efficient in taking handovers, which minimised the time they spent in the department. Once capacity in the majors area had been reached including an agreed number of trolley spaces in the corridor, patients remained in the back of ambulances under the care of ambulance crews until space could be freed up in the department.

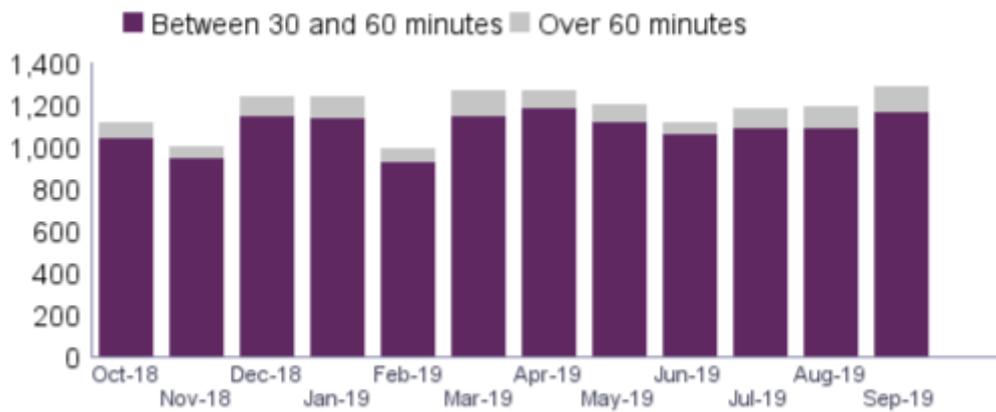
Staff used an informal triage system to prioritise patients for treatment, depending on how unwell they were. This included the monitoring of patients' vital signs. Staff did not use any formal/national guidance, such as 'Rapid Assessment and Treatment' models but decisions were generally based on "nurse's discretion" This meant there were limited criteria to help triage nurses make a judgment on the severity of the complaint patients presented with. However, in the children's emergency department, staff used the paediatric early warning score (PEWS) to help them decide on prioritisation of further assessment and treatment by medical staff.

The service monitored and audited the median time to initial assessment. From November 2018 to October 2019, the median time to initial assessment for all patients arriving in the emergency department (including self-presenting patients), averaged at 23 minutes. In the Urgent Care Centre, the median waiting time averaged at 24 minutes in the same period.

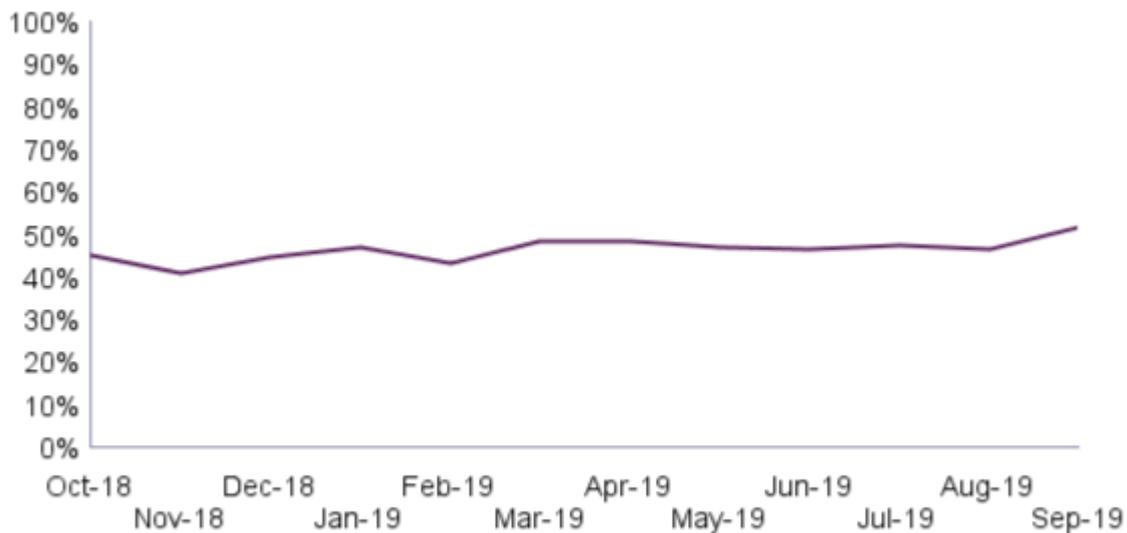
### **Percentage of ambulance journeys with turnaround times over 30 minutes**

From October 2018 to September 2019, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Great Western Hospital.

### **Ambulance: Number of journeys with turnaround times over 30 minutes - Great Western Hospital**



**Ambulance: Percentage of journeys with turnaround times over 30 minutes**

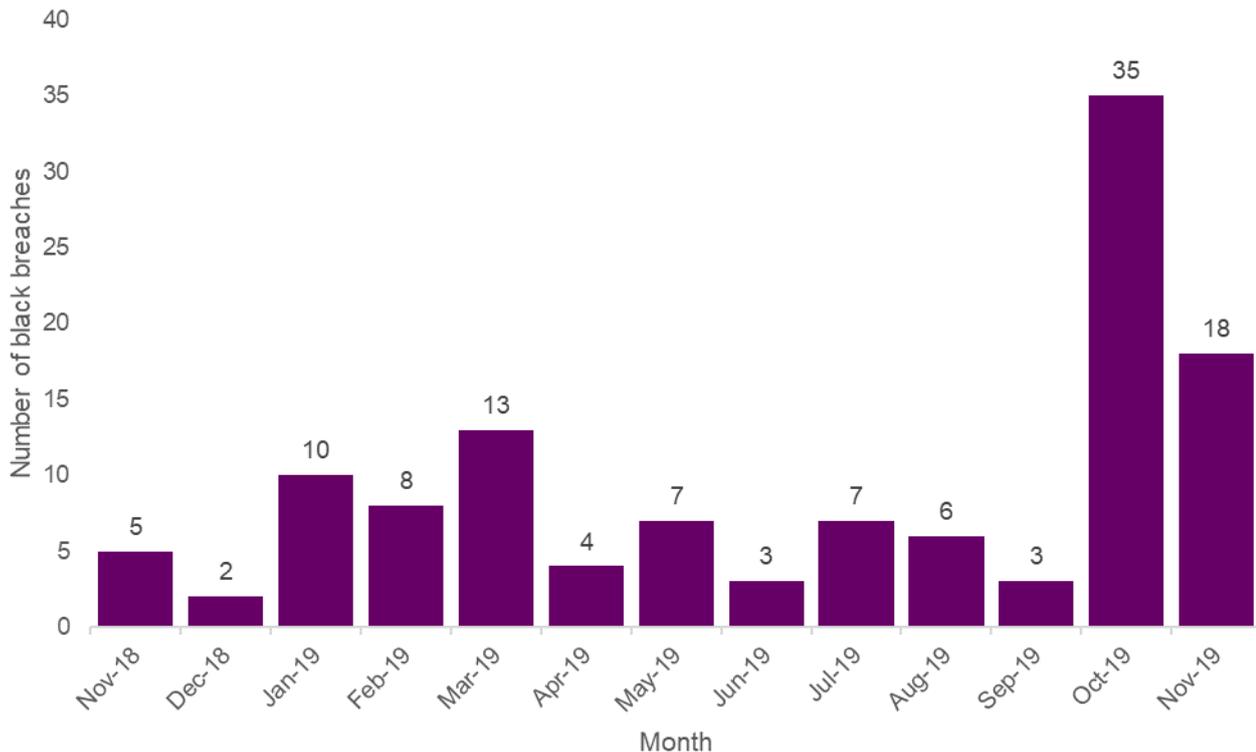


*(Source: National Ambulance Information Group)*

Ambulance turnaround times had slightly deteriorated since our last inspection, but attendances had also increased.

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From 29 October 2018 to 10 November 2019 the trust reported 121 “black breaches”.



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

Staff followed safe processes when anticipated emergencies arrived in the department. Emergency alerts to the department were identified by a 'red phone' system. When an emergency patient was due to arrive, a call ahead was received from the ambulance or air ambulance service. The estimated time of arrival was announced to ensure the correct healthcare professionals were ready to meet the patient and initiate immediate assessment and treatment.

Staff completed an 'emergency department patient safety checklist' (known as the SHINE document) for all patients admitted to the majors area, majors' chairs or the resuscitation bay. The safety checklist included risk assessments such as pressure ulcer risk assessment, mental health assessment, falls assessment and manual handling risk assessment. The checklist was used to document observation of vital signs had been completed, 'sepsis 6' delivered, ECG obtained and reviewed for patients presenting with chest pain, and refreshments offered. However, data from the department's 'quality dashboard' demonstrated vital observations were not always completed on arrival and repeated hourly, pain assessment and management were not always achieved in a timely manner (December 2019) and recording of ECG when patient presented with chest pain was not always completed within ten minutes. However, this was an improving picture.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. The national early warning score (NEWS) and paediatric early warning score (PEWS) are tools based on a scoring system reviewing six physiological measurements. These observations were documented electronically using hand held devices which also alerted staff to when the observations were next due to be checked. The electronic records were compatible with inpatient wards. If patients were transferred to another hospital, staff printed off relevant patient care records to go with the patient. Medical staff could view observations on a central monitor at all times. We reviewed 14 paper-based patient records, which confirmed most patients had their observations taken at least every hour during the first four hours they were in the department.

However, staff did not always document actions taken in response to the observations, such as escalation to medical staff or when decisions were made to stop regular neurological observations. The matron carried out quality audits, including the completion of patient records and escalation of deteriorating patients. We reviewed the results from February 2019 to January 2020: The audits consisted of 19 measures audited in 59 records (Jan 2020) to 81 records (July 2019). Results showed mostly compliance (scoring over 80% compliant) from July 2019 to January 2020.

In December 2019: Amber rated (compliance 50-79%) in eight measures:

- Vital signs recording on admission: measured = 64% and recorded = 64%
- Hourly vital signs measured 64% and recorded hourly 67%.
- Vital signs recorded and measured was amber rated in June, August, September, October and December 2019.
- ECG recorded within 10 minutes of arrival in patients presenting with chest pain was compliant in three months, amber in seven months and red in February and March 2019 where only 47% had their ECG recorded within 10 minutes. However, compliance (>80%) was recorded for all 12 months for ECG reviewed by doctor within 30 minutes of ECG but it not stated if results were obtained within 10 minutes of arrival.

There was no policy or guidance on how to manage a patient who stayed in the department for more than four hours. There was therefore no guidance for staff to ensure additional timely risk assessments were carried out and that patients' usual medicines were prescribed. Medical staff retained clinical responsibility for the care and treatment of patients while they remained in the emergency department. There were often long delays before speciality doctors reviewed patients in the department, which led to potential delays in additional patient assessments.

There was a risk, patients could develop pressure damage to their skin and underlying structures when they remained on a trolley for a prolonged period. Staff completed risk assessments for developing pressure area damage, but we did not see that patients were transferred to beds when they stayed in the department for more than four hours. However, audits confirmed there were no hospital acquired category 2,3 or 4 pressure ulcers in the emergency department between August 2019 and January 2020. We discussed this with senior leaders who told us due to crowding in the department it was not always possible to provide beds for patients.

Staff in the observation unit used an 'emergency department and observation unit pathway' which included risk assessments for mental and physical health needs, as well as a plan of interventions to be implemented. This also included intentional care rounds to ensure patients' needs were assessed and met at least every two hours.

Staff working in the emergency department had training in clinical holding (use of restrictive physical interventions that enable staff to effectively assess or deliver clinical care and treatment to individuals who are unable to comply). However, if a patient became violent, they contacted the hospital's security team. The hospital security team received training on restraint. This covered non-restrictive restraint, low level and personal intervention and physical restraint. During our last inspection, staff working in the observation unit did not feel appropriately supported in terms of skill mix, training and security. During this inspection, staff stated this had much improved. There were processes to ensure staff were supervised until they felt confident to work in the observation unit and more training was delivered. Staff had access to mental health professionals and worked well with the trust's security team which made them feel safe at work.

Staff knew about and dealt with any specific risk issues. Staff were knowledgeable about the signs

and symptoms of sepsis. They used a sepsis pathway to screen patients and escalate if treatment or review was required. Data from a monthly audit demonstrated 100% compliance between December 2018 to December 2019 except in two months: June 2019 = 80% and 0% was recorded for November 2019.

Staff had access to mental health liaison and specialist mental health support if they were concerned about a patient's mental health, 22 hours a day. Mental health liaison and specialist support was delivered by staff employed by a neighbouring NHS mental health trust and based in an office on the observation unit. Patients who had come in to the emergency department following an overdose were initially treated for their physical symptoms before having a mental health assessment. Staff used a recognised mental health assessment tool to assess patients presenting with mental health symptoms or conditions.

In the children's emergency department, staff could call the paediatric liaison team and the local children and adolescent mental health team (CAMHS) during the day for support or the on-call psychiatrist out of hours. Staff were able to adapt one of the rooms, so it became ligature free.

Staff said the mental health liaison team was very responsive and would usually arrive to assess patient within the hour, or within a target of four hours. If a young person between the ages of 16 to 18 were admitted, they contacted the local CAMHS team, but staff said they would not normally arrive until the next day. Children were transferred to the children's unit until they could be assessed. The team also had support from the local mental health trust's crisis team.

During our inspection, we spoke with one patient who had been admitted for three days on the observation unit. The patient had been kept safe during this time and had been allocated a registered mental health nurse on a one to one basis. However, the patient had experienced delays in their mental health assessment, such as Mental Health Act Assessment.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff used a mental health assessment tool to identify patients who were at high risk and arranged additional staff to provide one-to-one observation if this was required. If children or young people were in a crisis they would be admitted to the children's unit under the care of paediatric medical staff and be assessed by child and adolescent mental health services, the following day. Children were not admitted to the observation unit in line with standard operational procedures. Admission of adolescents were discussed on an individual basis. If children were required to spend a prolonged time in the children's department, staff arranged for a registered mental health nurse to provide one-to-one support and care for the child.

Staff in the observation unit used a 'close support' observation proforma to document observations when patients with mental health needs required one-to-one care. The document consisted of 15 different measures, which each had four written statements to choose from. Staff completed this once an hour and added up the score/risks. At the end of 24 hours, the recorded scores contributed to decisions about further one-to-one care based on the overall risk. The measures included general mood, likelihood of self-harm, violence and aggression and absconding. This risk assessment was used alongside a 'close support care plan' which provided a plan of care for patients who required close monitoring and extended to physical needs as well as mental health needs. There was a ligature risk assessment which was completed to ensure all ligature risks were removed if patients were admitted who were at risk of self-harm.

There was a "missing patient" risk assessment which assessed the response when a person absconded from the department. The risks assessed included 11 measures which had answered assigned to a certain value. Staff calculated the combined risk total and followed guidance

regarding an appropriate response, such as contacting the police.

Staff used a physical restraint checklist when it was necessary to restrain patients in the emergency department. The checklist prompted staff to ensure vital signs were taken and recorded every two minutes and after the restraint had been lifted. It also prompted staff to report the incident on the electronic incident reporting system. Staff had not received training in how to restrain people, so security were called if restraint was required.

The emergency department was not classified as a 'healthcare-based place of safety' for Section 136 patients. A Section 136 is part of the Mental Health Act and used by police to remove someone from a public place to a designated place of safety. However, if a patient was detained under a Section 136 and needed urgent medical assessment, they could be transferred and cared for in the emergency department. If a patient arrived under a Section 136, two accompanying police officers remained with the patient until the section expired.

Staff mostly shared key information to keep patients safe when handing over their care to others. Nurses escorted patients to inpatient wards and handed over to ward-based nurses. There was no discharge documentation from the emergency department, instead staff used photocopied paper-based patient records from the department. Staff involved the psychiatry team in discharge planning for a person with a mental health need and ensured the patient's GP was also provided with a copy of the discharge summary.

Shift changes and handovers included all necessary key information to keep patients safe. There was a formal handover and safety briefing twice a day. This was followed by a nurse to nurse handover of patients delegated to their care. Medical staff held handovers three times a day, also attended by the nurse-in-charge. This handover was held in a registrars' training room, away from the clinical area. This meant confidentiality was maintained and offered a teaching opportunity for staff. Each morning there was a 'bubble' meeting following the trust-wide bed meeting, to share information about internal and external operational pressures and included a member of the ambulance service.

### **Emergency Department Survey 2018 – Type 1 A&E departments**

The trust scored about the same as other trusts for all the five Emergency Department Survey questions relevant to safety.

<b>Question</b>	<b>Trust score</b>	<b>RAG</b>
Q5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.8	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.1	About the same as other trusts
Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.6	About the same as other trusts
Q33. In your opinion, how clean was the A&E department?	8.5	About the same as other trusts
Q34. While you were in A&E, did you feel threatened by other patients or visitors?	9.7	About the same as other trusts

*(Source: Emergency Department Survey 2018)*

## **Nurse staffing**

**There were not enough paediatric nurses employed to meet national guidance. However, in the adult emergency department there were enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service had enough nursing and support staff to keep patients safe. Leaders had submitted a business case in October/November 2019 to increase the number of nurses on each shift by three additional registered nurses. This was because of increased attendances and to trial out a new system of managing crowding in the department. This meant, there was one nurse to four or five patients allocated to cubicles. There were six additional agreed trolley spaces around the nurses' station and one registered nurse was delegated to look after these six patients. To help with basic nursing care, an additional two healthcare assistants had been agreed and funded. In the resuscitation area, there were two nurses allocated to the four patient bays. However, due to the complexity of patients admitted to this area, two nurses could be insufficient to meet the demands of safe care. The nurse-in-charge monitored this closely and moved staff from other areas to help if this was required and if possible.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The nursing staffing establishment (September 2019) was set at 94.21 whole time equivalent (WTE) and the actual staffing levels were 79.59 WTE. This meant there was a vacancy rate of 16% for registered nurses. It was difficult to recruit to vacant positions due to national shortages of nursing staff. Skill mix and staffing establishment were reviewed every six months and this was next due to be reviewed in March/April 2020.

The urgent care centre (UCC) was fully staffed with no vacancies at the time of our inspection. Staffing consisted of a mixture of registered nurses, emergency nurse practitioners (senior nurses with advanced skills), paramedics and healthcare assistants. At the time of our inspection, there were nine Band 7 staff and eight Band 6 staff. With the closure of the Walk-in Centre, an additional nine practitioners would be relocated to work in UCC.

There were two registered nurses (triage) allocated to carry out an initial assessment and to monitor 'fit to sit' patients in the area referred to as majors' chairs. In addition, two healthcare assistants were allocated to majors chairs area to support the nurses and medical staff. At times when the department was busy, this nurse could be looking after up to 15 patients, some of which could be quite poorly. These patients were too unwell to be referred to the urgent care centre. In addition, there were two healthcare assistants allocated to support care and treatment of this patient group. However, if nurses escalated concerns these were responded to by medical staff promptly.

Skill mix in the children's emergency department (ED) did not meet national recommendation (Facing the Future: Standards for children in emergency settings (2018) standard10). There were only two registered children's nurses employed in the department when national recommendations stated there should be two registered children's nurses on each shift. To help mitigate this, the department was working with the children's unit to introduce rotational posts for registered children's nurses to work in children's ED. Adult-trained nurses, with an interest in paediatric nursing, were rostered to work in children's ED and some had completed an additional qualification to transfer adult nursing skills to children. The service had also recruited two further

children’s nurses who were due to start in March and June 2020. We checked nursing rotas which demonstrated there were sufficient staff with children’s resuscitation skills rostered to work in the children’s department.

During busy times, it was difficult for staff to keep up with nursing tasks, such as taking vital observations or providing pain relief. In the children’s emergency department (ED), there were two registered nurses and one healthcare assistant (HCA) rostered to work during daytime hours. Overnight the children’s ED was closed, and all children were seen in the major’s area. There were busy times such as after school/late afternoon when the number of children in the department was frequently up to 30 children of which some could be very unwell. To mitigate this, additional staff were pulled into the children’s ED if staff escalated concerns or if triage times were not met.

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at trust level compared to the trust’s targets, where applicable:

<b>Urgent and emergency care annual staffing metrics</b>							
October 2018 – September 2019					November 2018 – October 2019		
<b>Staff group</b>	<b>Annual average establishment</b>	<b>Annual vacancy rate</b>	<b>Annual turnover rate</b>	<b>Annual sickness rate</b>	<b>Annual bank hours (% of available hours)</b>	<b>Annual agency hours (% of available hours)</b>	<b>Annual unfilled hours (% of available hours)</b>
<b>Target</b>		8%	13%	3.5%			
<b>All staff</b>	347	10%	16%	4.4%			
<b>Qualified nurses</b>	181	19%	13%	4.4%	15,866 (5%)	86,870 (25%)	9,682 (3%)

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)*

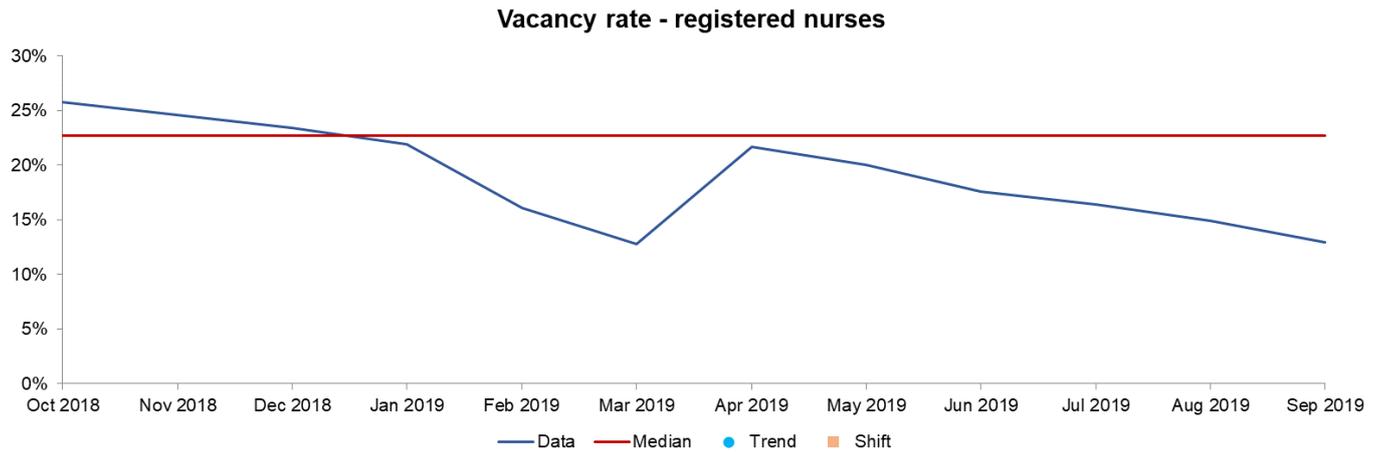
The ward manager could adjust staffing levels daily according to the needs of patients. The emergency department used bank staff whenever possible and offered a financial incentive for bank staff to work in the department. This was to help bring down the usage of agency nurses which was a high financial burden,

The actual number of nurses and healthcare assistants matched the planned numbers during our inspection. Staffing levels were displayed in the emergency department and during our inspection the planned numbers of registered nurses (19) matched the actual number. Staffing levels were reviewed throughout the day and reported to the trust wide bed management team at each meeting. Staff escalated if there were gaps to the ward manager and the matron. There was a staff social media group where staff shortages were announced to staff if they felt they had capacity to cover additional shifts.

Nurse staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use.

### **Vacancy rates**

The service had low and reducing vacancy rates.

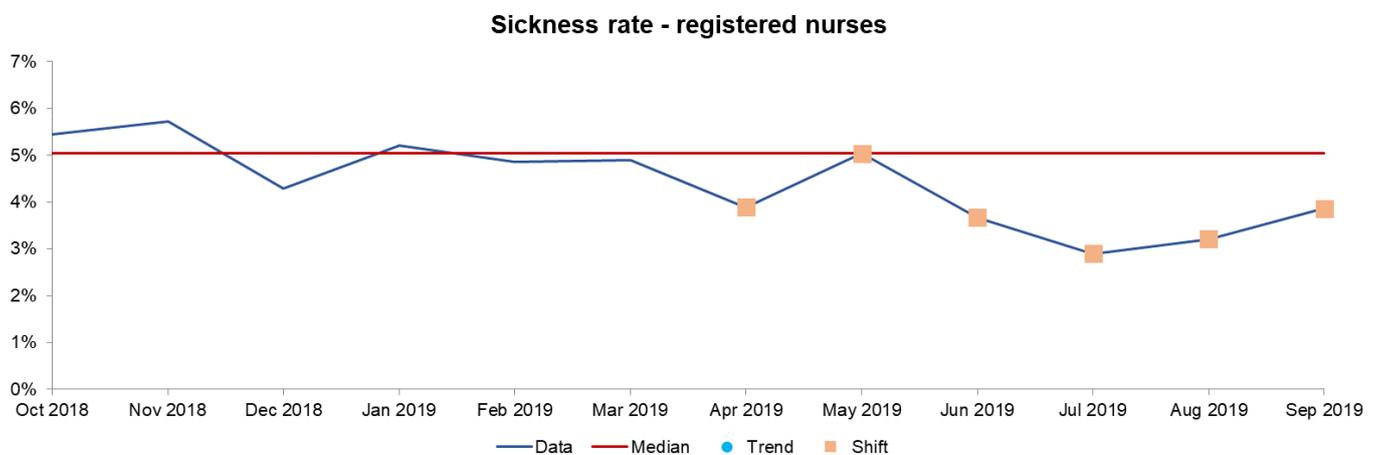


Monthly vacancy rates over the last 12 months for registered nurses were not stable and may be subject to ongoing change.

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

### Sickness rates

The service had low sickness rates.

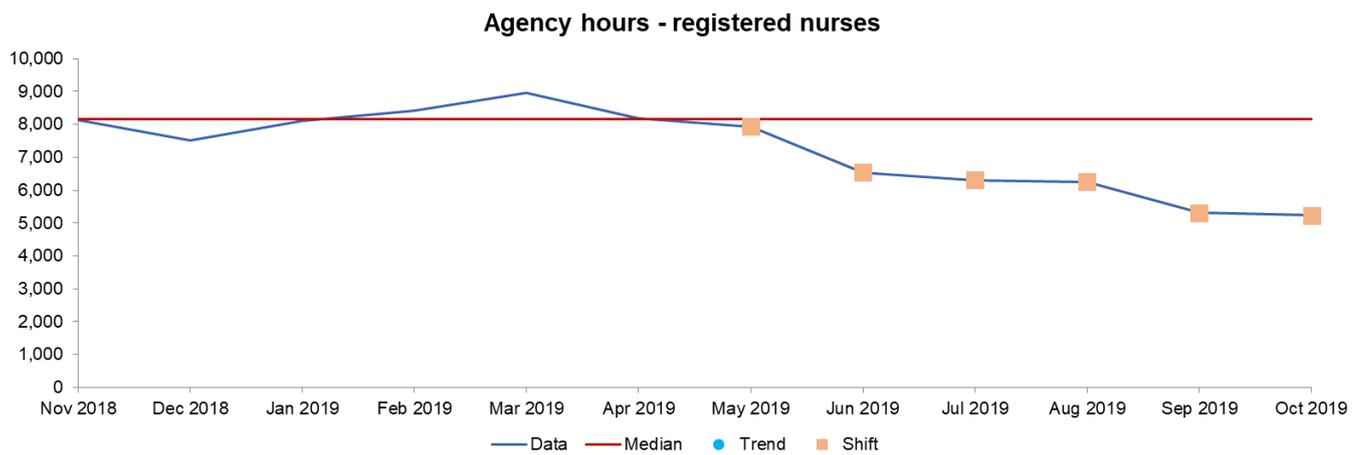


Monthly sickness rates over the last 12 months for registered nurses showed a downward shift from October 2018 to September 2019.

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

### Agency staff usage

The service had reducing rates of bank and agency nurses.



Monthly agency usage over the last 12 months for registered nurses showed a downward shift from May 2019 to October 2019.

*(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*

Managers limited their use of bank and agency staff and requested staff familiar with the service. The trust offered a financial incentive to substantive staff to work additional hours as ‘bank hours’ to help reduce the use of agency staff with associated costs.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff completed an induction pack, which was signed and sent to the ‘bank office’ who held all employment documentation for bank and agency staff. Staff told us most agency staff were known to the department and worked regularly in the department.

## Medical staffing

**The adult emergency department had enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, there was not a paediatric emergency medicine consultant to provide clinical leadership in the children’s emergency department. There was no medical cover for the urgent care centre at the time of our inspection.**

The service had enough medical staff to keep patients safe but there were vacancies in medical staffing. Leaders told us the trust was struggling to appoint to middle grade medical roles. The service used locum staff to ensure medical staffing levels were adequate to provide safe care.

There was a consultant lead in the department every day, known as the emergency physician in charge (EPIC) and who provided professional and clinical leadership. The service had increased senior medical cover at night up to two registrars to enhance senior decision making out of hours. However, there were no clear criteria when to call the on call consultants into the department for example, if there was a trauma patient or a deteriorating child.

Junior doctors felt well supported by middle grade staff and consultants. However, junior doctors were rostered to work a shift from 6pm to 4am, which they did not feel was safe and described it as “dangerous”. They were concerned about driving home at 4am after a busy shift. This had been raised with the deanery as a concern by the junior doctors working in the department, but a solution had not been found so they continued to cover this shift.

In the observation unit, there was a named consultant and senior doctor to cover each day. Once the daily ward round had been completed, the consultant supported the EPIC in majors.

There were no medical staff assigned to support staff working in the urgent care centre (UCC). If staff were concerned or needed advice, they phoned the EPIC in emergency department. There was a plan to recruit a GP to work alongside staff in UCC in the future. Funding had been secured but they had not yet been able to recruit to this post. There was no medical cover rostered to work in UCC until a permanent solution was implemented, even though a gap had been identified. This was identified as a risk on the UCC risk register.

There was a consultant with a special interest in paediatrics working as the paediatric lead, but there was no paediatric emergency medicine (PEM) consultant (who had undertaken specialist training in paediatric emergency medicine). This was not in line with national guidance: Facing the Future: Standards for children in emergency settings (2018) standard 9. We were told the trust was actively recruiting a PEM consultant. A consultant covered the children's emergency department (ED) Monday to Friday from 8am to 4pm and at weekends as a trial. However, staff told us there was a surge in attendance in late afternoon on most days which meant there was no planned consultant cover during the anticipated busiest time in the children's ED. A foundation year 2 (FY2) doctor was allocated to work in the children's emergency department every day from 12 noon to 10pm and a second registrar employed at night started their shift in the children's area, clearing any queue there as a priority. All junior doctors were encouraged to discuss all patients (including paediatric patients) with a consultant before discharging them.

The table below shows a summary of the medical staffing metrics in urgent and emergency care compared to the trust's targets, where applicable:

Urgent and emergency care annual staffing metrics							
October 2018 – September 2019					November 2018 – October 2019		
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
<b>Target</b>		8%	13%	3.5%			
<b>All staff</b>	347	10%	16%	4.4%			
<b>Medical staff</b>	44	2%	19%	1.2%	5,682 (6%)	2,578 (3%)	12,478 (13%)

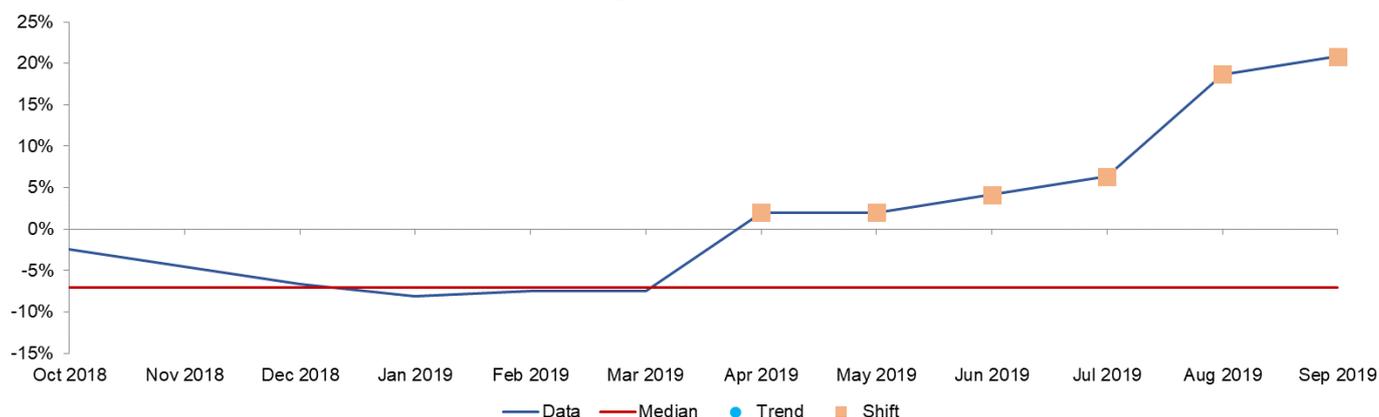
*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)*

The medical staff matched the planned number. Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use or agency use.

### Vacancy rates

The service had an increasing vacancy rates for medical staff.

### Vacancy rate - medical staff



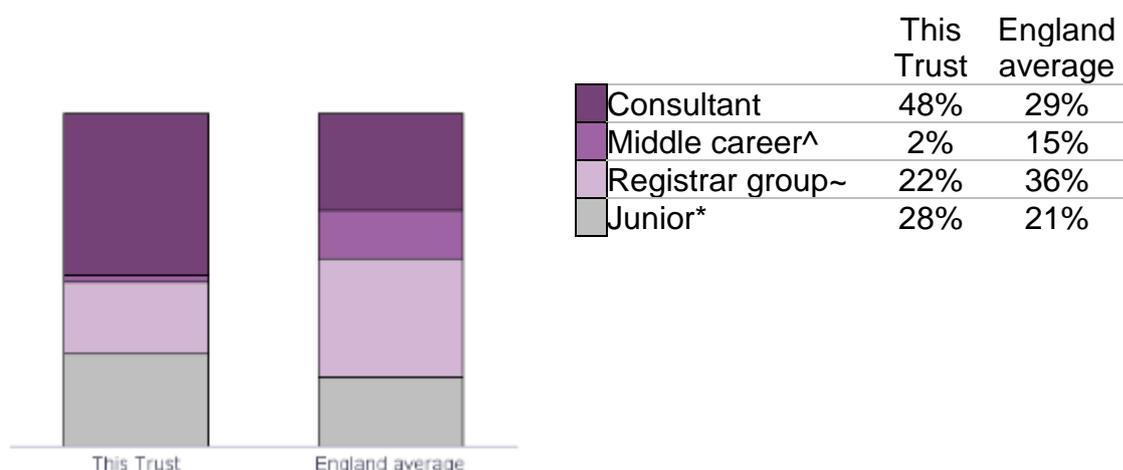
Monthly vacancy rates over the last 12 months for medical staff showed an upward shift from April 2019 to September 2019.

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

### Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In August 2019, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was higher than the England average.

### Staffing skill mix for the 25 whole time equivalent staff working in urgent and emergency care at Great Western Hospitals NHS Foundation Trust.



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

\* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

### Bank and locum staff usage

The service used bank or agency staff to fill unfilled shifts as far as possible. Managers could mostly access locums when they needed additional medical staff. From January 2019 to

December 2019, the trust reported 833 medical staff shifts in urgent and emergency care were filled by bank staff, while 584 shifts were filled by locum staff. However, 216 shifts for medical staff were not filled by either bank or locum staff to cover staff absence.

The service always had a consultant on call during evenings and weekends. Consultants stayed in the department until 10pm and were then on call overnight. They lived locally and could attend within 30 minutes as per guidance,

## Records

**Nursing documentation was not always completed in full and storage of records was not always managed effectively. Medical staff did not record when they had offered advice to patients seen in the urgent care centre although they had electronic access to their records.**

Patients' notes were mostly well completed and were legible, signed and dated. Paper-based patient records consisted of the so-called CAS card (the booking documentation with additional space for brief notes) and an 'emergency department safety check list ('SHINE' document). This was a patient record used to document care given each hour, for example monitoring of vital observations and pressure ulcer assessment. There was also additional opportunity to document any additional nursing interventions, such as escalation of deteriorating vital signs. Medical staff completed electronic patient records. We reviewed 14 records and found information was not recorded in three records to consistently demonstrate care and observations were always completed in a timely manner. For example, the 'SHINE' document required staff to complete vital observations every hour for the first four hours. We found in one set of notes that no documentation, including vital observations, had been completed for one patient from their admission at 3.28am until 7.45 am. However, when checking this on the electronic e-obs system, observations had been monitored during this time. This was not in line with how the documentation tool had been designed and should be used.

The information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. The department used paper care nursing records, which were scanned into an electronic system when the patient was transferred to the ward or discharged. The paper records were photocopied and transferred with the patient to the admitting ward. In the urgent care centre, practitioners undertook a peer review of each other's documentation in patient care records. The aim was to peer review three patient records per month using a standard template to ensure consistency of reviews and to provide quality assurance.

Although risk assessments were carried out, staff did not consistently document when actions had been taken. For example, in one set of patient records we reviewed, neurological assessments were not completed after the patient had been in the department for more than four hours. It was not clear when and why the neurological assessments had been stopped. In another set of patient records, a box was ticked to say, 'the national early warning score (NEWS) was greater than five or Glasgow coma score less than 14 and that this had been escalated'. However, there was no documentation of who this had been escalated to and when checking against the electronic observation record, we found the NEWS score was one and no neurological assessment had been carried out.

Paper-based CAS cards were stored in a divider by the nurses' station, away from immediate access by unauthorised people. The emergency department safety checklist was stored by the patients' trolley which could be in a holder in a cubicle or on the top of the nurses' station for

those patients on additional trolleys. It was important this document was easily available for staff to document care completed.

Staff in the urgent care centre documented when they had telephoned the emergency physician in charge (EPIC) in majors, for help and advice. However, the EPIC did not document in electronic paper records when they had given advice about patient treatment; this was recorded by the nurse in receipt of the advice. We suggested this should be recorded by the clinician giving the advice for clarity.

Access to electronic care records was secure with a 'tap-on tap-off' system which allowed staff to log in and out of electronic records quickly and easily.

## **Medicines**

**Medicines were prescribed, administered and recorded in line with national guidance within the department. However, there was no formal process to ensure patients who remained in the department for longer than four hours, were prescribed and given their usual medicines. There was a recognised risk that the systems used could lead to duplication of prescribing and administering medicines to patients who were admitted to inpatient wards.**

Medicines were mostly prescribed, administered and recorded in line with national guidance but there were a risk patients' usual medicines could be missed. Staff reviewed and administered patients' usual medicines if they remained in the emergency department for longer than expected hours. However, there was no process to ensure this was completed. Medical staff wrote a temporary prescription for medicines to be administered in ED before patients were transferred to inpatient wards. Inpatient wards used electronic medicines prescribing and there was a risk of duplication of administering of medicines as two separate systems were used because medical staff in ED did not have access to the electronic prescribing system. This was recognised as a risk and added to the emergency department's risk register (risk 2056) in February 2018 and regularly reviewed to review actions taken. There was a plan to provide access for medical staff to the electronic prescribing system when patients stayed in the department for longer than expected hours.

There were no specific training or competency assessment for nurses working in the children's ED to ensure safe children's medicine management, including medicines administered intravenously. Staff told us they learnt by working alongside experience nurses.

If patients were prescribed and given rapid tranquillisation, this was administered safely and in line with national guidance (National Institute for Health and Care Excellence (NICE), 2015). Rapid Tranquillisation is defined by NICE guidance as the administration of a medicine by injection when a person needs to be urgently sedated to reduce risk to themselves or others. There was a local policy providing guidance for staff in how to administer these medicines. Staff told us rapid tranquilisation was rarely used in the emergency department or the observation unit.

Staff mostly stored and managed medicines in line with the provider's policy and national guidance. Medicines, including intravenous fluids, were stored securely in a locked cupboard to ensure only authorised people had access to these. Controlled drugs were stored securely and managed appropriately. Regular balance checks were performed in line with trust policy.

Emergency medicines were stored in tamper-evident containers which were in date. However, in the resuscitation bay, we found the cupboards were not always locked and some intravenous fluids were stored on a trolley. There were staff always present which minimised the risk that medicines and intravenous fluids could be tampered with. However, we found two boxes of injectable medicines which were out of date in the resuscitation bay. We also noted portable oxygen cylinders were stored on the floor next to crates designed for safe storage, in both the emergency department and the resuscitation bay.

Fridge temperatures were not always recorded daily in the resuscitation area. We saw multiple gaps in recording of the fridge temperature. For example, the fridge temperatures were not checked on eight days in January 2020 and four days in February 2020. In December 2019, the fridge temperatures were not recorded on nine days and the maximum temperature was recorded as outside of the range (two to eight degrees) on nine of the days the fridge temperatures were recorded. Actions to escalate when maximum temperatures exceeded the reference guide, were not documented. We asked if this had been escalated but we were not given a clear answer. This meant we were not assured medicines were always stored at the correct temperature.

Prescription stationery (FP10 forms) was stored securely. Staff told us they rarely used FP10 forms to write medicine prescriptions for patients to take away. Prescription stationery was stored securely and there were processes to ensure documentation met auditing standards.

Nursing and paramedic staff in the urgent care centre were able to give certain medicines following a 'patient group direction' (PGD) and there was a procedure to review them. Staff required to administer medicines using a PDG received training in how to do this safely. PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines in the absence of a written prescription. Nurses and paramedics administered medicines under PGD using a designated local form designed to document the medicine administered. The form required two signatures and the name and dosage of the medicine administered under the PGD. The form was then scanned into the patient's electronic care records.

We found one PDG which had expired but this was removed after our inspectors raised this with the deputy pharmacist. Some PDGs were inherited from a previous provider, which ran the UCC until 2016. Some PGDs had their expiry date extended but we found that not all PDGs had been reviewed in a timely manner. There were processes to review PDGs regularly by the hospital pharmacy service. There were also processes to ensure the PDGs were read and signed as required by staff using these when administering medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were aware of examples of learning from incidents relating to medicines incidents. For example, medicines with similar names were stored in separate drawers in the urgent care centre following a significant event.

There were no arrangements for regular clinical pharmacist visits for the emergency department, but staff had access to emergency medicines from a robot, on-call pharmacist or an intranet medicines tracker.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. If a patient arrived in the emergency department

whilst dependent on drugs or alcohol, staff would admit them over night if they were unwell due to withdrawal. Staff otherwise offered patients a pathway in terms of local support and advice.

## Incidents

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

All staff knew what incidents to report and how to report them. Staff were familiar with the incident reporting system and were confident in raising concerns and reporting incidents and near misses in line with trust policy.

## Never events

The service had no 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. The trust did not report any never events in urgent and emergency from November 2018 to October 2019.

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

## Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in urgent and emergency care, which met the reporting criteria set by NHS England November 2018 to October 2019

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	5	62.5%
Medication incident meeting SI criteria	2	25.0%
Pressure ulcer meeting SI criteria	1	12.5%
<b>Total</b>	<b>8</b>	<b>100.0%</b>

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

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. 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. We reviewed investigations into serious incidents and noted duty of candour actions was identified, including the sharing of the investigation report. However, we reviewed three 72-hour reports and although the template prompted staff to apply duty of candour, staff did not always document if duty of candour had been applied or the reasons why not if this was the case.

Staff received feedback from investigation of incidents. Staff met to discuss the feedback and look at improvements to patient care. Immediate feedback from incidents was shared in twice daily safety briefs and incidents were discussed in monthly clinical governance meetings. Minutes of these meetings were available for staff to review if they had not been able to attend. When we asked staff about learning from incidents, we were given examples, such as providing additional teaching for staff.

There was evidence changes had been made as a result of feedback. For example, in the urgent care centre (UCC), the storage of medicines with similar names had been reviewed to ensure the wrong medicines were not given in error, following a serious incident in the department.

Leaders investigated incidents but had not all received training to do so. Senior staff told us the trust had stopped delivering this training for a period, but it had now been re-instated. Relevant staff had been booked onto this training over the next few months. We reviewed investigations into two serious incidents. These were reviewed in line with national guidance: NHS Improvement: Serious Incident Framework, 2015. Senior staff carried out an initial 72-hour investigation report to identify immediate service issues for correction. This was then followed by an in-depth root cause analysis which focussed on the relevant issues pertinent to the incident reported. Actions for learning were identified and action plans developed and included who was responsible for completing the actions and a target date to do so.

Managers debriefed and supported staff after any serious incident. Senior staff and leaders organised debriefing sessions following significant events and could include input from a clinical psychologist. Training for senior staff was being implemented to support colleagues following significant events. The trust was investing in trauma risk management (TRiM training) for senior staff to support all staff who may have experienced significant events with the potential cause a post-traumatic experience for those involved.

## **Safety thermometer**

There was limited safety thermometer data collected and this was not displayed. The safety thermometer is primarily aimed at acute/general wards rather than emergency departments.

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.

## Is the service effective?

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice although we were not assured clinical pathways were always reviewed and kept-up-to-date. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.**

Staff followed care pathways to plan and deliver high quality care according to best practice and national guidance. However, we were not assured these were always reviewed to ensure they were current and in line with up-to-date evidence-based guidelines. Staff followed specific pathways relevant to different specialties. There were programmes of clinical audit to review compliance with standards and identify areas for improvement. However, we noted some care pathways were not dated, version-controlled, referenced against national evidence-based guidance and did not have review dates. This meant it was not always clear if they were based on latest evidence-based guidance. For example, the ED stroke thrombolysis proforma was issued March 2014 and the transient ischaemic attack (TIA) clerking proforma did not have a date indicating when it was last reviewed. The National Institute of Health and Care Excellence (NICE) published guidelines: Stroke and transient ischaemic attack in over 16s: diagnosis and initial management (NG128) in May 2019. There was no evidence that the ED care pathways had been reviewed to ensure it provided current and up-to-date information for staff to follow.

We reviewed the provision of paediatric care against the Facing the Future: Standards for paediatric care (2018). These standards aim to ensure urgent and emergency care is fully integrated to deliver care that ensure children are seen by the right people, at the right place and in the right setting. We explored compliance during our inspection and found some evidence the service was fully or partly compliant with 43 of 67 standards. The gaps we identified related to staffing, skill mix and competence training/post graduate qualifications and sub-speciality competent consultants.

Staff protected the rights of patients' subject to the Mental Health Act and followed the Code of Practice. Staff working in the emergency department contacted their mental health lead consultant to make sure their policies were up to date with best practice.

Staff followed specific pathways to support patients who, for example, had overdosed on paracetamol. Senior nurses and consultants disseminated best practice within the teams during team meetings and handovers.

### Nutrition and hydration

**Patients did not routinely have access to water and some patients felt dehydrated. However, patients were provided with food and drink when they stayed in the department for a prolonged period.**

Staff worked to ensure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed volunteers carry out tea rounds and offered biscuits to patients in the department if their medical condition allowed them to eat and drink. The service had increased the number of healthcare assistants employed on each shift to support patients with their needs, including nutrition and hydration. There were water fountains in the department

and staff provided patients with drinks when they requested them. However, patients were not routinely provided with a jug of water and there were no tables to allow patients to store drinks so they could reach them. Some patients told us they would like a drink of water.

Audit results between February 2019 and January 2020, showed refreshments were offered within two hours of admission. The audit demonstrated above 96% compliance.

During our last inspection in 2018, we raised the lack of hot meal as a service improvement recommendation. We found staff had worked to improve access to food and drink when they stayed in the department for more than four hours. Hot soup was now available twice a day in addition to sandwiches and crisps/snacks.

### **Emergency Department Survey 2018 – Type 1 A&E departments**

In the CQC Emergency Department Survey, the trust scored 6.7 for the question “Were you able to get suitable food or drinks when you were in A&E?”. This was about the same as other trusts.

*(Source: Emergency Department Survey 2018)*

Staff completed patient’s fluid charts where needed. If patients were receiving intravenous fluids this was recorded on a fluid chart.

### **Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, they did not always use suitable pain assessment tools for children or those unable to communicate. Patients received pain relief to ease pain when they needed it.**

Staff assessed patient’s pain but did not always use a recognised tool. They gave pain relief in line with individual needs and best practice. Staff used a standard pain scoring tool asking adult patients to rate pain on a scale from zero to 10. We did not observe them using specific tools designed to assess pain in babies, children or adults with limited or no communication, although these tools were available. When we asked, staff told us “nurses just make an assessment”. We were therefore not assured staff used effective tools or documentation to reflect pain assessment in babies, young children and adults with limited communication.

A documentation audit carried out showed amber compliance (between 50% and 79%) with hourly pain assessment in February 2019 to June 2019.

Patients received pain relief soon after requesting it. Patient group directions were available for staff triaging children to ensure they received pain relief within 20 minutes of arrival in the department in line with national guidance (Facing the future: Standards for Children’s emergency Care (2018): Standard 23). However, we were not assured pain levels were re-assessed and acted upon within 60 minutes in accordance with national guidance. We did not see re-assessment had been documented in children and young people’s care records to assess if the pain relief had been effective.

Staff prescribed, administered and recorded pain relief accurately. During our inspection, patients told us staff asked them regularly if they were in pain and pain relief was given promptly if patients asked for this. We did not see any children complaining about pain or crying and only one adult complained about pain or discomfort from spending prolonged time on a trolley in the department.

### **Emergency Department Survey 2018 – Type 1 A&E departments**

In the CQC Emergency Department Survey, the trust scored 7.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

*(Source: Emergency Department Survey 2018)*

### **Patient outcomes**

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

The service participated in relevant national clinical audits. Outcomes for patients were similar to other NHS trusts when benchmarked against national standards. The emergency department regularly submitted data to the Royal College of Emergency Medicine (RCEM) national audits. The focus of the national audits changes each year. During 2017/18, the audits concerned patients admitted with a broken hip (neck of femur), procedural sedation and pain management in children.

#### **Royal College of Emergency Medicine (RCEM) Audit: Fractured neck of femur 2017/18**

Fundamental standards for patients with a broken hip were not meeting targets and the results were the same as or worse than the national median average. The fractured neck of femur audit was based on 38 patient records reviewed. Data showed:

- Standard 1: Patients had their pain assessed within 15 minutes of arrival to the department. This was a ‘fundamental’ standard (standard one) which meant all patients with a fractured neck of femur should have their pain assessed within 15 minutes of arrival in the department. The audit result demonstrated only 15% had their pain assessed within 15 minutes against a national median average of 29% and against an expectation of the Royal College of a 100% compliance rate.
- In the other fundamental standard (2c), patients in severe pain receiving analgesia within 60 minutes of arrival, the trust scored 44% and better than the national mean average, against an expectation of 100%. The national median average was 30%. The audit was based on 100 patients.

#### **RCEM Audit: Procedural sedation 2017/18:**

Performance against fundamental standards for patients needing procedural sedation, was better than the national average. This audit related to safety standards for patients undergoing procedures under sedation in the emergency department. The expectation was all audits should score 100%. The audit was based on 50 patient records and demonstrated results above the England average. However, the aspirational target was not achieved in any of the five fundamental standards.

- Standard 1: Patients undergoing procedural sedations in ED should have documented evidence of pre-procedural assessment: the trust demonstrated 52% compliance and better when compared with the national median average (34%).
- Standard 3: Procedural sedation should take place in a resuscitation room: the service demonstrated 100% compliance and better than the national median average (93%).
- Standard 4: Procedural sedations required the presence of a doctor, a second doctor, emergency nurse practitioner or an advance nurse practitioner and another nurse: The serviced demonstrated compliance of 56% and better when compared to the national median average (46%).
- Standard 5: Monitoring during procedural sedation must be documented to have included all four parameters stated: the service demonstrated 70% compliance which was better than the national median average (44%).
- Standard 8: Following procedural sedation, patients should only be discharged after documentation of formal assessment of suitability of four measures. The service demonstrated 100% compliance across all four standards and was better than the national median average (compliance between 37.5% and 63.6% across the four measures).

However, during our inspection we observed that patients were not always offered procedural sedation when potentially painful interventions were carried out. There were no policy or standard operating procedures to support staff when patients required sedation for procedures. We observed a patient having a fractured wrist re-aligned without the use of sedation but with the use of pain relief and medical gasses. We spoke with medical staff who had assessed the patient was not suitable for procedural sedation because of their comorbidities. Staff explained the decision was largely depending on the consultant who was overseeing the procedure. It meant there was not a consistent approach in line with national guidance, regarding who were offered procedural sedation, which medicines were used and guidance regarding the monitoring during and following the sedation.

#### **RCEM audit: Pain in Children 2017/18:**

The trust did not meet all fundamental standards for managing pain in children. The Pain in children audit was based on 89 records.

- Standard 1: Pain is assessed within 15 minutes of arrival. The service demonstrated compliance of 22%, which was slightly worse than the national median average 29%. The expectation was 100%.
- Standard 3: Patients with moderate pain should receive appropriate analgesia in accordance with local guidance within 20 minutes. The service demonstrated 100% compliance against a national median average of 26% and all patients (100%) with moderate pain received pain relief within 60 minutes against a national median average of 40%.

There were five standards for which the department had not submitted any data. These standards related to meeting standards for children with severe or moderate pain.

We discussed this with audit leads who told us they had adopted a new methodology to capture validated data for national audits. It was possible that the 89 records did not capture children in severe pain, but staff felt assured pain was managed well in both children and adults.

We reviewed and discussed the results of the Royal College of Emergency Medicine for Sepsis (2016/17) and asked audit leads about any actions taken as a result. The audit demonstrated poor compliance in four of 13 measures. The audit lead explained there had been a lack of validation of the audit data and they had changed the process for this to ensure better and validated data was submitted. The department had completed an internal re-audit of the same data set, to gain internal assurance the poor compliance was correctly attributed to poor data validation and not because of poor quality of care and treatment. The re-audit demonstrated results were above the England average in all but one measure and the standard was achieved in eight of 21 measures re-audited,

### Trauma Audit and Research Network (TARN)

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

<b>Metrics (Audit measures)</b>	<b>Hospital performance</b>	<b>Audit Rating</b>	<b>Met national standard?</b>
<b>Case Ascertainment</b> <i>(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</i>	64.9 – 74.1%	-	Did not meet
<b>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</b> <i>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</i>	59 mins	Takes longer than the TARN aggregate	Did not meet
<b>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</b> <i>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</i>	75.0%	Lower than the TARN aggregate	N/A
<b>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care</b> <i>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</i>	57.1%	Higher than the TARN aggregate	Did not meet
<b>Risk-adjusted in-hospital survival rate following injury</b> <i>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</i>	1.5 additional survivors	Similar to expected	Met

(Source: TARN)

Managers and staff used audit results to improve patient outcomes. There was a designated lead for the trauma audit, and they were looking into patient cases where the targets were not met, to identify learning. Data was entered by the trauma team which was separate from the emergency department. We were told the department had engaged in peer review arrangements within the trauma network. The audit lead explained the audit was based on a relatively small number of patients which can skew the compliance percentage. However, one of the outcomes of the audit was a review of policy and access to computerised tomography (CT) scan out of hours which could cause a delay.

Staff followed evidence-based guidance when treating people who presented with severe or life-threatening conditions. For example, if a patient was brought to the department with a suspected stroke, the ambulance crew took the patient straight to the computerised-tomography (CT) scanner before admitting the patient to the resuscitation bay. Data from the Sentinel Stroke National Audit programme (SSNAP) July 2019 to September 2019, demonstrated the trust achieved a B rating (second highest) for compliance with domain one: scanning within one hour of arrival to hospital. However, the trust scored a D (second worst) for patients receiving thrombolysis (clot busting medical treatment) within one hour of admission to hospital. During day time hours, speciality consultants were called to the emergency department to perform thrombolysis but out of hours and overnight, staff called the ED consultant on call who attended the department to perform thrombolysis.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an audit programme providing an overview of audits carried out to support the delivery quality and sustainable services. Audits were completed and benchmarked against compliance with national guidelines or national targets. Where improvements were required to meet national standards, there was an action plan with a target and a lead appointed to ensure actions were carried out. The audit programme demonstrated re-audits were carried out to re-examine results. Some audits were submitted for a peer review process with another NHS hospital. This provided some external scrutiny of audit results.

Managers shared and made sure staff understood information from the audits. Information from clinical audits was discussed in a monthly clinical governance meeting for the emergency department. All staff were invited to attend, and information was shared about compliance, actions taken and changes to how care and treatment was delivered if applicable.

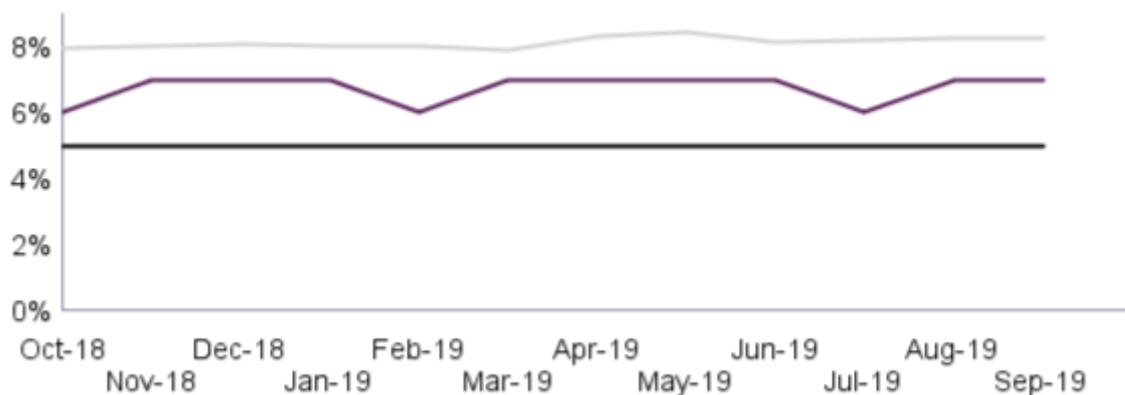
### **Unplanned re-attendance rate within seven days**

The service had a lower than expected risk of re-attendance than the England average.

From October 2018 and September 2019, the trust's unplanned re-attendance rate to ED within seven days was worse than the national standard of 5% and better the England average.

### **Unplanned re-attendance rate within seven days -**

— This Trust — England Avg. — Standard



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

## Competent staff

### Managers appraised staff's work performance and provided support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of adult patients. There was a plan to ensure all staff had completed the required competencies for their role. However, we were not assured the service had the overview of who had completed which competencies. Senior nursing staff and the practice educator were working to introduce a National Curriculum and Competency Framework Emergency Nursing (Royal College of Nursing, 2017) for all staff. This programme of training would follow the induction programme for new staff to promote safe working practices from competent staff.

Staff working in the urgent care centre (UCC) had completed some extended competencies developed internally and some had completed a post-graduate course: 'Minor injury and minor illness in children', at a nearby university. Competencies were achieved through peer training and signed off by the practice educator. However, not all staff held a non-medical prescribers' qualification (about 50%) and no staff were authorised to order diagnostic tests such as x-rays. There was no medical cover rostered to UCC. This meant there was a risk to delay in diagnostic testing and prescription of medicines which could impact on patient experience and efficiency of the department.

Staff working in the observation unit had not all received 'break-away' training, although conflict resolution was included in their mandatory training. Staff were not trained in how to restrain people at risk of harming themselves or others but had received training in clinical holding. If a patient became violent, they contacted the hospital's security team who had received training on restraint including non-restrictive restraint, low level and personal intervention and physical restraint

Specific training on mental health was not mandatory for staff. However, mental health leads within the trust provided bespoke training for staff as and when it was required. For example, the psychiatric liaison service attended the emergency department to train new staff. They would join the team to conduct patient reviews and shadow new staff to ensure they were following the correct pathways for supporting people with mental health needs. There were two band 5 nurses who had a special interest in mental health and children and adolescent mental health services (CAMHS). The trust was in the process of developing a mental health lead nurse role.

Staff were not rostered to work in the observation unit until they had worked in the emergency department for a minimum of six months. Staff would work shadow shifts in the observation unit and work shifts supported by the unit's mental health lead before being rostered to work in the unit independently.

### Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers supported staff to develop and staff were encouraged to undertake further training and development to support their role in the department.

From 12 November 2018 to 13 November 2019, 86.3% of staff within urgent and emergency care received an appraisal compared to a trust target of 80%. However, the trust target was not met for medical staff.

Staff group	12 November 2018 to 13 November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Allied Health Professionals	10	10	100.0%	80.0%	Yes
Additional Clinical Services	84	92	91.3%	80.0%	Yes
Administrative and Clerical	26	30	86.7%	80.0%	Yes
Nursing and Midwifery Registered	150	175	85.7%	80.0%	Yes
Medical and Dental	33	44	75.0%	80.0%	No

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. There was a range of opportunities for staff to receive supervision. There were senior nurse meetings, divisional ward managers meetings, and team huddles. Leaders operated an 'open-door policy', encouraging staff all levels to seek advice and/or discuss any concerns they had.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors felt well supported by consultants and registrars in the department. They had access to educational supervision and were given study leave. The junior doctors could book one-to-one sessions with consultants to ensure assessments and other training objectives were met. With the new concept of reverse streaming of patients, junior doctors did not have access to experience of working in a minors area and the learning and training opportunity this offered. However, overnight the urgent care centre was not operational, so junior doctors had some limited opportunity to treat patients who presented with minor complaints. There was also a plan to roster junior doctors to work in the urgent care centre under supervision to ensure their training needs were met.

The clinical practice educators supported the learning and development needs of staff. There was one clinical practice educator/lead who had some protected hours each week to support training and development of staff. They felt valued and enjoyed the role and had vision of further developing competency assessment and compliance with national standards. However, it was a

lot of work for one member of staff and they had suggested another person was assigned to this role on a part-time basis.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. All staff were invited to monthly clinical governance meetings and these were held on different days of the week to ensure staff with additional set commitments could attend some meetings. The meetings were recorded, and minutes were shared with staff.

Managers made sure staff received any specialist training for their role. Registered nurses could apply to complete post graduate courses at nearby universities to enhance their knowledge and skills of working.

Managers identified poor staff performance promptly and supported staff to improve. Leaders managed poor performance and worked with the trust's human resource department when and if further support was required to manage performance issues.

Managers recruited, trained and supported volunteers to support patients in the service. There was a volunteer present in the emergency department during day time hours Monday to Friday. They supported staff and patients and carried out regular 'drink trolley' rounds to ensure patients were offered regular refreshments.

## **Multidisciplinary working**

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

Staff worked across health care disciplines and with other agencies when required to care for patients. There were close and effective working relationships between staff and other disciplines, such as the mental health liaison team and the security team based in the hospital. We spoke with a stroke specialist nurse who reported good working relationships with staff in the urgent and emergency care department.

Staff worked with paediatric medical staff when children who were seriously ill or had suffered a trauma attended the emergency department. Some staff described the relationship with the paediatric medical staff as "trick", but the department worked to improve working relationships by arranging joint monthly meetings. The children's lead nurse stated the emergency department had good working relationships with the children's unit and with paediatric consultants.

Allied health professionals worked alongside staff in the emergency department to provide 'front door' physiotherapy. There was a physiotherapist and an occupational therapist rostered to work in the department to identify patients who may not need to be admitted to hospital. They worked in the department every day between 8am and 6pm to support patients and staff. They used a frailty scoring tool to help them assess risks. If patients needed to be admitted, there was a short-term frailty unit in the hospital where patients were referred to if appropriate. Data demonstrated the front door therapy team achieved an average of 260 of admission avoidance each month between April and December 2019. This equated to an average of 88% of medically fit patients were discharged by the team and therefore avoiding admission.

There was a trust-wide sepsis and acute kidney injury (AKI) team who staff could contact for additional support to manage patients with sepsis (a potential life-threatening condition caused by the body's response to an infection) or AKI. The nurse-in-charge in this team received a 'sepsis' alert from the electronic system used to record patients' vital observation. This alerted them to ensure patients were assessed by a doctor so timely treatment could be given. This helped ensure patients with suspected or confirmed sepsis received the right care at the right time.

Volunteers worked in the emergency department every day Monday to Friday. Staff said the volunteers were very helpful and could help them to ensure patients were offered hot drinks and could assist patients to eat and drink when this was necessary or required.

There was no play specialist employed in the department. National guidance: Royal College of Paediatrics and Child Health: Facing the Future: Standards for children in emergency care settings (2018: Standard 5 state all emergency departments that treat children must employ a play specialist.

The local 'children and adolescent mental health team' (CAMHS) team rang the emergency department and mental health liaison team every day to check if there were any patients (children or young adults) with a mental health need.

The adult emergency department had a good working relationship with the mental health liaison team and found them to be very responsive when they needed support.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff in the emergency departments completed a 'red, amber and green' (RAG) rated triage mental health risk assessment. They also completed an assessment form if the patient had self-harmed. Patient identified with high risks and mental health were transferred to the Observation Unit. The department also had observation bays opposite the nurse's station and filled out hourly observation sheets if the observation unit was full. We reviewed three mental health patient records during the inspection. All three records had a RAG rated mental health risk assessment and summaries.

## **Seven-day services**

### **Key services were mostly available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. There was a small x-ray department adjacent to the emergency department. This provided access to two plain film x-rays rooms and one computerised tomography (CT) scanner. Medical staff could request x-ray 24 hours a day and the CT scanner was operational between 8am and 8pm.

Consultants led daily ward rounds on the observation unit daily, including weekends. This ensured their ongoing health needs were reviewed and actions taken to discharge patients if they no longer needed to stay in hospital.

## **Health promotion**

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

The service had relevant information promoting healthy lifestyles and support. Staff gave patients advice about how to manage conditions when this was required and pertinent to the presenting condition that brought them into hospital. There were leaflets available to patients regarding a range of medical conditions and healthy living advice such as smoking cessation.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff spoke confidently about assessing people's mental capacity. There was a proforma template to guide staff through the two-stage process when assessing patients' capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff obtained verbal consent to carry out care and treatment procedures where written consent was not required. Consent to treatment was recorded in the three files we reviewed during the inspection, for patients admitted with mental health needs.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. There was a 'best interest decision record' which staff used to ensure all relevant aspects of making a best interest decision had been explored, acted upon and documented. Staff we asked, were confident in discussing the processes of best interest decisions.

Staff made sure patients consented to treatment based on all the information available. The team received support from the on-call psychiatrist if they admitted a patient who was detained under the Mental Health Act or needed support assessing a young person using the Gillick competence framework. They also received support from the mental health liaison team and mental health lead within the department.

Staff demonstrated good understanding of treating patients who were served a 'Section 136', including recent changes to the holding time. A Section 136 is part of the Mental Health Act and is used by police if they think people are suffering a mental health crisis and need to be taken to a place of safety. Staff followed the correct procedures when requesting an extension for one patient who was detained on a Section 136 during our inspection. Staff maintained clear communication with police officers during their stay. They were aware of the start time of the 24-hour duration and regularly communicated with each other about when it expired. We spoke with the patient who confirmed they had been informed of their rights and was kept updated about their treatment and what might happen next. A mental Health Act assessment was planned for as soon as the patient finished their treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989

and 2004 and they knew who to contact for advice. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. All nurses we asked, including student nurses, had a clear understanding and were confident with consent processes for children and young people.

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

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust set a target of 80.0% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from 22 November 2018 to 21 November 2019 for registered nursing staff in urgent and emergency care is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	295	337	87.5%	80%	Yes
Mental Health Act	282	338	83.4%	80%	Yes

In urgent and emergency care the target was met in all MCA/DoLS training modules for which registered nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from 22 November 2018 to 21 November 2019 for medical staff in urgent and emergency care is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	76	90	84.4%	80%	Yes
Mental Health Act	56	90	62.2%	80%	No

In urgent and emergency care the target was met for one of the two MCA/DoLS training modules for which medical staff were eligible.

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

Due to patients normally only being in the emergency department for a short time, formal MCA and DoLS applications were normally completed by the ward they transferred to. If in an emergency a patient refused treatment, staff explained the treatment was in their best interests and if required, the consultant made a best interests decision about what to do in the least restrictive way.

## Is the service caring?

### **Compassionate care**

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff showed compassion in the way they interacted with patients.

We observed staff introduce themselves to patients and they checked with patients their preferred name(s) when they first met. Staff took time to listen to patients and answered questions patients or their relatives asked.

Patients and relatives were complimentary about staff and described staff as “lovely and respectful – but feel for staff as they are up against it”. Other comments included, “never feel unsafe” and “will score the department 10/10” and one patient described their experience as “superb”.

Following the inspection, the trust shared examples of positive feedback from patients and their relatives. Feedback described care as being professional and compassionate, while also appreciating the challenges staff worked under with the department being busy.

In the CQC 2018 adult inpatient survey, the emergency department was an outlier for lack of privacy when being examined or treated in ED. During our inspection in 2018, we reported on and served an improvement notice for the lack of dignity afforded to patients in the emergency department. Leaders in the department had identified actions to improve on this and staff were involved to embed better practice to maintain patient dignity in the department. These actions included no longer looking after two patients in one cubicle.

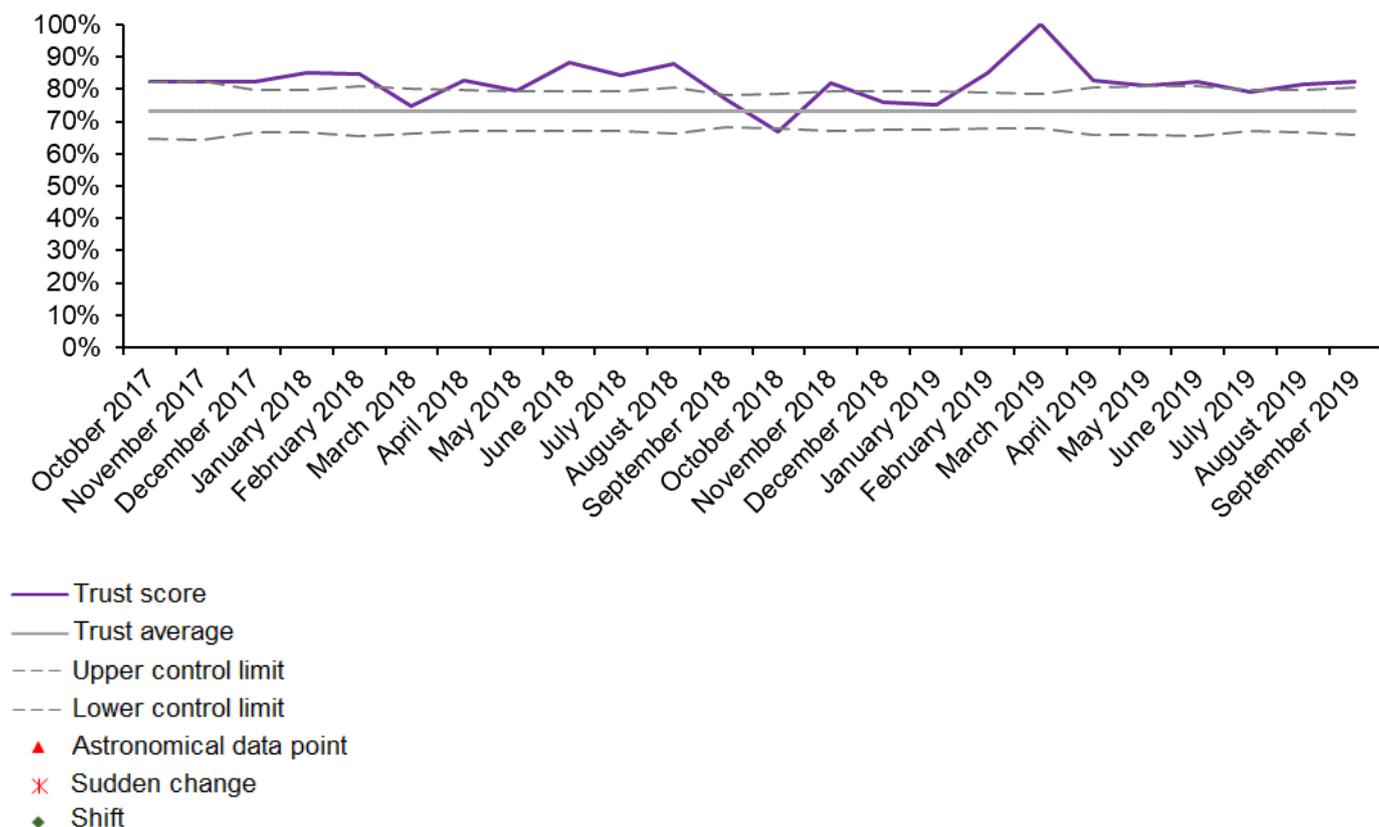
During this inspection, we found staff always took care to consider patients’ dignity and noted patient dignity was constantly reviewed. However, staff were constrained by the environment and the increase in attendances to the hospital. In September 2019, a risk for lack of privacy and dignity due to use of free-standing privacy screens in the resuscitation bay was added to the risk register (ID 2387). We observed this was still current practice at the time of our inspection but were reassured that staff and leaders were aware of the problem and looked for ways to improve this.

### **Friends and Family test performance**

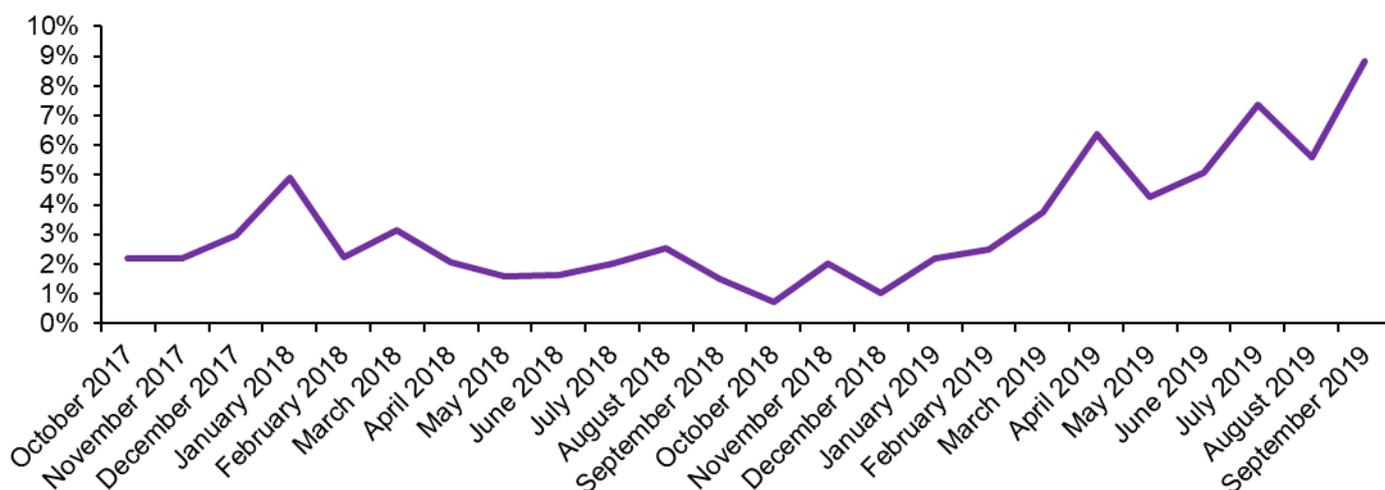
A high proportion of patients gave positive feedback about the service in the Friends and Family Test (FFT) survey, although the response rate was low. Since December 2018, there was an improvement in the rate of response to the FFT.

The Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 66.7%% and 100.0% from October 2017 to September 2019.

## Friends and family test performance – Great Western Hospitals NHS Foundation Trust – October 2017 to September 2019



## Great Western Hospitals NHS Foundation Trust – response rate October 2017 to September 2019



(Source: Friends and Family Test)

Staff followed policy to keep patient care and treatment confidential. However, due to environmental constraints this was difficult at times due to crowding in the emergency

department.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff demonstrated a non-judgemental attitude when supporting patients with a mental health issue. They showed understanding about their condition and talked to patients with respect.

We spoke with two patients with mental health needs who had been seen or were currently in the emergency department. They said staff treated them with respect, and they were seen quickly. Patients said staff were very understanding, and they had their preferences met. One patient said staff could not have done more to help them, and they were very compassionate. Patients were kept informed of where they were with their treatment.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed staff treat all patients equally and with respect. Staff understood the impact of patients' personal, cultural, social and religious status and beliefs and staff cared for all patients with compassion.

## **Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Children who died in the community were taken to the emergency department where staff could support and look after the family. The nurse paediatric lead told staff they could contact her at any time if a deceased child was brought in so they could provide support for staff and care for the deceased child's family. There was a 'sudden infant death policy', which was available to staff on the trust's intranet.

Staff told us of an example of care that demonstrated staff's thoughtfulness and compassion. Staff had moved patients to ensure a side room could be allocated to a couple both admitted to the emergency department, to enable the wife to be with her husband at the very end of his life.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed an examination in the urgent care centre. The emergency nurse practitioner (ENP) demonstrated a caring approach and answered all questions from the patient clearly. When the patient became distressed, the ENP supported them in a compassionate way.

The hospital had a department for spiritual care who supported patients and their relatives/carers. There were a chapel and a prayer room, which were open 24 hours a day. The service also offered bedside ministry for patients who could not access the chapel or prayer room, as required.

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

**Staff supported and involved patients, families and carers to understand their condition**

## **and make decisions about their care and treatment.**

Staff worked to ensure patients and those close to them understood their care and treatment. Most patients we spoke with knew what they were waiting for in respect of a plan of treatment such as blood test result and so on. But some patients were less aware of what they were waiting for. We spoke with one patient in majors' chairs who were not sure if they were being admitted or discharged, although they were receiving treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff spoke clearly when patients were hard of hearing to ensure they had understood the information that was given. Staff had access to translation services which could be arranged over the telephone. Due to the unplanned nature of the emergency department, it was rare interpreters could attend in person for logistical reasons.

Staff supported patients to make informed decisions about their care. Staff took time to explain information to patients and listen to questions patients or their relatives had about the care and treatment given. Staff were compassionate in how they supported patients who received bad news. We observed staff care for the relatives of one patient who had been given bad news. Staff ensured privacy and took time to explain what had happened.

Patients gave positive feedback about the service. Relatives were complimentary and described the care as "good" but stated staff were busy.

## **CQC Emergency Department Survey 2018 – Type 1 A&E departments**

The feedback from the Emergency Department survey test was positive. The trust scored about the same as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain.

*(Source: Emergency Department Survey 2018)*

## Is the service responsive?

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

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the changing needs of the local population. Leaders worked with the trust executive team to plan how to deliver unscheduled and emergency care in the future. Leaders understood the challenges to service provision created by a growing population in Swindon. There was an external review carried out in September 2019: Getting it right first time (GIRFT) and the service had used this information to help formulate an action plan to reduce operational pressures and crowding. The trust acted to improve patient flow by introducing a 'Full Hospital Protocol' and had added an additional 20 beds to the trust's bed base.

There was a high, and increasing, number of daily attendances in the department. This led to crowding in a constrained environment that was not designed to meet the high number of attendances. The service took action to find solutions such as:

- Introducing 'reverse streaming' meaning about 1,000 patients were directed to the Urgent Care Centre each month. This was operational between 7am and 10pm.
- Introducing 'majors chairs' which had improved the time to initial assessment times from 25% to 82% (January 2020) of self-presenting patients who were seen within 15 minutes of arrival in the department. The median time to assessment was 10 minutes.
- Securing funding for a second registrar working at night as a second senior decision maker.
- Rostering a consultant to work in the children's emergency department at weekends.

There was a bigger vision and plan to create an 'integrated front door', which included the delivery of all non-planned patient presentations to the hospital. The 'integrated front door' included access to the medical and surgical assessment units, urgent care centre and a bigger emergency department. Funding had been secured and there were plans to go ahead with phase one which was planned to be completed by 2023.

There was a plan to change the urgent care centre to an urgent treatment centre (UTC), which was ready to be launched once GP provision had been secured. The unit would be GP-led and would enable patients to access services through 111 referral or GP referrals. The UTC would remain co-located within the emergency department and have full access to diagnostics. This was planned to start in March/April 2020 or as soon the service had recruited a GP to lead this service.

The trust worked with external partners to review services to ensure they were efficient, sustainable and delivered the care people needed. There was a plan to close the Swindon Walk-in Centre at the end of March 2020. This service was managed by the trust, but analysis of services provided showed most services were already provided elsewhere, such as in GP practice, homeless services and wound management clinics. We were told the additional

anticipated number of patients presenting to the emergency department/urgent care centre would be 20 or 100 patients every day, depending on who we asked. This meant we were not sure the full impact of the closure was known. There was a plan to redeploy nine emergency nurse practitioners working in the walk-in centre to the urgent care centre so they could help absorb the additional anticipated workload.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The observation unit had designated male and female bays with separate toilets. Staff said they did not admit patients of the opposite sex to the same bay. If the need arose, patients would remain in the majors' area of the emergency department until a bed in the right bay was freed up.

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

**The service was inclusive and took account of patients' individual needs and preferences as far as possible. Staff coordinated care with other services and providers.** However, patients who spent more than four hours in the department or majors' chairs, were not always offered a chance to have a wash or clean their teeth. When patients required assistance with personal needs, such as toileting, patients on trolleys in the middle of the majors area had to be wheeled into an empty cubicle. Staff tried to keep a cubicle empty for this use, but this was not always possible. In these cases, staff would use a cubicle from a patient who had gone to x-ray or for a scan, the minors procedure room or the plastering room to allow patient their dignity.

Staff had taken limited steps to make sure patients living with mental health condition, learning disabilities and dementia, received the necessary care to meet all their needs as far as possible. There was an observation unit in the adult emergency department where patients could wait while admission to a psychiatric unit or other action was arranged. The observation unit was a much calmer environment which patients admitted there appreciated.

There was an electronic patient record system, which alerted staff to patients who were living with dementia and staff could use a purple 'Forget-me-not' flower as a visual reminder and prompt to provide extra support. However, the department was not designed to meet the needs of patients living with dementia or learning disabilities. In the urgent care centre, there was a plan to make one of the cubicles dementia and child friendly.

Staff supported patients living with dementia and learning disabilities and were aware of 'This is me' documents and patient passports. Patients' carers or family were encouraged to stay with patients as far as possible as this meant patients with additional needs had someone with them that they knew. Staff were aware of the possible impact being in hospital and in a busy environment could have on patients and those living with dementia or a learning disability.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Electronic systems had the functionality to alert staff to patients' additional communication needs such as those with visual impairment or hearing difficulties. However, reception staff told us the function was rarely used. This was not in line with the NHS England Accessible Information Standards, which was introduced in 2016.

Staff made sure patients, loved ones and carers could get help from interpreters or signers when needed. Staff could arrange for interpreting services. This was mostly by telephone interpretation

due to the nature of the department. Arrangements could also be made for British Sign Language interpreters to assist if required.

The service worked with external partners to manage patients who attended the department frequently. This group of patients are also known as 'high impact users'. There was a consultant and band 6 nurse lead for this area. Staff worked to develop individual care plans for each patient which aimed at enabling the person to stay out of the department if possible.

Patients were given a choice of food and drink to meet their cultural and religious preferences as far as possible. Some relatives told us they had also been offered tea and biscuits when they had been in the department for a longer period.

The waiting room in the children's department was child-friendly and equipped with some toys and books for young children. There was access to a separate toilet. There were four cubicles dedicated to children which were just about big enough for their parents to be with their child. There were no adolescent themed cubicles for older children and young adults. If children's ED was busy and all cubicles occupied, nurses triaged children in the waiting area, but this compromised patient confidentiality and privacy. We also noted there was not a 'distraction boxes' in each children's cubicles, although staff had access to one 'Starlight Distraction Box (portable toolkits filled with a variety of toys, games and puzzles providing healthcare professional with items to distract a child whilst medical procedures are undertaken).

The service had suitable facilities to meet the needs of patient's' families. There were processes to ensure children attending with an adult patient were kept safe. Staff discussed the most appropriate action to take, which could be treating the adult patient in the children's emergency department (ED), or a healthcare assistant from the children's ED look after the child in the waiting area until a relative arrived.

There was a relatives' room available for relatives of patients in the department which had tea and coffee making facilities. This room was also used for bereaved relatives and had interlinked access to a viewing room where relatives could view their deceased loved ones. The door was locked when not in use. There was an adjacent toilet for relatives if required. However, there was limited information displayed or available for relatives, including information on how to comment on care provided.

There was no policy or guidance for staff about patients who were 'admitted' to majors chairs, including which patients were 'fit to sit' or how long they should be waiting in chairs. We observed two patients who had been in this part of the department for over 13 hours, including overnight. We spoke with one patient and their relative who told us they had been offered to rest on a trolley overnight within the major's department but had been asked to go back to the major's chair in the morning.

There was direct access from outside and it also included the receptionist area. It meant the environment was cold and draughty and there was little confidentiality at initial assessment. There was a standard operating procedure: Initial Assessment and Triage (December 2019) which stated the initial assessment could be carried out within this area if the patient consented when a trolley was needed for another patient.

There were no written criteria for patients accepted for care and treatment in the urgent care centre, including children. However, we were told the threshold was low regarding children and if staff were concerned, they would stream paediatric patients back to majors. Only one practitioner working in UCC had paediatric training.

Processes to repatriate property were not always effective. Staff were unsure of the processes and we noted there was a fair amount of property stored in the sluice in majors.

### **CQC Emergency Department Survey 2018 – Type 1 A&E departments**

The trust scored about the same as other trusts in all three Emergency Department Survey questions relevant to the responsive domain.

*(Source: Emergency Department Survey 2018)*

### **Access and flow**

**People did not always receive care and treatment when they needed it or in the right setting. Waiting times and arrangements to admit, treat and discharge patients did not meet national standards. There were differing opinions on how ‘decision to admit’ standards were interpreted and managed.**

Crowding was a big issue and a risk to safe patient care, patient experience and staff well-being. During our last inspection, we raised this and served requirement notices to address flow through the emergency department. Since our last inspection in 2018, the department had worked to improve flow through the department. Leaders had worked to change the way care was delivered to ease the pressure on the emergency department. They had implemented ‘reverse streaming’ and converted the waiting room into ‘majors chairs’ where staff observed and monitored patients closely while they were waiting and, in some cases, staff provided treatment, such as intravenous fluids and antibiotics.

The trust had introduced a ‘Full Hospital Protocol’ (2019). This was a tool aimed to provide a quantitative (numerical) method of defining the trust’s operational pressure escalation level (OPEL) but did not provide information of actions to be taken to ease the pressure. It was not specific to the ED although it did include some indicators such as the number of patients waiting over four or 12 hours. There was a standard operating procedure which set out indicators to determine the level of operational pressure the department was working under at any given time. However, staff did not refer to this or use it to escalate operational pressures and crowding in the department. They did complete situation reports regularly throughout the day.

Leaders told us of agreed actions to manage crowding in the department, although this was not written as part of an agreed policy. These included:

- Up to six patients were transferred to corridor areas inpatient wards within the hospital before 9am each morning.
- There were six additional trolleys marked ‘A-F’ around the nurses’ station, which seemed to be permanently in use.
- Trolleys G-K occupying spaces opposite the nurses’ station and outside cubicle 7.
- Two additional trolleys in the old waiting area.

This meant there could be up to 13 adult patients on trolleys in addition to 17 cubicles in the department, and a further 15 patients admitted to majors' chairs.

Once these spaces had been filled, there was an agreement with the NHS ambulance service that no further patients would be off-loaded into the department but would remain in the ambulance.

The service introduced 'reverse streaming' in November 2019. This meant most self-presenting patients were directed to the urgent care centre (UCC) and then streamed back to the emergency department if their clinical needs could not be met. Since the introduction, UCC had seen an increase in attendances of approximately 1,000 patients per month but had maintained 95% compliance with the national four-hour target (patients spending less than four hours in the emergency department).

The service monitored how many patients were streamed from the emergency department. We looked at data of streamed patients from February 2019 to end of January 2020. During this period, 1,741 patients were streamed from the emergency department to their GP, out of hours GP, to the Swindon Walk-in Centre and to 'other healthcare providers'. It was not possible to see the any changes to this data with the implementation of the reverse streaming process although figures showed 32,238 patients (26% of the total attendances) received care in the urgent care centre from January to December 2019.

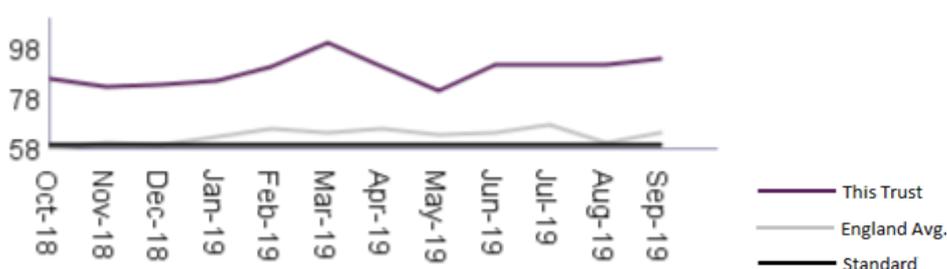
Medical and surgical expected patients did not routinely present to the emergency department but were advised to go straight to the respective medical and surgical assessment units. This helped to ease crowding and ensure patients were in the right place to receive the care and treatment they needed.

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

Managers monitored waiting times and worked hard to make sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. However national targets were not met in respect of the time patients waited for their treatment to begin and the time they spent in the emergency department.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the recommendation for all 12 months from October 2018 to September 2019.

### **Median time from arrival to treatment from October 2018 to September 2019 at Great Western Hospitals NHS Foundation Trust**



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

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

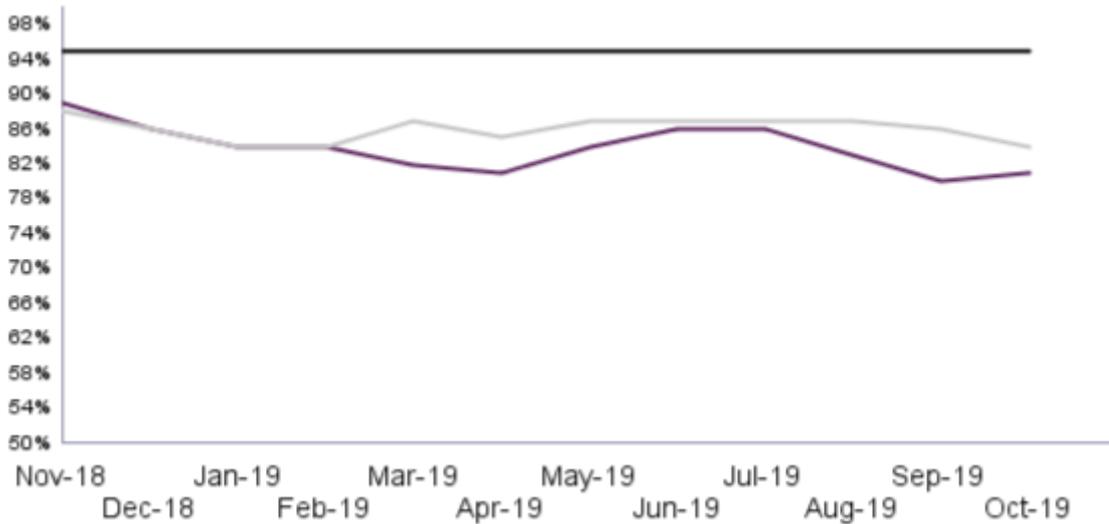
Managers and staff worked to make sure patients did not stay longer than they needed to although the department was often crowded. There were processes to assess capacity and demand but not all staff were aware of triggers that indicated exceeding demand and crowding in the department. Leaders and senior clinicians described the main reason for crowding in the department as 'exit blockers' (a term used when patients are unable to be transferred out of the emergency department because of lack of capacity/beds in the hospital). Leaders told us there were agreed 'triggers' that demonstrated the department was crowded and that there was a risk to safe patient care. However, staff could not describe these triggers and did not have an overview of the level of escalation/crowding in the department. They were unable to communicate to us 'how crowded the department was' in comparison to other times and if this was improving or getting worse. Some staff stated crowding was escalated when there were more than six patients on trolleys waiting but they were not sure how and who escalated the increased pressures and to whom. Following the inspection, we asked for the standard operating procedure (SOP) setting out advice and support for staff to identify when the department became too crowded and actions to take to ensure safe care and treatment of patients. The SOP stated triggers that indicated when crowding in the department escalated including internal and external factors and actions to mitigate risks. However, we were not assured the SOP was embedded effectively amongst staff.

Designated staff attended bed meetings three times a day. More frequent meetings sometimes took place at times of extreme operational pressures in the hospital. In this meeting, staff shared key data, and triggers were used to highlight operational pressures and crowding within the emergency department and the impact this had on safe patient care and staff well-being.

The Department of Health's standard for emergency departments is 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From November 2018 to October 2019 the trust failed to meet the standard and from March 2019 to October 2019 performed worse than the England average.

### **Four-hour target performance - Great Western Hospitals NHS Foundation Trust**

— This Trust — England Avg. — Standard



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

Following the inspection, we asked for up-to-date data to demonstrate compliance with the national four-hour target. The trust shared data from November 2019 to February 2020, which demonstrated compliance with the national four-hour target was between 53.62% (December 2019) and 61.4% (January 2020).

We reviewed data published by NHS England who reported compliance with the four-hour target as follows: November 2019 (76.7%), December 2019 (73%) and January (79.4%). This meant an average of 858 patients spent more than four hours in the department and an average of 76 patients spent more than 12 hours in the department across the same three months. We were concerned the trust may not have an accurate overview as these two sets of data did not match.

In the urgent care centre (UCC), the four-hour target was consistently above 95% despite an increase in the number of patients attending. Daily attendances had increased to between 100 and 150 patients from 80 to 100 patients before the reverse streaming was introduced in November 2019. Patients could self-refer to UCC. Other referral routes were through 111 triage and from the emergency department. Triage was undertaken by one nurse but there was a plan to increase triage to two nurses as surges in attendances had showed triage times increased at these times.

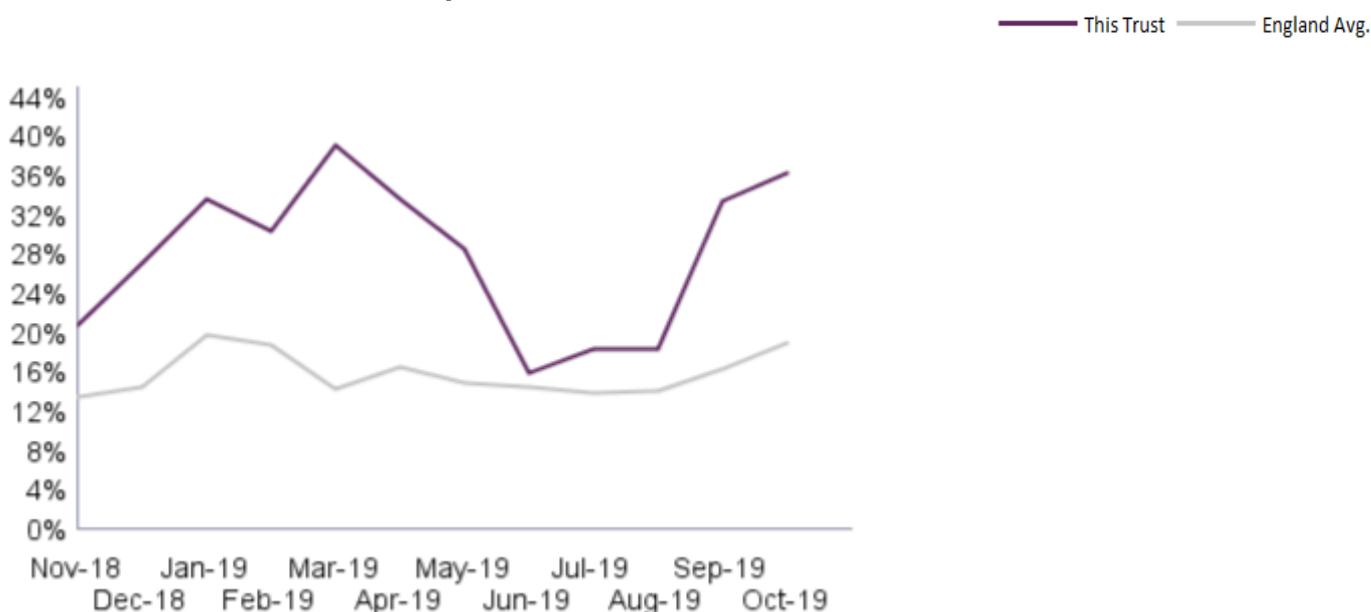
**Percentage of patients waiting more than four hours from the decision to admit until being admitted.** From November 2018 to October 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

There was lack of clarity about when the 'decision to admit' was made and by whom. Leaders and senior clinicians in the department were of the opinion the 'clock started' when they referred patients to a speciality team. Whereas speciality teams worked on the premise the clock started from when they had reviewed and accepted the patient onto their case load. NHS England: A&E Attendances and Emergency Admission Monthly Return Definitions (2015) state: "time of decision to admit is defined as the time when a clinician decides and records a decision to admit the patient, or the when treatment that must be carried out in A&E before admission is complete – whichever is the later".

We were concerned speciality teams and the clinicians in the department had conflicting views which had a negative impact on patient safety, the overall four-hour target and on patient flow through the department. It was recognised at trust level that there was a risk to patients staying longer than appropriate in the emergency department before accessing speciality care on inpatient wards. However, leaders were unsure of the actions taken to address this issue at trust level.

The trust's full escalation protocol excluded the 'decision to admit' breaches when reviewing operational pressures. We were therefore not assured there was a trust wide agreed approach to support the emergency department to achieve national targets. The lack of clarity confirmed the main reason for the four-hour breaches were 'exit blockers' and the inability to transfer patients to inpatient beds.

### Percentage of patients waiting more than four hours from the decision to admit until being admitted - Great Western Hospitals NHS Foundation Trust



(Source: NHS England - A&E SitReps).

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

Over the 12 months from November 2018 to October 2019, 56 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were October 2019 (27) and April 2019 (18).

Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
Nov-18	485	3
Dec-18	653	0
Jan-19	793	0
Feb-19	646	0
Mar-19	888	4
Apr-19	761	18

May-19	666	2
Jun-19	371	0
Jul-19	424	0
Aug-19	438	0
Sep-19	734	2
Oct-19	836	27

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

Following our inspection, we asked for up-to-date data in relation to ‘decision to admit to patients waiting departure more than 12 hours following the decision to admit. This data demonstrated there had been a trend of increasing number of patients waiting for more than 12 hours in the emergency department after the decision to admit had been made:

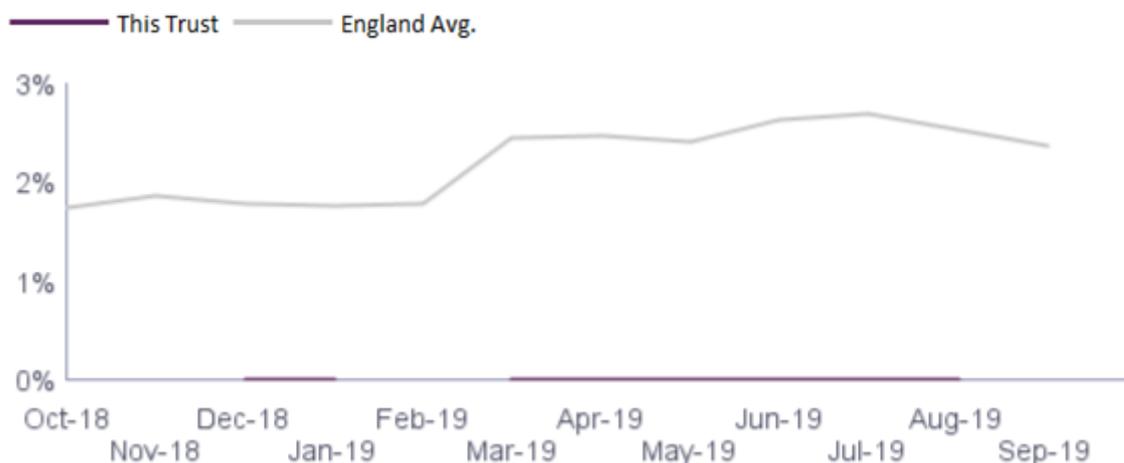
- October 2019: 27 patients
- November 2019: 49 patients
- December 2019: 73 patients
- January 2020: 107 patients
- February 2020: 30 patients.

Prior to October 2019, between two and 16 patients waited more than 12 hours once the decision to admit had been made between April 2019 and September 2019.

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

The number of patients leaving the service before being seen for treatments was low. From October 2018 to August 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than England average.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen**

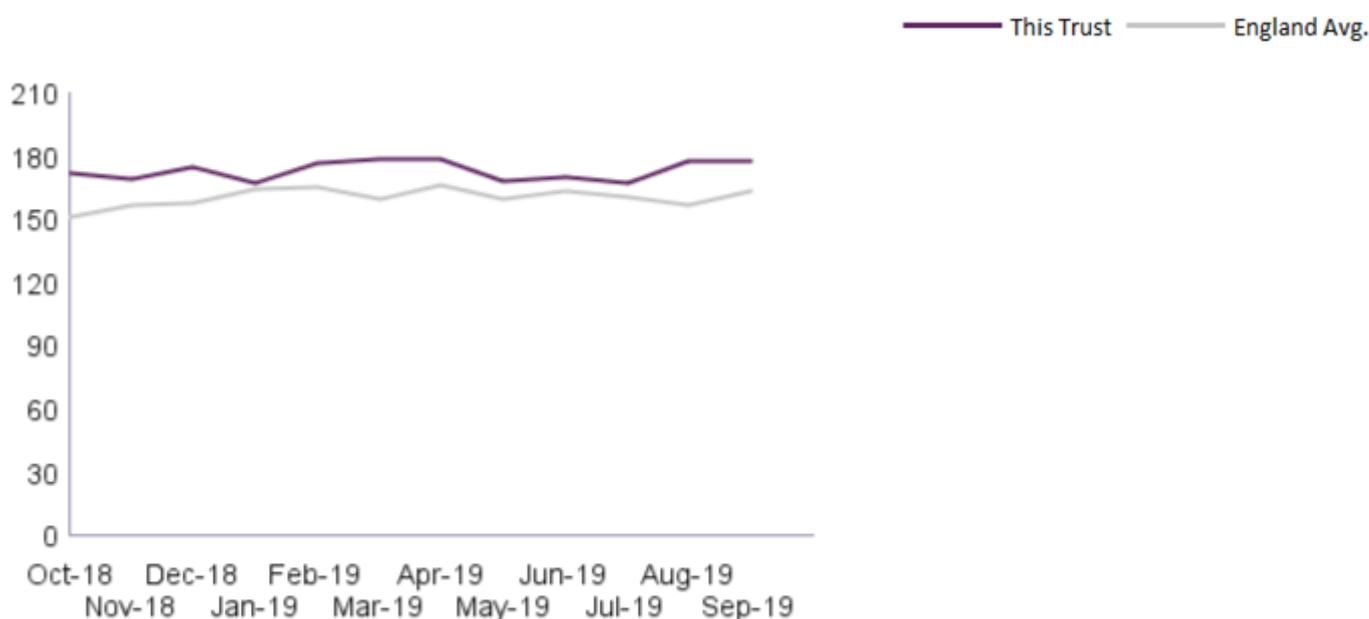


(Source: NHS Digital - A&E quality indicators)

**Median total time in A&E per patient (all patients)**

From October 2018 to September 2019 the trust’s monthly median total time in A&E for all patients was higher than the England average.

**Median total time in A&E per patient - Great Western Hospitals NHS Foundation Trust**



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

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The emergency department SHINE document included a discharge patient checklist which included prompts such as: safe to be discharged, removal of cannula, advice given, medicines advice given, information shared with next of kin/care homes and if transport had been organised. Staff used a 'mental health patients' discharge checklist when patients with mental health conditions were discharged from the observation unit. This included information about where the patient was going and who would be there to support them.

Staff supported patients when they were referred or transferred between services. There was safety checklist for staff to use when they transferred unwell children from the children's emergency department to the paediatric unit. When patients were discharged, electronic discharge summaries were shared with patients' GPs.

The observation unit had eight bed spaces (four female and four male). Staff told us they were never asked to have a ninth patient in the corridor. Instead staff worked to identify patients who may be moved to an inpatient ward or be discharged before accepting additional patients. Children and young people under 18 years of age were not admitted to the observation unit. They were admitted to the children's unit if required.

## Learning from complaints and concerns

**The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they would phone up the hospital to make a complaint if required. Information was available on the trust website regarding how to provide feedback, including making a complaint. However, the service did not clearly display information in all patient areas about how to raise a concern. During our inspection we did not see any information displayed about how to provide feedback or make a complaint. For example, we did not see information displayed in the majors area or in the relatives' room. Following our inspection, the trust confirmed there were posters displayed in the emergency department. We suggested this should be better signposted.

Staff understood the policy on complaints and knew how to handle them. Staff were aware of the trust complaints procedure and told us they would inform patients to contact the patient advice and liaison services (PALS) if concerns could not be resolved at the time they were raised.

Managers investigated complaints and identified themes. We reviewed three responses to complaints about care and treatment in the emergency department. The responses included an explanation following an investigation into the concern(s) raised, an apology and set out what actions the service was going to take as a result of the concerns raised. Complaints and lessons learnt were shared with staff in a monthly clinical governance meeting.

### Summary of complaints

From November 2018 to October 2019, there were 153 complaints in relation to urgent and emergency care at Great Western Hospital. The trust took an average of 19.9 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be closed within 25 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical Treatment	70	45.8%
Staff	26	17.0%
Communications	15	9.8%
Other	10	6.5%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package	8	5.2%
Access to treatment or drugs	7	4.6%
Waiting Times	7	4.6%
Prescribing errors	3	2.0%
Privacy, dignity and wellbeing	3	2.0%
Patient Care including Nutrition/Hydration	2	1.3%
End of Life Care	1	0.7%
Integrated Care including delayed discharge due to absence of care package	1	0.7%
<b>Total</b>	<b>154</b>	<b>100.0%</b>

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

### Number of compliments made to the trust

From November 2018 to October 2019 there were 61 compliments at Great Western Hospital about urgent and emergency care.

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



## Is the service well-led?

### Leadership

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

Leaders had the skills, knowledge, and experience that they needed. Urgent and emergency was managed in the unscheduled care division. Although some leaders were new in post, they understood their role and the challenges the busy department presented. They told us they worked well together and worked to improve the service and achieve compliance with national standards. They were clear that safe patient care was the top priority in the department.

The emergency department leadership structure comprised of a clinical lead consultant, an interim divisional lead and a matron. They all reported to leaders at divisional level, who in turn reported to the trust's executive team. The day-to-day operational leadership was provided by a ward manager, supported by band 7 nursing staff.

Leaders understood the challenges to quality and sustainability of the department. They identified actions needed to address these. Leaders understood clearly the challenges the emergency department had in meeting targets and to provide safe care to patients. They were aware of the impact high operational pressures had on staff and praised all staff for their resilience to provide compassionate care to patients. Leaders had worked hard to implement changes to ease the operational pressure on the emergency department and needed support from other medical and surgical specialities to achieve better patient flow from the department into inpatient wards. Leaders recognised this was compromised with insufficient ability to discharge patients from inpatient wards back to their usual place of living.

Leaders understood the challenges to provide safe care and treatment in a crowded department where capacity did not meet demand. Leaders discussed the challenges to provide safe care and treatment in the department and actions they had taken or were planning to implement to ensure the ongoing safe treatment of patients. These included the implementation of reverse streaming, majors chairs and the plans to develop an integrated 'front door' to improve flow and to ensure patients received the right care in the right place.

Leaders were visible and approachable. Leaders operated an 'open door' policy and encouraged staff to speak with them about concerns. There was a 'positive/negative' box in the staff room, where staff could leave positive or negative feedback anonymously if they wanted to. Leaders reviewed comments weekly and addressed these as required. All staff we spoke with stated leaders were visible in the department most days and staff felt able to approach any of the leaders to discuss concerns.

Executive leaders visited the department regularly. During our inspection, the interim chief executive visited the emergency department, together with the trust's staff well-being lead. They provided a tea-trolley round for staff, making them a cup of tea and offered them a biscuit in appreciation of how busy they were. Staff addressed the chief executive by their first name which indicated staff recognised them and that they were known to staff working in the department.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. We observed strong leadership from leaders both in the emergency department and the urgent care centre. Senior leaders were focused on patient safety and in finding solutions to the challenges faced by the service.

There were established procedures to ensure structured leadership on each shift in the emergency department. Each shift had an emergency physician in charge (EPIC), providing clinical leadership, a co-ordinator and a nurse-in-charge. Each of these three shift leaders had specific roles to ensure comprehensive and safe operational leadership. The EPIC provided clinical leadership, the co-ordinator provided overview of operational pressures and took handover from ambulance staff. The nurse-in-charge provided clinical leadership for nursing staff and helped ensure treatment plans were carried out and flow was maintained, for example by supporting transfer of patients to inpatient wards.

The emergency department had a consultant mental health lead and a band seven nurse who sat on the mental health operation group.

## **Vision and strategy**

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

There was a clear vision and a set of values, with patient care, quality and sustainability as the top priorities. Leaders were clear that maintaining safety and dignity for patients, relatives and staff in the emergency department was their top priority. They had implemented actions to improve patient flow, to manage and reduce crowding and improving performance to ensure patients received safe care and treatment in the right place.

The emergency department had a ward 'vision' which captured all care provided. However, it did not include visions specific to provide care for patients living with mental health conditions.

There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. The strategy was aligned to local plans in the wider health and social care economy. Staff were aware of the vision and strategy and had been consulted with. Leaders were aware of the challenges and a 'Way Forward' project had been launched to create an integrated 'front door'. A substantial national investment had been secured to support new ways of working and to increase the physical footprint of urgent and emergency care in the hospital. The project was on course for timely completion in October 2023.

## **Culture**

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

The culture in the department was centred on the needs and experiences of people who used the service. The values of the trust were displayed in the department and used on patient documentation as reminders to staff. The values were: service, teamwork, ambition and respect. We observed staff working towards these shared values providing care and supporting

colleagues. We observed staff were resilient and providing good care to patients, despite the ongoing and increasing operational pressures.

Staff felt positive and proud to work in the organisation. Staff told us they enjoyed their work and working in the team. We observed staff worked hard and they were dedicated and delivered good care. Leaders told us they were very proud of staff who they described as resilient and adaptable.

Most staff felt supported, respected and valued. However, some staff in the urgent care centre did not “feel a part of the team” and they did not all feel empowered to call medical staff in the emergency department when they needed help. Some staff felt the response they got depended on who was the emergency physician in charge on the day and some staff had received a negative reaction when they had telephoned for help or advice. This meant there was a concern some staff would not contact medical staff which in turn meant there could be a risk to patient treatment.

The culture in the department encouraged openness and honesty at all levels in response to incidents. Staff spoke to us about an open culture where staff could challenge decisions made about patient care. This demonstrated a good culture where staff felt able to ask for help and escalate concerns. However, one member of the multidisciplinary team told us they did not feel able to challenge decisions about patient treatment if they were not in agreement with the decisions made.

Leaders and staff understood the importance of being able to raise concerns without fear of retribution. Staff were aware of how to contact the freedom-to-speak-up guardian but stated they could raise concerns directly with leaders of the department if required.

There was a strong emphasis on safety and well-being. The trust had recently introduced Swartz-rounds (a forum for staff to get together to talk about the emotional and social challenges of caring for patients). In addition, the emergency department had applied for funds to provide training for some staff to become trauma risk management (TRIM) practitioners. TRIM is a trauma-focused peer support system designed to help people who have experienced a traumatic event. In the meantime, senior clinicians held debriefing sessions following traumatic events. Staff also told us they used each other for peer support and the ED manager told us staff could call them at any time if they needed to, following traumatic events in the department.

The trust valued staff wellbeing and had employed a full-time well-being lead. We met them and the chief executive during our inspection, as they were providing refreshments for staff who may not have had time for a break. This was valued by staff. The well-being lead and the ward manager had also organised a special pampering day for staff where they could attend for different therapies such as barbering, manicure, massage and so on.

Staff used ‘favourable event reporting forms (FERF) to highlight when colleagues recognised good care provided for patients. Staff also used a term: ‘you have been mugged’ which was a mug that was filled with treats and presented to a colleague in appreciation of good care delivered or support for colleagues. This was passed on once a month and shared on secure social media for all staff.

There were cooperative, supportive and appreciative relationships among staff. Staff described good team work and that the team ‘pulled’ together to support each other.

## **Governance**

**There were effective governance processes and staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, mortality and morbidity reviews did not include a review of patients who were admitted through the emergency department but later died. Minutes of clinical governance meetings did not demonstrate all standard agenda items were regularly discussed.**

There were governance systems, but these did not always ensure sufficient oversight of risks. There was a clear governance meeting structure within the emergency department, at sub-divisional level and at divisional level. feeding in to the trust-wide governance systems. This ensured effective communication pathways from department to board level.

The service held clinical governance meetings every month. This meeting was attended by both nurses and medical staff. Minutes of the meeting were structured and covered performance, incidents, learning from deaths, complaints and audits, although the depth of the minutes was not sufficiently detailed to inform those unable to attend. We reviewed minutes from two meetings. Some standard agenda items were not discussed in either meeting (November 2019 and January 2020) as reports or evidence had not been received. This included a review of the risk register, meaning risks were not consistently discussed or shared with all staff regularly.

There was a regular 'Friday' meeting where clinical incidents were discussed to improve oversight. This meeting was attended by the clinical lead consultant, the ward manager and the matron. The aim of the meeting was to discuss incidents, including serious incidents to identify immediate learning from when things went wrong. The meeting was also used to determine which incidents should be investigated further and reported to external stakeholders in line with national guidance.

There was a separate monthly meeting for senior nurses (Band 7). Minutes of these meetings confirmed agenda items such as staffing, well-being and incidents were discussed. However, the agenda template used was not consistent and the depth of information recorded varied and was not always in enough detail to be meaningful to those who were unable to attend. We noted also the risk register was not discussed in either of the meeting minutes we reviewed and meant we were not assured senior staff were kept up-to-date with risks entered onto the department's risk register.

Serious incidents were investigated, and learning identified to improve practice. When asked, leaders spoke of learning from an incident of a missed diagnosis of a fractured neck of femur. The fracture was later diagnosed using computerised tomography (CT scan) and the department was in the process of including CT scanning into the clinical pathway for patients presenting with signs and symptoms of a fractured neck of femur.

Patient experience was shared with others, including the divisional board. The matron had presented 'a day in the life of ED' to the divisional board. This presentation helped explain the pressure the department was under and to demonstrate the compassionate care staff delivered. The presentation included an example of this where staff were innovative in the way they worked to enable a married couple, who were both patients in the department, be together at the very end as one of them passed away in the department.

There were mostly effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services. There was a departmental quality dashboard which included internal audits on vital observations monitoring, investigations initiated, pain assessment, ECG recordings, compliance with clinical pathways (stroke and fractured neck of femur), sepsis, next of kin informed and refreshments offered to patients within two hours of

arrival. Compliance ranged between 64% and 100% completion across all measures. Compliance was discussed in the departmental clinical governance meeting in January 2020 but was not discussed or documented in the minutes from the meeting in November 2019.

Monthly mortality meetings were held and chaired by the mortality lead and if they were absent a consultant would step in to lead the mortality review meeting. Following the inspection, we requested minutes of the last two meetings, and we received presentations (minutes) from October and November 2019, which meant we were not assured mortality meetings were always held monthly as intended. However, mortality reviews and meetings did not include morbidity reviews where patients may have presented to the emergency department and transferred to another ward where they later died. The mortality reviews were not consultant-led, and no consultant was appointed to lead on mortality review as part of their job plan. Instead, mortality reviews were led by a staff grade doctor who was new to the role.

The mortality meetings were recorded, and minutes shared with staff by email. Reviews were presented by foundation doctors (year two) and used as a teaching tool by registrars and/or consultants. The reviews looked at the overall care and quality of record keeping, which was scored between one (very poor) and five (excellent). If the outcome scored one or two, the death review was referred to the trust mortality group. The review included a discussion of whether deaths were more than 50% avoidable and if another speciality mortality meeting was required.

The service did not use a national tool such as the Royal College of Physicians: Structured judgement review (2016) to review patient deaths and the mortality lead was not aware if the trust had introduced medical examiner. The medical examiner is a national framework which will deliver a new level of scrutiny whereby all hospital deaths will be subject to either a medical examiner's scrutiny or a coroner's investigation.

Staff at all levels were clear about their role and understood what they were accountable for and to whom. We spoke with staff of varying seniority. All staff discussed their roles and responsibilities with clarity and were clear about how and to whom to escalate any concerns.

## **Management of risk, issues and performance**

**We were not assured there was sufficient oversight of risks as these were not consistently discussed in clinical governance meetings. However, there were effective systems to manage performance and leaders identified most risks and issues and identified actions to reduce their impact. There were plans to cope with unexpected events.**

There were processes to manage current and future performance and these were reviewed regularly. However, risks were not routinely discussed in departmental clinical governance meetings or in the Band 7 senior nurses meeting, which meant we were not assured staff in the department had sufficient knowledge of risks within the service.

There were arrangements for identifying, recording and managing risks which included mitigating actions taken to reduce the level or risk. Leaders recognised most of their risks, and these were added to the emergency department's risk register. There were two risk registers: open risks and accepted risks. There were 17 risks on the open risk register and three on the list of accepted risks. Each risk was assigned to a 'risk owner', had a target risk score based on the likelihood and consequence of the risk. The risk register demonstrated when each risk was last reviewed and the current risk score.

We reviewed the board papers from January 2020 and found three risks associated with the emergency department were discussed (risks over a risk score of 16). These were: risks to

patients staying in ED longer than was appropriate before accessing speciality care, achieving infection prevention and control standards due to crowding and risk of inability to manage evacuation in the event of fire due to crowding. Two of these risks were on the departmental risk register but given a lower risk score. Leaders were unsure of how and when risks would be entered onto a corporate risk register

The top four risks (risk score 15 to 18) on the emergency department's risk register were related to:

- Risks to paediatric patients due to lack of paediatric emergency consultant (18).
- Risk of duplication of medicines when patients were transferred to inpatient wards as different medicine prescribing methods were used (16).
- Two risks related to crowding in the department: increased length of stay leading to inadequate capacity to clinically deliver safe and dignified care (16) and risk to patient and staff (low morale and negative impact on well-being) (15).

When we asked leaders about the biggest risks they referred to crowding as one of the top risks.

There were three accepted risks. These were: risk of maintaining patient confidentiality due to crowding in the department and close proximity of patients to whiteboard, nurses' station and phones. Another risk referred to high vacancy rate, leading to high use of agency staff. The third accepted risk referred to a risk to the line of sight of children in the children's emergency department's waiting area. Staff had reduced the risk by moving a book case to the 'blind spot' meaning children were likely to spend limited time in this area. Staff were aware of the risk and checking the waiting area regularly was embedded and assigned to healthcare assistants working in the area.

The urgent care centre had separate risk registers relating to open and accepted risks. There was one accepted risk which was a recognition that working in a challenging environment could be a contributing factor to stress for staff. The risk was entered in May 2016 but remained on the risk register and showed the risk was regularly reviewed. The open risk register had three risks: two of the risks related to inadequate experience and knowledge of practitioners and lack of dedicated clinical supervision of staff.

Impact on quality and sustainability was assessed and monitored when service improvement/development of services or efficiency changes were considered. The service had introduced the 'reverse streaming' concept in November 2019, meaning there was no minors unit as most self-presenting patients were referred to the urgent care centre (UCC) by receptionist staff. Following our inspection, we requested the risk assessment which had been completed to assess the risks of reverse streaming processes and the concept of 'majors chairs'. However, risks associated with reverse streaming of patients to/from the urgent care centre and the introduction of major's chairs were not identified by the service or the trust as risks entered onto the risk registers for ongoing monitoring and review. Registered nursing staff in UCC told us there was a lack of referral pathways to ensure the correct support, for example from medical staff in the emergency department or from speciality doctors.

Senior leaders recognised the operational pressures needed to be managed by the trust and the wider health care system. It was not within the powers of the emergency department to resolve patient flow problems through the hospital and into the wider health care system on discharge. Leaders recognised that, although a bigger emergency department and a new integrated 'front door' model of care would help ensure patients were in the right place to receive the care they

needed and the model may encourage and manage admission avoidance, it would not necessarily help overcrowding in the department if patient flow through and out of hospital was not improved.

There were plans and processes to cope with unexpected events. Staff had access to a folder referred to as 'IRespond' which held information and advice of actions to take if they encountered an unexpected event. For example, the folder held advice for staff on processes to cope with testing for a high-profile virus. Staff were familiar with the folder and the contents and described it as the 'first port of call' if they were faced with an unexpected event. Staff received alerts from the 111 service and arranged a suitable time for patients to come to the department for testing. Staff performed test and examinations outside of the department and observed guidance from healthcare experts.

## **Information management**

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

There was a holistic understanding of performance, which sufficiently covered information on quality, operations and finance. Information was used to measure improvement. Data was collected to review performance and to identify where service improvements were required. Leaders recognised when there were issues with data collection or the validity of the data and worked to resolve the issues. The service had changed the way data for national audits were entered to ensure accuracy and consistency. The service was planning to introduce a new electronic oversight tool to ensure there was a 'real time' overview of operational pressures in the department.

Staff had easy access to electronic systems by using a 'tap on- tap off' key function. This was efficient and ensured electronic data was kept confidential as it was easy to use and therefore staff did not leave computers while still logged in. All staff we asked, told us they like this system and that it saved them a lot of time.

All medical records were stored on a shared electronic database which all staff could access in the emergency department. However, nursing staff did not have access to the mental health database (RiO), so had to rely on the mental health liaison team or the doctors to access this for them if required.

Quality and sustainability did not always receive sufficient coverage in relevant meetings at all levels. Mortality and morbidity reviews lacked ownership at consultant level to ensure enough scrutiny and learning from deaths. Risks were not consistently discussed in meetings and meant there was a risk staff at all levels were not familiar with risks and the risk register. However, quality and sustainability were discussed in clinical governance meetings, at divisional level and fed into trust governance oversight meetings.

Medical staff explained it was difficult to navigate the trust intranet to find clinical guidelines. This had been raised with department leaders who were planning to introduce an App which could be downloaded to provide easy access to the trust clinical guidelines.

## **Engagement**

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

## **partner organisations to help improve services for patients.**

There was a trust-wide website which was accessible to the public. The information pertinent to urgent and emergency services was generic and based on national guidance but did not offer any information specific to the service at Great Western Hospital. However, there was a large section dedicated to patients and visitors, offering guidance and advice.

The emergency department sought to engage with and provide information for the public about the department. There was a video recording on the trust website where the matron explained about what goes on behind the scenes, provided assurance for the public about waiting times and described plans to develop the service further. Leaders stated that through working with staff about the changes referred to as 'reverse streaming', staff felt more empowered to make other changes and were keen to suggest different ways of working.

In the children's emergency department, there were child friendly feedback forms and a letter box to post these back to the service. Following our inspection, we asked for response rates and of any changes to the provision of care as a result of feedback received from children. We did not see any feedback forms in other areas such as the majors area, including displayed information about how to raise a concern or complaint about care. However, this information was available on the trust website.

Leaders were aware of the positive impact patient feedback could have on the way care and treatment was delivered in the department. The matron and manager of the emergency department contacted and interviewed 20 patients and their families, who had waited a long time, each month. The interview format asked about pain management, if they were treated with respect and dignity and about the care they received. Feedback from these interviews was used to improve care delivery and, as a result of feedback from these patients, funding had been secured to employ two healthcare assistants to meet personal care needs for patients spending a long time in emergency department.

Feedback was collected from the NHS friends and family test. However, the response rate was low, and information was not specific to the emergency department, including the urgent care centre.

Leaders did not use all available patient feedback to help them evaluate patient feedback as they were not aware of the CQC Emergency Survey, 2018 (published October 2019) and had not used this information to identify where improvements were required. This survey was based on 272 people who had used the emergency services at the trust. The lowest scores related to waiting times (6/10) with information about waiting times scoring 3.9/10, which was about the same when compared to other trusts. We observed there were no waiting times displayed in waiting rooms providing information for patients.

There was a trust-wide information booklet for staff which was issued every quarter. We reviewed the Autumn 2019 edition, which included information about the new clinical model: Way Forward Programme. This helped ensure all staff were aware of the planned new model to deliver an expanded and integrated 'front door' urgent and emergency care services.

Staff worked well with other healthcare providers to ensure patients received the right care. There were close working relationships with a neighbouring mental health NHS trust. Staff participated in networking with other emergency departments in nearby NHS trusts. This provided opportunities to share experience and external peer review of services.

## **Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The department had introduced innovative ways of working that helped to improve care in an effective way. These included 'point of care' testing for flu, introducing electronic recording of vital observations and tap on-tap off technology to access IT systems.

Leaders were working with IT professionals to develop a live emergency department (ED) dashboard, meaning there would be instant access to live data about ED performance. Staff explained the trigger systems would be built into this dashboard to illustrate and enhance understanding of when the department was crowded and under operational pressure.

Staff were open to learning and continuous improvements to the way they delivered care to patients. Quality improvement training was being offered but this was still fairly new to the trust. However, staff felt empowered to suggest improved ways of working and leaders listened to these suggestions and helped implement these if this was considered to be safe and beneficial.

## Medical care (including older people's care)

### Facts and data about this service

Medical care sits in the unscheduled care division of the trust. There are 320 beds, located across 11 wards:

- Acute Cardiac Unit
- Acute stroke unit (Falcon)
- Dove ward - cancer services
- Jupiter ward - care of the elderly - refurbished in 2014 to create a dementia-friendly environment
- Kingfisher ward - short stay medical ward
- Linnet Acute Medical Unit (LAMU), including the Medical Expected Unit (MEU)
- Mercury ward - cardiac and endocrinology
- Neptune ward - gastroenterology
- Saturn ward – respiratory medicine
- Teal ward - general medicine. Teal Older Persons Short Stay Unit (TOPSSU) provides high intensity therapies and medical care to support earlier discharge for appropriate patient groups
- Woodpecker ward - general medicine (with a dedicated team of ortho-geriatricians).

In addition, there are the following services:

- Cardiac Catheter Suite and Cardiac Rehabilitation Service
- Dorcan unit is a short stay ward, which provides extra capacity at busy times. It cares for patients who are well enough to leave hospital but are waiting for their out-of-hospital care package to be finalised.
- Orchard ward - normally a 'step up ward' to avoid the need for admission. This is a temporary medical outlier ward
- There is a discharge lounge open from Monday to Friday 8am to 6pm
- Day therapy Centre - chemotherapy
- Endoscopy unit
- Front door frailty team
- Ambulatory Care and Triage (ACAT) opened Dec 2018

*(Source: Routine Provider Information Request AC1 - Acute context)*

Medical care was provided for adults of all ages. The trust had 48,722 medical admissions from July 2018 to June 2019. Emergency admissions accounted for 24,123 (49.5 %), 1,279 (2.6 %) were elective, and the remaining 23,320 (47.9%) were day case.

Admissions for the top three medical specialties were:

- General Medicine – 24,458
- Gastroenterology – 5,589
- Medical oncology – 5,174

*(Source: Hospital Episode Statistics)*

During our inspection, we visited 14 wards, which included medical wards, therapy areas and surgical wards where medical patients were cared for when medical wards were full. We spoke with 34 patients or their relatives and 68 staff including; junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, bank and agency nursing staff, pharmacy staff, administrative and clerical staff and volunteers.

We observed interactions between patients, their relatives and staff, considered the environment and looked at 22 medical and nursing care records. Before our inspection we reviewed performance information from and about the hospital.

## **Is the service safe?**

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

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

## Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it most of the time.

### Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training. This had improved since our last inspection.

Overall, the trust set a target of 80% for completion of mandatory training, except for Information Governance, which was set at 95%.

A breakdown of compliance for mandatory training courses as of February 2020 for registered nursing staff in medicine is shown below:

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection Prevention (Level 1)	284	287	99.0%	80.0%	Yes
Duty of Candour	277	281	98.6%	80.0%	Yes
Venous Thromboembolism	245	250	98.0%	80.0%	Yes
Manual Handling - Object	281	287	97.9%	80.0%	Yes
Health, Safety and Welfare	279	287	97.2%	80.0%	Yes
Conflict Resolution	278	287	96.9%	80.0%	Yes
Equality and Diversity	274	287	95.5%	80.0%	Yes
Information Governance	273	287	95.1%	95.0%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	265	281	94.3%	80.0%	Yes
Referral to Treatment (RTT) Level 1	48	52	92.3%	80.0%	Yes
Alcohol Brief Advice	259	281	92.2%	80.0%	Yes
End of Life Care Level 2	235	255	92.2%	80.0%	Yes
Learning Disabilities Awareness Level 2	258	281	91.8%	80.0%	Yes
Slips, Trips and Falls	258	281	91.8%	80.0%	Yes
Learning Disabilities Awareness Level 1	263	287	91.6%	80.0%	Yes
Food and Hygiene Safety Level 1	255	281	90.7%	80.0%	Yes
Infection Prevention (Level 2)	251	286	87.8%	80.0%	Yes
Manual Handling - People	240	274	87.6%	80.0%	Yes
Mental Health Awareness Level 1	251	287	87.5%	80.0%	Yes
Adult Basic Life Support	248	284	87.3%	80.0%	Yes
Fire Safety 1 year	247	287	86.1%	80.0%	Yes
NEWS (National Early Warning Scoring System)	241	281	85.8%	80.0%	Yes
Medicine management training	239	281	85.1%	80.0%	Yes

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Smoking Brief Advice	235	281	83.6%	80.0%	Yes
Blood Transfusion	147	183	80.3%	80.0%	Yes

In medicine, the 80% target was met for all the 25 mandatory training modules for which registered nursing staff were eligible. The 95% target was met for Information Governance.

Medical staff received and kept up-to-date with their mandatory training most of the time.

A breakdown of compliance for mandatory training courses as of February 2020 for medical staff in medicine is shown below:

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Health, Safety and Welfare	173	184	94.0%	80.0%	Yes
Duty of Candour	170	182	93.4%	80.0%	Yes
Equality and Diversity	171	184	92.9%	80.0%	Yes
Infection Prevention (Level 1)	171	184	92.9%	80.0%	Yes
Manual Handling - Object	170	184	92.4%	80.0%	Yes
Blood Transfusion	48	52	92.3%	80.0%	Yes
Information Governance	169	184	91.8%	95.0%	No
Conflict Resolution	168	184	91.3%	80.0%	Yes
Venous Thromboembolism	165	182	90.7%	80.0%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	164	184	89.1%	80.0%	Yes
Slips, Trips and Falls	164	184	89.1%	80.0%	Yes
Adult Basic Life Support	157	183	85.8%	80.0%	Yes
Infection Prevention (Level 2)	150	183	82.0%	80.0%	Yes
End of Life Care Level 2	147	184	79.9%	80.0%	No
Learning Disabilities Awareness Level 2	143	182	78.6%	80.0%	No
Fire Safety 1 year	144	184	78.3%	80.0%	No
Learning Disabilities Awareness Level 1	144	184	78.3%	80.0%	No
Mental Health Awareness Level 1	142	184	77.2%	80.0%	No
Conflict Resolution Advanced	10	13	76.9%	80.0%	No
NEWS (National Early Warning Scoring System)	133	182	73.1%	80.0%	No

In medicine, the 80% target was met for 12 of the 20 mandatory training modules for which medical staff were eligible. The 95% target was not met for Information Governance.

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

The mandatory training was comprehensive and met the needs of patients and staff. Modules focused on the essential skills and knowledge staff needed to maintain patient and staff safety. Most clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Compliance for medical staff was below the trust target for some of these modules. The trust had staff who provided bespoke training on mental health issues when it was required. Staff on care of older people wards received training on dementia which included information on delirium and cognitive impairment. Managers monitored mandatory training and alerted staff when they needed to update their training. Training due, was discussed with staff at meetings with their managers. Those who did not meet the target were encouraged to attend and book sessions as soon as they were able. Medical staff told us there had been some IT issues with recording modules they had attended. They had repeated the online training, but it was still not recorded as completed. They had raised this with managers. We saw records of how managers monitored staff attendance at training. Ward staff were given areas of responsibility such as hand hygiene, dementia care and fire safety. The leads supported their colleagues to maintain standards and promoted their understanding.

## Safeguarding

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

### Safeguarding training completion rates

Staff received training specific for their role on how to recognise and report abuse.

The trust set a target of 90% for completion of safeguarding children training and 80% for adult safeguarding and PREVENT training. PREVENT training is aimed at recognising when people are at risk of being radicalised to support terrorism.

A breakdown of compliance for safeguarding training courses from 22 November 2018 to 21 November 2019 for registered nursing staff in medicine is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Preventing Radicalisation - Prevent Awareness - No Specified Renewal	2	2	100.0%	80.0%	Yes
Safeguarding Children (Level 1)	587	620	94.7%	90.0%	Yes
Safeguarding Adults (Level 1)	586	620	94.5%	80.0%	Yes
Safeguarding Children (Level 2)	581	617	94.2%	90.0%	Yes
Preventing Radicalisation - Basic Prevent Awareness - 3 Years	247	280	88.2%	80.0%	Yes
Safeguarding Adults (Level 2)	530	617	85.9%	80.0%	Yes

In medicine the safeguarding targets were met in all six safeguarding training modules for which

registered nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from 22 November 2018 to 21 November 2019 for medical staff in medicine is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	263	294	89.5%	80.0%	Yes
Safeguarding Adults (Level 2)	257	290	88.6%	80.0%	Yes
Preventing Radicalisation - Basic Prevent Awareness - 3 Years	114	135	84.4%	80.0%	Yes
Safeguarding Children (Level 1)	262	294	89.1%	90.0%	No
Safeguarding Children (Level 2)	256	290	88.3%	90.0%	No
Safeguarding Children (Level 3)	0	2	0.0%	90.0%	No

In medicine the safeguarding targets were met for three of the six safeguarding training modules for which medical staff were eligible.

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

Most staff had attended each of the modules required and where compliance was just below the target managers encouraged staff to attend as soon as they were able. Staff in the trust safeguarding team had achieved level 3 safeguarding training and staff in medical care had access to them for additional advice and support.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. This included descriptions of how they would report unusual bruising as well as how patients behaved when their relatives visited.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Safeguarding leads were available to support staff to report concerns and worked with staff in the local authority to protect patients. Information about outcomes of referrals was fed back to staff using email and verbally.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave examples of referrals they had made to safeguarding leads.

Staff followed safe procedures for children visiting the ward and knew who to contact if they had any concerns about a child's safety. Managers were available to support and knew who to contact if concerns arose outside of normal working hours.

## **Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean in most areas. Some fixtures and fittings looked in need of cleaning**

## **in the acute medical unit.**

Most ward areas were clean and had suitable furnishings. Most of these furnishings were clean and well-maintained. This was a concern in some areas of the service at our last inspection and was still a concern in the medical assessment unit, which included the medical expected unit (MEU). During our current visit we found storage areas were tidy and clean, with items stored off floor areas and in designated cupboards. Items we reviewed had not exceeded their expiry dates. However, we found areas of the acute medical unit which appeared to need cleaning. This included light pulls and a stain on a wall (the cause of which we could not identify). We repeatedly found items of equipment, such as shower chairs and toilet seat raisers which were not clean. Some lids used to cover commodes could not be reliably sanitised. This was because they had splits in their fabric exposing foam which could not be cleaned. We saw chairs used by visitors had splits exposing foam padding which could not be effectively cleaned.

Maintenance of some areas of the acute medical unit made it difficult to maintain hygiene. We saw areas where repair work had been undertaken around a sink and wood had been left exposed. The wood could not be reliably cleaned. Following our visit, we saw the service had requested maintenance and repair of these areas and trust approval had been given to carry out the work.

Cleaning records were up-to-date and demonstrated that most areas were cleaned regularly. However, we could not be assured these records accurately reflected cleaning actions in the acute medical unit. This was because of the area we found which did not appear to have been thoroughly cleaned. Cleaning supervisors reviewed cleanliness with nursing staff and any areas which fell below required standards were fed back to cleaning staff to be rectified. We saw cleaning records had been signed and dated when completed. Nursing staff cleaned equipment after patient contact most of the time and labelled equipment to show when it was last cleaned. We observed staff using this system to ensure most equipment was hygienic.

Staff followed infection control principles including the use of personal protective equipment (PPE). Gloves, masks and aprons were available and easily accessible for staff to use. At this inspection we saw staff using equipment to reduce the risk of cross-infection for patients. We saw staff moving patients into side rooms as soon as they learnt there was an infection risk.

The service audited and reported on staff compliance with trust policies regarding infection control practices. Hand hygiene audits were carried out as part of a monthly audit programme for each area. Poor staff compliance was fed back to each individual at the time and managers were informed. This was reported to and monitored by the infection control team.

The trust screened patients for the presence of MRSA and decolonisation therapy was commenced if found. Some patients may carry MRSA without experiencing any ill effects. It can transfer to other patients who may be vulnerable and cause them serious problems. We saw records showing patients had been screened for MRSA on their admission to a ward.

The service monitored the incidence of health associated onset of infections in the medical care directorate. Each case was reviewed and lapses in care identified to inform actions needed to improve. From August 2019 to January 2020 there had been 15 incidences of clostridium difficile and eight of Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia. Clostridium difficile can cause vomiting and diarrhoea and MSSA can cause serious problems if it gets into

the bloodstream. The infection prevention and control team monitored results each month. We saw records where these were discussed, and actions fed back to areas of risk.

There had been some incidences of infection in patients who had a urinary catheter across the trust. The service monitored these and were planning to trial the use of a comprehensive catheter pack when inserting catheters.

Infection control was a focus for the service. Some patients were cared for overnight in the endoscopy area at times of high patient demand. The infection prevention and control team had risk assessed the endoscopy area for infection risks. The area was cleaned daily after each endoscopy session and before ward patients were moved to the area.

Endoscopy services followed trust protocols for decontamination of equipment. There were segregated clean and dirty areas and processes were monitored.

## **Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe in most areas. Staff managed clinical waste well.**

The service had enough suitable equipment to help them to safely care for patients. The service had areas where patients could be cared for according to their need. There was an ambulatory care unit for patients who could sit and wait for treatment and specialist wards such as cardiac wards, respiratory wards and an area used to receive patients who were expected. There were side rooms in each area which could be used to isolate patients for infection control reasons. The Acute cardiac unit was adjacent to the critical care unit and monitoring equipment was available as needed. There were accessible bathrooms in most areas to support patients who had difficulty with mobility; however, on Dorcan Ward, the toilet/washroom was not accessible to patients who used a wheelchair and staff told us such patients would not be admitted there. Staff were able to access lifting equipment to safely support them moving patients. Pressure relief mattresses were easily available from the equipment library. Staff reported they never had a problem accessing equipment they requested.

Patients could reach call bells and staff responded quickly when called. We saw staff answering call bells promptly. Audits were carried out of how quickly staff answered patient bells and ward managers fed this back to staff. Extra beds which were used when there was greater demand for the service were placed in areas which did not have call bells. We saw staff provided patients with individual portable hand bells to use.

The design of the environment followed national guidance in most areas. Wards had bays of beds which could be used for either female or male patients. However, we saw, at times when there was high demand for the service, patients were cared for in areas not designed for individual patient care. Additional beds were placed in areas which did not have individual equipment such as piped oxygen and suction or curtains to surround the bed. Staff mitigated patient risk by providing portable suction and oxygen equipment and trolleys for the additional beds. Single rooms were available for use to prevent cross-infection between patients. Staff had managed outbreaks of infectious conditions, such as norovirus (winter vomiting bug) by cohorting patients. Cohorting was where patients with the same infection were cared for in the same ward area and

away from other patients. Rooms usually used for relatives were used to isolate patients when single patient rooms were in full use.

On the Medical Expected Unit (MEU) up to six patients were frequently cared for in the corridor. The area was not designed for inpatient care and working conditions were cramped and challenging for staff. The addition of tables for each patient, temporary screens used when examining patients, and relatives, standing or sitting wherever they could find a space, meant that the corridor was often congested. Manoeuvring patients was difficult and posed a fire evacuation risk and there was a risk that staff access may be hampered when required to provide emergency resuscitation. The fire evacuation risk had been identified and was on the division's risk register. Some actions had been taken to reduce risks, such as specifying where patient beds could be placed and reviewing with fire safety officers. There were plans to review these risks further with fire safety officers.

Some wards monitored people who accessed the ward to maintain patient safety. This was to maintain safety of patients who were experiencing some confusion (and may have a Deprivation of Liberty Safeguard application in place). Staff accessed the ward using a swipe card. Visitors were allowed entry to the ward by ringing a buzzer and waiting for staff to release the door lock.

Staff carried out daily safety checks of specialist equipment. At our last inspection we found that not all emergency equipment had been checked daily by nursing staff. This equipment was secured using a tamper-evident tag. We checked emergency equipment at the current visit and found staff had signed and dated logs of when equipment had been checked with minimal gaps. However, we found one emergency trolley had a noticeable amount of dust on its surface. Staff were informed and responded promptly to clean the equipment.

Staff disposed of clinical waste safely. Disposal of sharps such as needles, was managed safely and bins not overfilled. Other waste was segregated and stored safely away from patients and visitors until it was collected for final disposal. Equipment was available in the case of cytotoxic spillage and staff knew how to access and use it. Staff used specialist disposal systems for hazardous waste which reduced risks to patients and staff.

Endoscopy services had ready access to emergency equipment to treat and resolve large bleeds patients may experience at the time of their procedure.

## **Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them when required. This was documented using an electronic system. The NEWS (national early warning score) was calculated and if it showed a risk of five or above, would automatically alert the senior nurse and the relevant doctor. The system alerted nursing staff when further observations were due. Further actions were also prompted electronically, and staff were reminded to document that sepsis had been considered and the sepsis specialist team alerted if needed. Actions around sepsis were audited and matrons informed us there was 100% staff

compliance.

Staff knew about and dealt with any specific risk issues. This included risks of falling, developing a venous thromboembolism (blood clot), mental health issues and dietary requirements. We saw records documenting these risks when patients had been admitted. Some of these risks were documented on an electronic system and some on paper records. Patients who had neutropenic sepsis following cancer treatment were managed safely. Neutropenic sepsis is a side effect of chemotherapy where patients have an increased risk of developing sepsis. Staff described how they would manage the condition and how they would contact specialist staff for further support. There was a specialist nursing team for the management of sepsis. This team were alerted by staff who used the electronic system at the time sepsis was suspected. They responded immediately to follow up on care and treatment for these patients.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). In the care for older people ward, staff had support from the old age psychiatry team who they said responded promptly. We saw records showing assessments and advice provided to keep patients safe. We saw staff supervising patients on a one to one basis to keep them safe. In the care for older people wards, we saw staff had completed dementia and delirium care plans. These prompted staff to follow a list of daily actions to support that patient.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff gave examples of when patients' mental health deteriorated. The psychiatry team risk assessed patients and supported staff to meet patients' specific needs. Ligature risks were assessed and documented using a risk assessment tool. Actions were advised to reduce the risk and included providing one to one care. Patients' needs were reassessed, and records updated during their stay in the hospital.

Staff shared key information to keep patients safe when handing over their care to others. This was shared verbally between staff and patient records were handed over to staff on the new ward.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff used a template to handover key information to colleagues at change of shifts. Risks were highlighted using symbols on boards behind patient beds to alert staff to care needs. This included risks of falling, dietary requirements and cognitive function.

## **Nurse staffing**

**The service had enough nursing, and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Therapy staff were slightly below the agreed establishment levels for the service. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service had enough nursing and support staff of relevant grades to keep patients safe. At our previous inspection we found there was a shortage of nursing staff and a heavy reliance on bank and agency staff. The service had undertaken activities to attract staff to the service and staff numbers had increased. The vacancy rate was just above the trust target.

Therapy staffing on the stroke unit had been reviewed and increased. There was still a vacancy in occupational therapy of one whole time equivalent and recruitment processes were being undertaken to fill the vacancy. These staff worked across acute and rehabilitation areas of the patient pathway.

Managers used a national tool to accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. At our visit actual staffing matched that planned most of the time. There were occasions when there was one less health care assistant than was planned. This was displayed on wards for visitors and updated daily. Gaps in rotas were filled by bank and agency staff. Staff told us gaps of registered nurses were easier to fill than for health care assistants. There were plans to increase the numbers of substantive health care assistants and interviews had been arranged for the coming week. Staff told us staffing numbers in all areas had improved since our last visit although it still felt busy due to the increased number of patients who needed medical care.

Ward managers could adjust staffing levels daily according to the needs of patients. They followed trust systems to provide additional staff where it was needed most. Staff on Dove ward had frequently been moved during our previous inspection. Staff told us this was no longer an issue for staff.

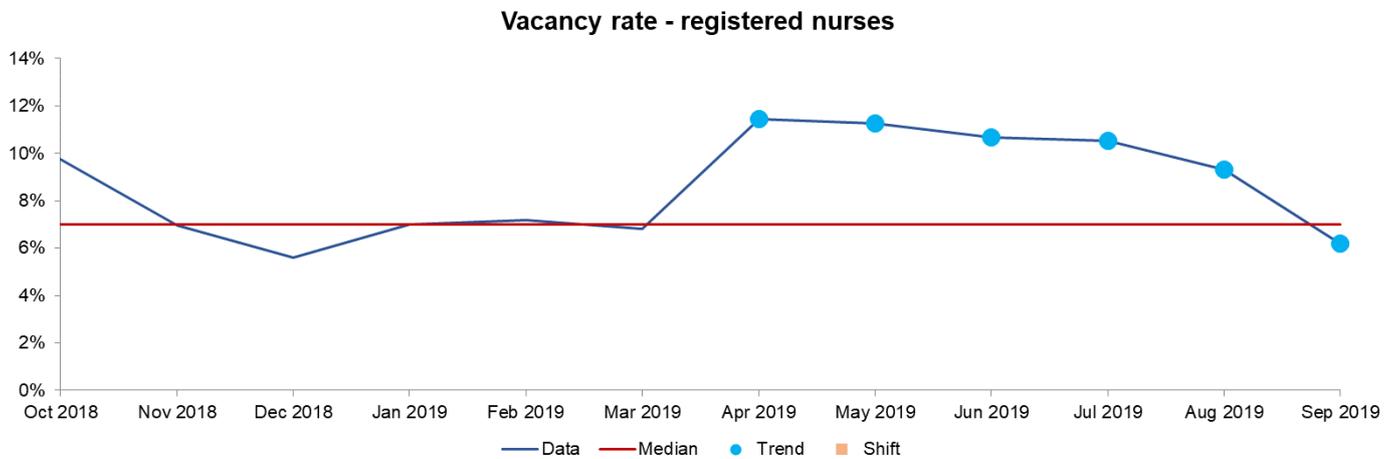
The table below shows a summary of the nursing staffing metrics in medicine compared to the trust's targets, where applicable:

<b>Medical care annual staffing metrics</b>							
October 2018 – September 2019					November 2018 – October 2019		
<b>Staff group</b>	<b>Annual average establishment</b>	<b>Annual vacancy rate</b>	<b>Annual turnover rate</b>	<b>Annual sickness rate</b>	<b>Annual bank hours (% of available hours)</b>	<b>Annual agency hours (% of available hours)</b>	<b>Annual unfilled hours (% of available hours)</b>
<b>Target</b>		8%	13%	3.5%			
<b>All staff</b>	793	7%	11%	3.5%			
<b>Registered nurses</b>	327	9%	12%	3.7%	45,192 (8%)	35,743 (6%)	7,270 (1%)

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)*

Nurse staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and agency use.

## Vacancy rates

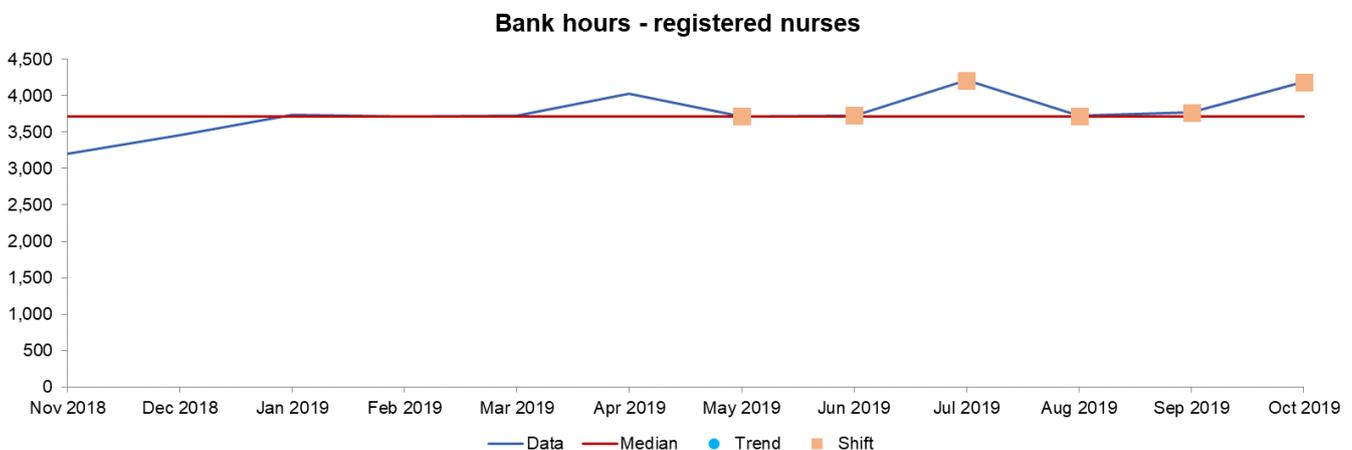


Monthly vacancy rates over the last 12 months for registered nurses showed a downward trend from April 2019 to September 2019. This was in line with the staff recruitment activities.

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

## Bank and agency staff usage

The service had variable rates of bank and agency nurses.



Monthly bank use over the last 12 months for registered nurses showed an upward shift in some months, from May 2019 to October 2019.

*(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*

Managers limited their use of bank and agency staff and requested staff familiar with the service. We spoke with agency and bank staff who had worked in the ward areas regularly. More staff were requested at times when there was high demand within the service.

Managers made sure all bank and agency staff had a full induction and understood the service. Bank and agency staff confirmed they had received an induction when they worked in any area that was new to them.

## Medical staffing

The service had enough medical staff to keep patients safe. However, service leads were aware the current staffing situation was not sustainable in the long term. Service leads had undertaken a review of medical staffing and recommended increasing consultant and junior doctor numbers in some areas. There had been some recruitment of non-training grade medical staff to increase medical staffing numbers. These were staff who wished to work in the service but were not planning on taking on consultant roles. In addition to this a junior doctor was allocated as a 'float' across the service. This person supported areas which were busy or short of medical staff.

The table below shows a summary of the medical staffing metrics in medicine compared to the trust's targets, where applicable:

Medicine annual staffing metrics							
October 2018 – September 2019					November 2018 – October 2019		
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
<b>Target</b>		8%	13%	3.5%			
<b>All staff</b>	793	7%	11%	3.5%			
<b>Medical staff</b>	149	6%	6%	1.4%	23,215 (7%)	9,661 (3%)	39,574 (13%)

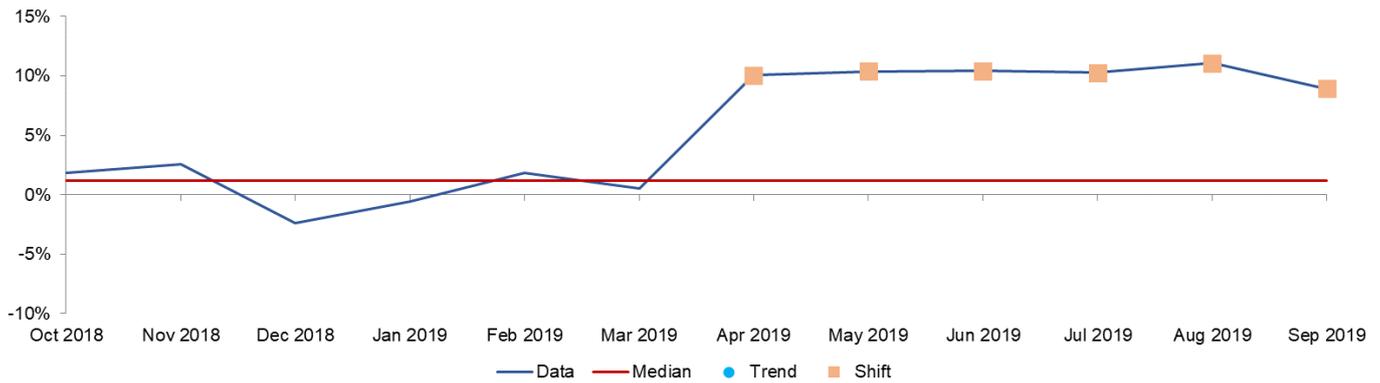
*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)*

Medical staffing matched the planned number on the rota.

Medical staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

### Vacancy rates

### Vacancy rate - medical staff

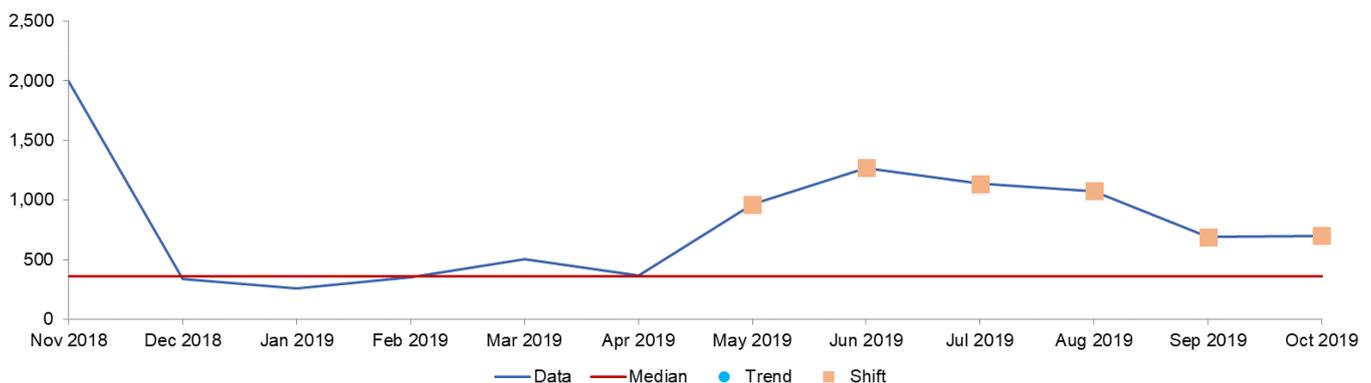


Monthly vacancy rates over the last 12 months for medical staff showed an upward shift from April 2019 to September 2019. This was explained as being due to staff retirement from the service and recruitment processes were being undertaken to fill the gaps.

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

### Bank and locum staff usage

#### Agency hours - medical staff



Monthly agency use over the last 12 months for medical staff showed an upward shift from May 2019 to October 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Managers could access locums when they needed additional medical staff. Where possible they used medical staff who were familiar with the service.

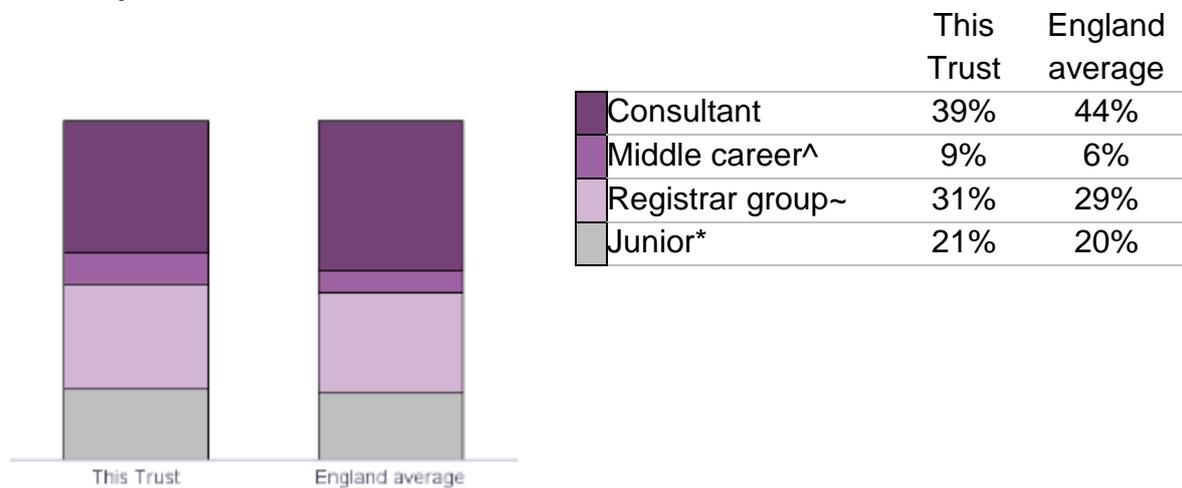
Managers made sure locums had a full induction to the service before they started work.

### Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In August 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was about the same as the England average.

### Staffing skill mix for the 180 whole time equivalent staff working in medicine at Great Western Hospitals NHS Foundation Trust



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

\* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/08/2019 - 31/08/2019))

The service always had a consultant on call during evenings and weekends. This included general medicine and specialty areas. The stroke service used a combination of specialist stroke medical staff and neurologists to cover the service out of hours. There was also a regional network of stroke consultants available to offer specialist advice out of hours. Cardiac and respiratory specialties had consultant cover for their areas.

Information exchanged at handovers promoted patient safety. We saw comprehensive handovers between medical, nursing and therapy staff at shift changes. Risks were highlighted and continuing care actions were shared with staff taking over care. Nursing staff held safety briefings at the start of each shift.

## Records

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

Our last inspection found patient records were not always kept up-to-date, stored securely or individualised.

At the current inspection we found patients' records were held securely in locked trolleys. All trolleys we saw were either locked or in use by staff.

Patients' notes were comprehensive, and all staff could access them easily. Authorised staff could access records using a number code on the trolleys. Medical records we reviewed were up-to-date, signed and dated and the plan of care was clearly documented. Records were well

organised and easy to navigate. Therapists, specialists and mental health liaison staff added to the records to ensure the person overseeing care was aware of all assessments and care needs. However, one patient record we reviewed did not have a complete mental health risk assessment by the psychiatric team. A summary was included, and staff told us they received an additional verbal handover from the psychiatric team.

Staff were able to review plans for patient care over the weekend. Criteria-led discharge plans were completed each Friday for patients who could possibly be discharged over the weekend. These contained guidance for staff about criteria for patients who could be discharged without consultant review.

Some nursing records were not completely up-to-date and did not provide assurance that care had been provided in a timely way. We saw assessments were completed either on the electronic system or in the individualised patient care plans. These provided guidance for staff caring for patients and the frequency of care rounding observations which were needed. Care rounding records were signed by staff once they had completed checks on patients, such as skin integrity checks, pain and comfort. The records were kept in or around the patient bed space. We found some of these had not been completed within the recommended time for some patients. This was particularly an issue for patients cared for in the corridor on the medical expected unit, where care rounding forms were not completed consistently or regularly and the frequency of rounding required was not documented.

When patients transferred to a new team, there were no delays in staff accessing their records. Records went with patients to their new areas and we saw staff handing over care to staff in the new ward area.

## **Medicines**

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked cupboards and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored and managed securely. Newly installed medicines cupboards had digital locks. Regular balance checks were performed in line with trust policy. The service used an electronic system for prescribing and administering medicines. This had inbuilt safety mechanisms to guide and support staff. The system was not used for intravenous medicines at the time of our visit but was to be introduced in the next phase of extending the system. Paper intravenous charts we reviewed were accurately completed and staff were fully aware of how to use the system.

Staff reviewed patient's medicines regularly, documented allergies and provided specific advice to patients and carers about their medicines. We saw nursing staff introduce themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. Handovers between staff highlighted when patients were prescribed time critical medicines such as for Parkinson's conditions. Each ward was supported by clinical pharmacy colleagues and could access prescribing guidelines on the local intranet. We saw

patients' allergies were documented. Chemotherapy patients had access to information about their treatment. They were able to attend clinics which were run by a specialist clinical pharmacist.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines fridge records showed medicines were stored at the correct temperatures. However, we found one liquid medicine did not have a clear expiry date identified. This was because there was no date of when it was opened, recorded on it. This was highlighted to the chief pharmacist for their action and they planned to remind staff of correct procedures. The electronic prescribing and medicines administration system was password protected and secure. Other prescription stationery was stored securely.

Dove ward were trialling of a method to support suitable patients to self-administer medicines. Special bedside lockers were operated by patients who had a dedicated arm band to open the locker. Patients were assessed for their ability to reliably operate the system. This meant patients would be able to access medicines, including time critical medicines, when they were due instead of relying on nursing staff to administer them.

Staff followed current national practice to check patients had the correct medicines. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet. Patient Group Directions were used and reviewed in line with national guidelines. Patients' medicines were reconciled in line with current national guidance on admission and when transferring between locations. There was a pharmacy lead for monitoring of antibiotic use. Laminated cards were carried by prescribers to promote best use of antibiotics. These were based on the national antimicrobial stewardship toolkit. Patients had blood samples tested by microbiology. Results of these samples were checked by the clinical pharmacist and required changes to prescriptions were shared with prescribers.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff knew how to report incidents or near misses via the trust's electronic reporting system. Staff we spoke with felt confident in raising an incident should they need to. They gave us examples of what they would report as an incident and how they would respond to the person involved.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Staff in medical care followed trust policy on the administration of covert medication if a patient's mental health deteriorated and needed restraining.

## **Incidents**

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

## that actions from patient safety alerts were implemented and monitored.

Staff we spoke with knew what incidents to report and how to report them. Staff described issues they had reported to their managers and how they used the electronic reporting system. They received feedback from managers about actions taken as a result.

Staff raised concerns and reported incidents and near misses in line with trust policy. Slips, trips and falls were reported, and themes identified. Any incidents relating to patients who were living with dementia were reported to the dementia strategy group for their information and analysis of how they could improve the service for these patients.

There was a newly formed Serious Incident Review and Learning Group which reviewed all serious incidents with a focus on improvement. There was evidence that changes had been made as a result of feedback. We saw meeting records which documented discussions around incidents reported. One near miss incident regarding use of nasogastric tubes resulted in additional training and support for staff. A greater variety of sizes for hoist slings was provided following an incident reported by staff.

Staff understood duty of candour. They described how they were open and transparent and gave patients and families a full explanation if things went wrong. 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. Each of the incidents we reviewed included contact with patients/relatives. Staff offered opportunities for patients/relatives to ask questions and be involved in the investigation.

## Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from November 2018 to October 2019.

A breakdown of incidents by incident type are below.

Incident type	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	2	40.0%
Pressure ulcer meeting SI criteria	1	20.0%
Medication incident meeting SI criteria	1	20.0%
Slips/trips/falls meeting SI criteria	1	20.0%
<b>Total</b>	<b>5</b>	<b>100.0%</b>

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

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Each of the three incidents we reviewed had been fully investigated and recommendations for improvement had been made.

## **Never Events**

The service had no never events on any of the medical care wards.

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.

The trust did not report any never events in medicine from November 2018 to October 2019.

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

Staff received feedback from investigation of incidents and never events, both internal and external to the service. Matrons shared information at meetings with matrons across the trust and cascaded learning to staff. Learning from national safety alerts was shared at team meetings and daily safety briefings at the start of a shift.

Staff met to discuss the feedback and look at improvements to patient care. A new role had been developed and was being recruited to. This was a role which would increase supervision for patients who may be at risk of falling and prevent the potential for patient harm.

Managers debriefed and supported staff after any serious incident. Staff confirmed they felt well supported and had no issues reporting concerns to their managers.

## **Safety Monitoring**

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

The medical service used its own data set to monitor patient harms. This was based on the national Safety Thermometer data. 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.

The service continually monitored safety performance. Safety data was displayed on wards for staff and patients to see. The information displayed was comprehensive and included incidence of patient falls, pressure ulcers, infections and hand hygiene audit results on each ward. The results of audits were monitored and reported to service leads and captured on a dashboard for

executive team oversight. However, we found areas on one ward, of potentially poor hygiene which had not been identified in routine audits which was a potential infection control risk.

Staff used patient safety data to further improve services. Ward managers discussed trends with staff at ward rounds and safety briefings and highlighted areas for improvement. Staff we spoke with were aware of the performance for their ward.

## Is the service effective?

**Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff had access to an electronic records system they could all update.**

### **Evidence-based care and treatment**

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Audits were carried out to ensure practice was compliant with the policies. New guidance was assessed and incorporated into the policy when it was reviewed. The service monitored policies which needed updating at monthly governance meetings. All policies we saw were up-to-date.

The service had a comprehensive audit plan and contributed to national and local audits. We saw action plans where they used results to guide practice. Service leads used specialist guidelines to improve stroke services and meet national guidelines. Cardiac services met national guidelines for their service.

Patients' needs were assessed, and staff followed national guidance to determine the best treatment options. This included patients with heart disease, lung cancer, risk of pressure ulcer formation and a risk of falling. Steering groups for pressure ulcer formation and falls risks monitored actions and incidences of each.

Records we reviewed on the acute medical unit showed patients were reviewed by a consultant and seen within nationally advised time frames after their admission. Patients who were elderly and frail were referred for a comprehensive assessment of their physical, mental and social needs. The electronic system prompted staff to assess patients who were over 65 years of age for further frailty assessment. We saw this documented in records we reviewed, and staff described how they would refer these patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We saw staff routinely referred to the psychological and emotional needs of patients, their relatives and carers at handover meetings.

## **Nutrition and hydration**

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Special diets were catered for and menus indicated which foods were suitable for diets such as diabetic patients or those needing high protein foods. Patients were able to store food brought in for them in ward fridges. Snacks were available for patients who needed to eat more frequently or needed smaller portions.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. This was completed when patients were moved from the medical assessment unit and admitted to a ward area.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Dietitians carried out swallow tests for patients who had suffered a suspected stroke. Dietary advice was written in the patient record and on a board at the head of each bed. Nursing staff were being trained to carry out swallow assessments to ensure patients received the assessment if they were admitted at the weekend and no speech and language therapist was available. Dietitians provided advice for patients who could not tolerate nutrition orally. Special feeding regimes were advised and provided.

## **Pain relief**

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. This included methods of assessing patients who had difficulty communicating. Staff monitored non-verbal signs of pain and discomfort which patients displayed. A specialist pain team was available to support patients who experienced more difficult to control pain.

Patients received pain relief soon after requesting it most of the time. There were increased demands on staff time when we visited, and two patients told us staff had taken longer than usual to respond to requests for pain relief. They acknowledged how busy nursing staff were. We heard and saw patients being asked about their pain and comfort levels in a way they could understand and respond to.

Staff prescribed, administered and recorded pain relief accurately. This was recorded on the electronic medicines system.

## **Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make**

**improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.**

The service used national and local audit data to identify where improvements could be made. The cardiology department had met standards set and achieved accreditation with the British Society of Echocardiography. Joint Advisory Group (JAG) on Gastrointestinal Endoscopy (JAG) accreditation had been achieved and renewed in October 2019.

### **Relative risk of readmission**

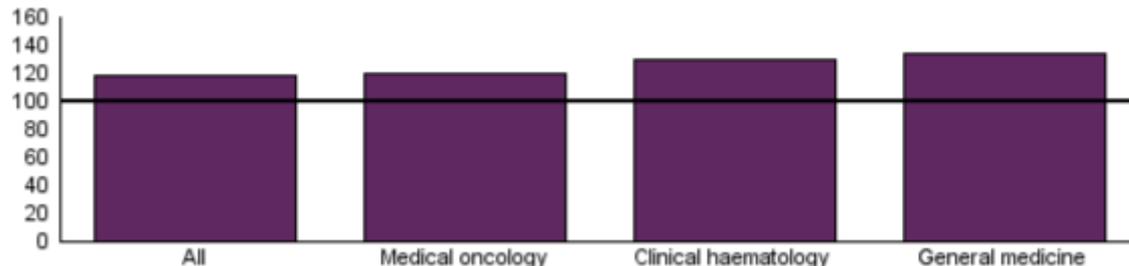
From June 2018 to May 2019, patients at Great Western Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

### **Elective admissions**

The following specialities had a higher than expected risk of readmission for elective admissions:

- All
- Medical oncology
- Clinical haematology
- General medicine

### **Elective Admissions - Great Western Hospital**



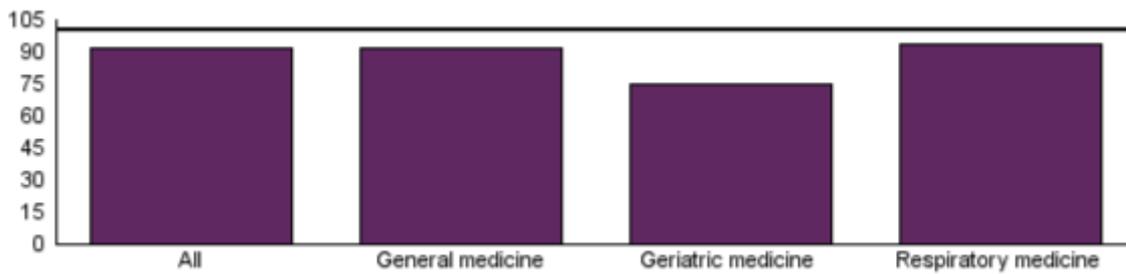
*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.*

### **Non-Elective admissions**

The following specialities had a lower than expected risk of readmission for non-elective admissions:

- All
- General medicine
- Geriatric medicine
- Respiratory medicine

### **Non-Elective Admissions - Great Western Hospital**



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 site based on count of activity.

The service participated in relevant national clinical audits. Outcomes were reviewed in detail and action identified for improvement.

Our last inspection found that patient outcomes, when benchmarked, did not always compare favourably with the England average. At the current inspection we found outcomes for patients were positive, and mostly met expectations, such as national standards and benchmarks. Where there were shortfalls, action plans were produced to improve outcomes for patients.

Managers and staff used audit results to improve patient outcomes. Managers shared and made sure staff understood information from audits. Improvement was checked and monitored. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw ongoing audits of pressure ulcer incidence, patient falls and compliance with the management of suspected sepsis. Ward managers told us how they used the information and were adapting nursing practice to improve care. One ward manager was introducing a practice of the registered nurse on shift carrying out skin checks at the change of staff, between night and day shifts. This was a practice usually carried out by health care assistants. The new practice was designed to reduce pressure ulcer incidence. Registered nursing staff were responsible for assessing patient care and providing guidance to health care assistants.

### Sentinel Stroke National Audit Programme (SSNAP)

Great Western Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D in the latest audit, July 2019 to September 2019. This was an improvement on the previous results.

### Great Western Hospital

	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sept 19
<b>Team centred performance</b>					
Domain 1: Scanning	B↓	A↑	A	B↓	B
Domain 2: Stroke unit	D	D	E↓	E	E
Domain 3: Thrombolysis	B↑	C↓	C	D↓	D
Domain 4: Specialist assessments	E	E	D↑	E↓	D↑
Domain 5: Occupational therapy	B↑	C↓	D↓	E↓	C↑↑
Domain 6: Physiotherapy	C↑	D↓	E↓	E	D↑

Domain 7: Speech and language therapy	E	D↑	C↑	E↓	D↑
Domain 8: Multi-disciplinary team working	D	C↑	B↑	D↓	B↑↑
Domain 9: Standards by discharge	D	C↑	B↑	B	A↑
Domain 10: Discharge processes	D	D	C↑	B↑	A↑
Team-centred total key indicator level	D	D	D	D	C↑

<b>Overall Scores</b>	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sept 19
SSNAP level	D	D	D	E↓	D↑
Case ascertainment band	B↓	A↑	B↓	A↑	A
Audit compliance band	B	B	B	C↓	C
Combined total key indicator level	D	D	D	D	C↑

(Source: Royal College of Physicians London, SSNAP audit)

The service had taken action and was continuing to improve patient outcomes. Some of these actions included recruiting a specialist nursing team, increased therapy staffing and an early supported discharge service. They had used a predictor tool devised by a high performing trust in stroke services. This predictor indicated Great Western Hospital stroke services would achieve an overall C rating by the end of March 2020. Following our inspection, the trust confirmed it had achieved a C rating in the latest audit, October to December 2019.

### Lung Cancer Audit

The table below summarises the trust's performance in the 2018 National Lung Cancer Audit.

<b>Metrics (Audit measures)</b>	<b>Trust performance</b>	<b>Comparison to other Trusts</b>	<b>Met national standard?</b>
<b>Crude proportion of patients seen by a cancer nurse specialist</b> <i>(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</i>	83.6%	Does not meet the audit aspirational standard	Did not meet
<b>Case-mix adjusted one-year survival rate</b> <i>(Adjusted scores take into account the differences in the case-mix of patients treated)</i>	32.8%	Within expected range	No current standard
<b>Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery</b> <i>(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients)</i>	19.1%	Within expected range	Met

<i>seen)</i>			
<b>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment</b> <i>(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</i>	60.7%	Within expected range	Did not meet
<b>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy</b> <i>(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</i>	71.4%	Within expected range	Met

*(Source: National Lung Cancer Audit)*

We saw results were discussed at local governance meetings and actions identified where improvement was needed. The National Lung Cancer Audit results had been an improvement on the previous audit results for these conditions.

### **Chronic Obstructive Pulmonary Disease Audit**

The table below summarises the trust's performance in the October 2018 to April 2019 Chronic Obstructive Pulmonary Disease Audit.

<b>Metrics (Audit measures)</b>	<b>Hospital performance</b>	<b>Audit's Rating</b>	<b>Met national standard?</b>
<b>Percentage of patients seen by a member of the respiratory team within 24hrs of admission?</b> <i>(Specialist input improves processes and outcomes for COPD patients)</i>	68.7%	Better than national aggregate	Met
<b>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%)</b> <i>(Inappropriate administration of oxygen is associated with an</i>	100.0%	Better than national aggregate	Met

<i>increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</i>			
<b>Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival</b> <i>(NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</i>	40.0%	Better than national aggregate	Met
<b>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy</b> <i>(Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</i>	0.0%	Worse than national aggregate	Did not meet
<b>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission</b> <i>(Completion of a discharge bundle improves readmission rates and integration of care)</i>	80.0%	Better than national aggregate	Met
<b>Percentage of patients with spirometry confirming FEV1/FVC ratio &lt;0.7 recorded in case file</b> <i>(A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</i>	33.4%	Worse than national aggregate	Did not meet

*(Source: Chronic Obstructive Pulmonary Disease Audit)*

Results were shared with the specialist team, leads for medical care and with trust executives. Where improvements were needed, or national standards could not be met an action plan was produced, and risks escalated to the risk register. The service did not contribute to the asthma part of this audit due to a lack of resource. A business case was being prepared to support an increase in resource to enable the service to provide information for future audits. We saw assessments prompted staff and they had offered patients who smoked, the opportunity for support to stop smoking. The records we reviewed documented patients had declined and staff confirmed this was usually the case.

### **National Audit of Dementia**

The table below summarises the trust's performance in the 2017 National Audit of Dementia.

<b>Metrics (Audit measures)</b>	<b>Hospital performance</b>	<b>Audit's Rating</b>	<b>Met national standard?</b>
<b>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good</b> <i>(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</i>	55.4%	Worse	No current standard
<b>Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?"</b> <i>(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</i>	70.9%	Worse	No current standard
<b>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium</b> <i>(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</i>	52.0%	Similar	No current standard
<b>Multi-disciplinary team involvement in discussion of discharge</b> <i>(Timely coordination and adequate discharge planning are essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</i>	78.6%	Similar	No current standard

*(Source: National Audit of Dementia)*

We spoke with clinical leads for dementia. They were positive about the impact the dementia strategy group were having in dementia care across the trust. They used results from the national audit for dementia to drive changes. We saw documented discussions in departmental governance meetings tracking progress of actions. There had been some improvements when compared with the previous audit and continuing improvements were identified. Dementia leads

aimed to increase awareness of dementia across the trust and improve screening for delirium. There had been some degree of success. Dementia leads had been consulted on the design of some trust facilities which were to be redeveloped and how they could make them more suitable for patients living with dementia.

The cardiac service had adopted a method of monitoring patients while maintaining their mobility. Monitoring had previously been carried out with patients needing to remain in bed or in a chair, with connections to a bedside monitor. Cardiac telemetry allowed patients to be monitored and able to move around the ward and hospital as they wished.

## Competent Staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Nursing staff were provided with support for their role and assigned a mentor when new to the service. Newly appointed staff found the system supportive and promoted their learning.

## Appraisal rates

From 12 November 2018 to 13 November 2019, 87.1% of staff within medical care received an appraisal compared to a trust target of 80%.

Staff group	12 November 2018 to 13 November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Allied Health Professionals	1	1	100.0%	80.0%	Yes
Estates and Ancillary	1	1	100.0%	80.0%	Yes
Additional Clinical Services	177	197	89.8%	80.0%	Yes
Administrative and Clerical	85	95	89.5%	80.0%	Yes
Nursing Registered	304	342	88.9%	80.0%	Yes
Healthcare Scientists	43	49	87.8%	80.0%	Yes
Medical	126	160	78.8%	80.0%	No

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal dates were monitored and where they did not meet the trust target of 80% meetings were arranged and staff encouraged to attend. Managers gave all new staff a full induction tailored to their role before they started work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they had training needs identified at their appraisals and in between times. They felt able to approach their managers to request

attendance at relevant training modules.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff had face to face meetings with their managers and felt supported to fulfil their role. We heard how staff had attended training with mental health colleagues to improve skills in caring for patients who were living with dementia.

Managers made sure staff received specialist training for their role. Specialist nursing staff had attended additional training for their roles and achieved further qualifications. Nursing staff who led on specialisms such as infection control and dementia care attended meetings to update knowledge and share with their colleagues. Some nursing staff were being trained to complete swallow assessments which would support patients who were admitted over the weekend.

Junior medical staff were positive about the support they received from senior colleagues and training provided. They felt encouraged to take responsibility and well supported by consultants. Simulation training was used to update practical skills such as life support processes. This gave staff the opportunity to discuss how they could improve their practice at the debrief part of the training. There was an educational supervisor lead and each doctor was allocated an education supervisor to support them. There was teaching from consultants and more senior medical staff on a weekly 'grand round' and departmental teaching within specialties

Clinical educators and the training academy supported the learning and development needs of staff. We heard of many occasions when modules had been designed by the training academy to meet bespoke needs of staff. The academy also promoted external courses for staff and worked with local universities to support staff accessing these courses.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes were put in communication books and emailed to staff for them to see.

Managers identified poor staff performance promptly and supported staff to improve. Additional training or supervision was supplied for staff who needed further support.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were receiving training to enable them to safely support patients who needed help with eating and drinking.

## **Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They took an active part in patient care and supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw how staff worked as part of a team to benefit patient care. Daily board rounds were used to assess continuing care and treatment needs. These were well attended by therapists, social workers, medical and nursing staff and were comprehensive in their content. Staff from learning disability or dementia services attended morning ward rounds for relevant patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was an agreement between this trust and a local mental health trust to provide support with mental health needs of patients. We saw and heard from staff how they felt supported by mental health colleagues and how this helped staff to care for patients safely.

Staff referred patients for mental health assessments when they showed signs of mental ill health. We saw mental health was reviewed during patient stays and treatment was adjusted according to the assessed need. Patients who may be at risk of absconding, were cared for with least restrictive options. We saw how this supported patients to receive the treatment they needed.

Patients had their care pathways reviewed by the relevant consultants. Consultants followed a system of reviewing their patients including at weekends. It was clear to see from records and boards displayed in patient bed spaces who had overall responsibility for each patient.

## **Seven-day services**

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

Consultants led daily ward rounds on all wards, including at weekends. Patients were reviewed by consultants depending on the care pathway. Consultants worked on a rota to provide on call support out of hours.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Support for mental health was from a crisis service out of hours. The service performed procedures to prevent patients' conditions deteriorating for patients with cardiac illness.

Services for patients who had experienced a stroke were limited at weekends. Measures were taken to provide safe care using agreements with surrounding health trusts and advice from specialist staff in the regional network. There was no established rota for therapy staff to work on the stroke unit at a weekend. Staff could choose to work at a weekend and would be paid for this as overtime.

## **Health promotion**

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

The service had relevant information promoting healthy lifestyles and support on the wards/units. Leaflets were available for patients and relatives to read about conditions they were living with and support services available. The stroke unit worked closely with rehabilitation services and supported patients to be independent as much as they could be. Patients told us they felt informed about how to care for themselves when they returned home. Mental health staff worked with patients to improve their outcomes and ability to cope at home. Older patients were encouraged to mobilise and improve their activity levels to reduce deterioration from being in a hospital environment. Patients who had experienced a stroke were discharged with a stroke passport. This held information for them of who to contact in health and social care, any appointments and what their health and social care plan was at discharge from the service.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, the rationale for best interests decisions was not always fully documented.**

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. We observed staff seeking patient consent for any activities undertaken and care provided. Staff clearly recorded consent in patients' records. Staff on the care for older people wards supported patients to make decisions by using a consent form, which was based on guidance issued by the Department of Health. These had been reviewed and updated by the service in October 2019. The consent form had a flowchart which staff used to measure a patient's ability to consent to a specific medical or surgical intervention. We saw consent forms signed by patients undergoing procedures, which were signed and dated by the senior doctor caring for the patient.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but did not always fully document the information. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions but did not always document this accurately. We saw best interests meetings had taken place and advance decisions made about their care. These decisions were documented in patients' records in most cases. In three of eight records we reviewed, mental capacity had been accurately recorded but best interest forms had not been fully completed. The incomplete forms were for patients on Jupiter ward, which was a general medical ward.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff worked alongside the patient's independent mental capacity advocate (IMCA) to organise their recovery in the most appropriate setting. Staff described the processes they used and gave examples of working alongside mental health colleagues. We saw how staff managed and documented care for patients who had expressed suicidal thoughts. Mental health liaison staff had documented advice for care and communicated this to ward staff.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw applications had been completed and sent to the local authority for approval. This is a process to authorise the trust to deprive a person of their liberty for up to seven days. It must be in the person's best interest and follow strict criteria. We saw how staff managed patient behaviour with the least force necessary. Patients were observed but not deprived of their liberty in order to encourage them to accept treatment and care they needed.

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

Nursing staff received and kept up-to-date with training in the Mental Capacity Act and

Deprivation of Liberty Safeguards. Medical staff received and kept up-to-date with training for Mental Capacity Act but had not all attended training on the Mental Health Act.

The trust set a target of 80% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training modules from 22 November 2018 to 21 November 2019 for registered nursing staff in medical care is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	562	613	91.7%	80.0%	Yes
Mental Health Act	543	613	88.6%	80.0%	Yes

In medicine the target was met for all MCA/DoLS training modules for which registered nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training modules from 22 November 2018 to 21 November 2019 for medical staff in medical care is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	253	294	86.1%	80.0%	Yes
Mental Health Act	174	294	59.2%	80.0%	No

In medicine the target was met for one of the two MCA/DoLS training modules for which medical staff were eligible.

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

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and DoLS. Medical staff described their involvement with mental health assessments and their experience of detaining patients under the Mental Health Act. Staff from mental health teams supported trust staff in following the correct pathway for patients.

## Is the service caring?

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from patients and those close to them, was positive about the way staff treated them.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients and relatives told us staff always introduced themselves and we observed staff doing so. We saw staff respecting patients' views and always asked consent before performing any procedure. We heard how staff were collecting donated clothes and having them washed for patients to wear if they had not brought any in for themselves. This was to provide a sense of normality for patients and provide dignity.

Patients said staff treated them well and with kindness. All interactions we observed between staff, patients and visitors were respectful. We saw staff providing care in difficult situations and maintaining kindness and respect. Staff were challenged because of a high number of patients to care for. They maintained respectful interactions and treated patients as individuals. One patient told us "It's the little things that make the difference that people don't see."

Staff followed policy to keep patient care and treatment confidential. We observed staff lowering their voices to maintain patient confidentiality. This was challenging in busy areas and some patients felt conversations could be overheard by others. Staff used curtains to protect patients' dignity but, although temporary screens were sometimes used in corridor areas, this was not always possible.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed how staff supported patients with mental health needs with respect. Some patients wanted to leave the ward for a breath of fresh air but were at risk of leaving the hospital instead of receiving care they needed. This was discussed with the patients and staff accompanied them when they left the ward for a short time. Natural conversation made the patients feel comfortable and supported rather than observed or restricted.

Patients gave positive feedback about the service. A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. Service leads monitored response rates and took action to gain more patient feedback.

Staff gave examples of how they used patient feedback to improve the quality of care they provided. We heard of staff responses to comments made by patients. Some actions concerned noise levels at night and lights left on. Staff arranged for maintenance of squeaky doors and lights to be dimmed at night.

## **Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff took time to have conversations with patients and their families and provided further information in the form of leaflets to support the conversations. Patients stated staff were “very caring and understanding”. We also heard patients comment on how busy nursing and medical staff were.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff spoke calmly to patients who displayed confusion, found out what they wanted and supported them to achieve their aim. There were not many private spaces on wards to use for sensitive conversations. Staff used what space they could, such as relatives’ rooms where they were available or unused clinic or office space. Patients told us they felt supported by staff.

Staff demonstrated empathy when having difficult conversations. We saw senior staff having kind conversations with patients and their families. Patients told us staff apologised readily if responses or planned care actions were delayed.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed staff making every effort to support patients to accept care they needed. They expressed understanding of patients’ situations and explained next steps in care.

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

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

Staff made sure patients and those close to them understood their care and treatment. Most patients felt they were informed of the plan for their care and some were still undergoing investigations and awaiting the outcomes. However, many patients and relatives in the medical expected unit expressed frustration that they did not know what was going on.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff answered questions, giving time for information to be processed. Staff told us how they could use a language support service if English was not a first language for patients and relatives. There was also a device to support communication with patients who experienced hearing difficulties and used sign language. Patients told us they understood their options of care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback forms were available for patients to provide their views on the service. Patients we spoke with knew how to do this. We heard feedback from patients stating, “doctors talk to you and explain everything” and “doctors put you at ease”.

Staff supported patients to make advanced decisions about their care. We saw treatment escalation plans were used to record whether patients wanted to be resuscitated if they became very unwell. Discussions were documented and families were involved in the conversations.

Staff supported patients to make informed decisions about their care. Patients we spoke with felt fully informed about their care and choices they could make. Some patients were still having their condition assessed and no clear plan of care had been decided. They were aware of the reasons for investigations and next steps in their care and felt staff had helped them to understand choices available.

## Is the service responsive?

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

**The service planned and provided care in a way that met the needs of local people and the communities served, however bed capacity did not always meet demand. The service also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services to meet the needs of the local population; however, it was acknowledged by the trust that the hospital did not have sufficient capacity to meet the needs of the growing population of Swindon. This was most acutely felt in medical care, where demand for inpatient care was often more than bed capacity. The trust had recently acquired one floor of a nursing home in Swindon, where patients, previously accommodated on Orchard Ward, were cared for. This allowed Orchard ward to be used as a medical ward, thus providing some much-needed additional capacity over the winter months. Although this provision was temporary, discussions were ongoing about extending the arrangement or making it permanent.

Insufficient bed capacity impacted on patients' experience. Some patients were accommodated in areas not designed for inpatient care, such as endoscopy, theatre recovery and the day surgery unit. Extra bed spaces had been established on wards and patients were sometimes cared for in a ward corridor (known as 'boarding'). The decision-making process to place patients in these areas, the identification of suitable patients, and the circumstances in which this decision would be taken were set out in the Full Hospital Protocol (see Access and Flow below).

Extra bed spaces were established at the end of ward bays. Bed spaces were small, cramped and not fully equipped. In some cases, the door to the bay opened onto the bed, there was little room for relatives to sit by the bedside and privacy was compromised by ill-fitting curtains. The limitations were all set out in the Full Hospital Protocol, so it was clear that a formal risk assessment had taken place, and these were accepted risks in the context of a hospital in extreme escalation.

On the Medical Expected Unit (MEU) up to six patients were accommodated on trolleys in the corridor most of the time. On 11 February 2020 it was reported at the site management meeting that the longest wait on a trolley was 23 hours. Staff on MEU recognised that corridor care was not a dignified or comfortable experience for patients and had taken steps to improve this. This included the provision of tables, a call bell, eye masks and ear plugs to aid sleep. Despite these commendable intentions and efforts, when we spoke with patients who had spent the night in this corridor, they described an uncomfortable night with little sleep. We noted the operational checklist for the MEU (dated 5 July 2017) stated "Patients will not be queued overnight".

Staff knew about and understood the standards for mixed sex accommodation and knew when to

report a potential breach. However, there were frequent mixed sex breaches when the hospital was under extreme pressure. There were 540 mixed sex breaches reported in December 2019 in the medical expected unit (MEU). The nature of this assessment unit meant, that in theory, patients would only stay for a short time. However, shortfalls in bed capacity meant patients stayed for longer, including overnight. Staff on the unit, felt there was little they could do to avoid mixed sex breaches, given how busy the unit was. However, they told us they did not receive complaints from patients or relatives about this.

Facilities and premises were not wholly appropriate for the services being delivered. Dorcan ward had been established as an escalation ward for some years. Originally an 'overflow ward' for use during extreme operational pressure, it was now open all year round to provide additional capacity. At our last inspection, the ward was designated a short stay ward for stable medical patients and accommodated both male and female patients. As there were not separate toilet facilities for men and women, men had to use toilet and bathroom facilities on a neighbouring ward. At this inspection we found the ward now only accommodated men. Although still designated an outlier or escalation ward, the admission criteria had been extended and many of the patients stayed a long time. There were toilets and a washroom available on the ward but no bathroom facilities. Staff told us most of the time, patients could access bathroom facilities on the neighbouring ward, although at times of extreme escalation this may not be possible. In these circumstances, patients were supported to have a wash with bowls of water by their bedside. The ward sister acknowledged this was not ideal but told us they had not received any complaints about the lack of bathroom facilities. The ward also had no piped oxygen, meaning that oxygen cylinders had to be stored on the ward, and no sluice, which required staff to use facilities on a neighbouring ward.

The medical expected unit (MEU) was a short stay assessment unit and accommodated patients on trolleys or chairs, in bays and on the corridor. Patients often stayed longer than they should because of poor patient flow in the hospital. Six patients were regularly accommodated in the corridor, where they had no privacy. A cubicle space in one of the bays had been allocated to allow patients examinations to take place in private. Patients were provided with small tables to allow them to have access to drinks, and a bell to summon staff assistance. However, they had little space to store their belongings and relatives often had to stand as there was insufficient room for them to sit. It was reported at the site management meeting on 11 February 2020 that, in addition to six patients in the corridor, one patient had spent the night on the settee in the relatives' room. When we visited the MEU, staff told us this patient had been accommodated in the relatives' room as a precaution because they had a weakened immune system and were susceptible to infection. On 13 February we again saw the relatives room used as a side room to isolate an infectious patient. This meant relatives were sometimes unable to use the relatives' room.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Psychiatry support was available five days a week and out of hours urgent referrals were made for support. There were specialist dementia nurses and learning disability nurses. We saw that staff worked closely with these teams.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients were placed on specialty wards depending upon their need and when there

was available space. This included respiratory, cardiac, stroke, gastroenterology and oncology. The cardiac service did not have any outlying patients (cardiac patients on other wards). However, other patients were not always cared for on the ward for their specialty due to lack of bed space. These patients were individually risk assessed and those with the greatest need were allocated beds in the specialty ward.

The service relieved pressure on other departments when they could treat patients in a day. The service had opened a same day emergency care unit in December 2018. This was known as the Ambulatory Care and Triage unit (ACAT) and operated Monday to Friday from 8am to 8pm. The unit assessed patients urgently referred by their GP to establish whether they required admission. Patients were assumed to be ambulatory until proven otherwise. Patients requiring admission received diagnostic tests before their transfer to the inpatient assessment area. Point of care testing was available to diagnose conditions such as community acquired pneumonia, upper gastrointestinal (GI) bleed and sepsis. This meant some patients who would previously have been admitted could, for example, be discharged with appropriate medicines, or seen on an outpatient basis. Data shared with us in September 2019 showed out of 3,421 patients seen in ACAT since it opened, 451 patients (13%) avoided admission.

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

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff received training on the needs of patients living with dementia. Staff followed trust policy and supported patients living with dementia and learning disabilities by using 'All About Me' documents and patient passports. For patients living with dementia, staff supported them to fill out a booklet on their admission, called 'All About Me'. Staff used this booklet to collect information about the person's preferences around eating, drinking and personal hygiene. Patients also stated things that made them happy or upset, the way they preferred to communicate and information about their life so far. We saw these used for patients to support staff in providing individualised care for patients.

Wards were designed to meet the needs of patients living with dementia. Orchard ward had recently been painted in colours chosen by the staff to aid people to orientate themselves, with each bay painted in a different colour. Other medical care wards we visited had bays identified using a symbol as well as different coloured bays. Jupiter ward had been designed in a way that supported patients living with dementia. A seating area with comfortable sofas was available. This was in an area that was easily monitored by staff and patients were able to play board games and listen to the radio. Signage for patient areas was pictorial and large, which supported patients with poor vision or cognitive problems.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, patients and their loved ones and carers could get help from interpreters or signers when needed. This was accessible using phone or face-to-face systems. The service had information leaflets available in languages

spoken by the patients and local community. Picture symbols were used on menus and leaflets were available in easy read format, larger print or braille. There was a newly acquired electronic visual service which provided British Sign Language for patients who were deaf.

Patients were given a choice of food and drink to meet their cultural and religious preferences where possible. Wards had facilities to store food which visitors had brought in for patients. Food was labelled, stored in ward fridges and brought out when requested.

## **Access and flow**

**People could access the service when they needed it. They received care promptly but not always in the most appropriate environment for their needs. The service admitted, treated and discharged patients in line with national standards.**

Managers monitored waiting times to ensure patients could access services when needed and receive treatment within agreed timeframes and national targets. However, patients did not always receive timely care in the most appropriate environment because of lack of capacity and flow.

The trust had effective oversight of patient flow and there were structure and processes to manage patient flow. There was a site management function, overseen by the Chief Operating Officer and their deputy. A Head of Patient Flow appointed in the summer of 2019 managed a team of site managers. The trust operated a command and control system for site management, with designated senior divisional managers rotating through the gold command position, supported by deputy divisional managers (silver command). Gold command chaired site management meetings (three daily), which were attended by senior representatives from all divisions. There was a structured agenda, which focused on activity/attendance, targets, bed availability, actual and planned discharges and flow. There was a review of outliers and staffing, infection control and any support services/estates/equipment issues which may impact on service delivery and patient safety. Real time hospital activity from the hospital's electronic patient records system was displayed and updated on interactive screens. An action log was maintained and reviewed at each meeting. Night plans were discussed at the afternoon meeting and a further update was provided by telephone to on call managers in the evening.

The trust used the Operational Pressures Escalation Levels (OPEL) framework, which allowed them to assess the severity of operational pressure and the appropriate escalation response. There was a list of escalation options to guide the order of escalation and de-escalation.

There was a discharge lounge for medical patients, which was open from 8am to 8pm Monday to Friday. This was an area which was used for patients who were fit for discharge and waiting for medicines or transport home. The service was taking steps to promote and increase its use. This included the re-launch of an initiative known as '10 before 10', which encouraged wards to anticipate and plan discharges early in the day to support inpatient flow.

There were numerous initiatives and workstreams to address the many factors which impacted on flow and patient experience. The Ambulatory Care and Triage unit was using 'point of care' testing systems to diagnose patients with suspected flu, community acquired pneumonia and sepsis. This reduced waiting times for test results, which traditionally would have been processed

by laboratories and aided clinical decision-making regarding admission.

Managers and staff worked to make sure they started discharge planning as early as possible. Estimated discharge dates were discussed and reviewed at board rounds. There was a criteria-led discharge proforma produced on Fridays, printed on yellow paper and stored in patients' records so that discharges could be facilitated at the weekend without consultant review if criteria were met.

Staff planned patient's discharge carefully, particularly for those with complex mental health and social care needs. The discharge team supported patients with complex needs who were to be discharged. They liaised with community and mental health services to provide suitable care for patients going home. We observed discussions on board rounds between mental health services, social workers and therapists to identify actions needed to discharge patients safely. The medical care service was trialling a 'green to go' form to promote safe discharges. This was a list of prompts for staff to action when planning discharges and included who to contact prior to discharge. The trial had been active for three months and was to be audited. Matrons told us there had been fewer complaints about discharge since the trial had begun.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. However, the divisional management team told us the trust was one of the worst performing in the country in relation to delayed transfers of care. Delayed discharges were monitored by the site management team and discussed at site management meetings. There was regular dialogue with external health and social care partners, with conference calls held three times a week to facilitate discharge for patients who often had complex medical and social care needs.

There was a focus on stranded patients; the medical director led daily review of patients with a length of stay over 20 days. Patients were reviewed and coded using methodology and criteria developed by the ECIP (Emergency Care Improvement Programme) so that there was a clear understanding of any blockages in the system. On 12 February, there were 75 patients with a length of stay of more than 20 days. The average length of stay for this group of patients was 36.69 days. This information was tracked over time and broken down by ward to support an understanding of where hold ups were.

Staff supported patients when they were referred or transferred between services. Managers worked to minimise the number of medical patients on non-medical wards; however, there were a significant number of medical patients accommodated on non-medical wards and overnight in escalation areas, which were not designed for inpatient care. These patients were known as medical outliers.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. There was a team of doctors employed to review medical outliers daily. The team of five or six junior doctors was led by two locum consultants and carried two phones so that ward staff could seek advice or request an urgent patient review. Nursing staff caring for medical outliers told us they had no concerns about the responsiveness of the medical team. Out of hours, medical advice was provided by the on call medical registrar. Because of their temporary employment status, there had previously been concerns about the resilience of this team and therefore the consistency of cover. This was managed and overseen by a deputy

divisional director who facilitated a daily board round with the doctors. The deputy divisional director overseeing this during our inspection told us medical cover had been “patchy” during December 2019 but was now more consistent. Regular updates were reported at each site meeting to confirm the team was fully resourced and ensure that all medical patients received a medical review. We were told that in the absence of locum consultants, relevant speciality doctors were asked to review patients, and this continued to be overseen at site management meetings. The management of outliers was set out in an operational checklist dated May 2017, which we noted was overdue for review, and did not accurately set out the strengthened process described to us during our visit.

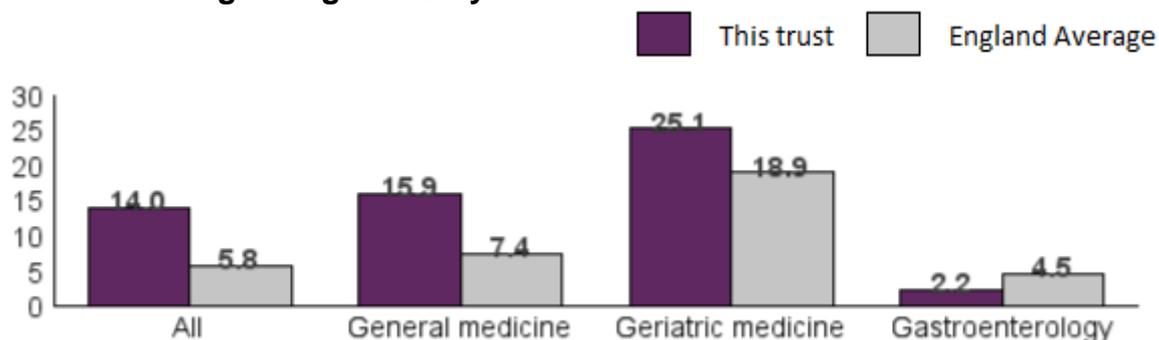
### Average length of stay

From July 2018 to June 2019 the average length of stay for medical elective patients at the trust was 14.0 days, which is higher than the England average of 5.8 days. For medical non-elective patients, the average length of stay was 5.5 days, which is lower than the England average of 6 days.

### Elective Average Length of Stay

- Average length of stay for elective patients in general medicine is higher than the England average.
- Average length of stay for elective patients in geriatric medicine is higher than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.

### Elective Average Length of Stay – Trust Level

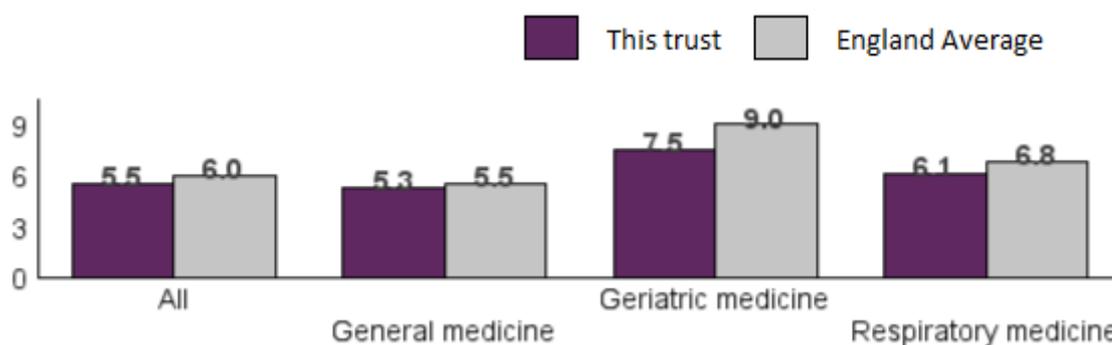


Note: Top three specialties for specific trust based on count of activity.

### Non-Elective Average Length of Stay

- Average length of stay for non-elective patients in general medicine is similar to the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is similar to the England average.

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



Note: Top three specialties for specific trust based on count of activity.

## Great Western Hospital

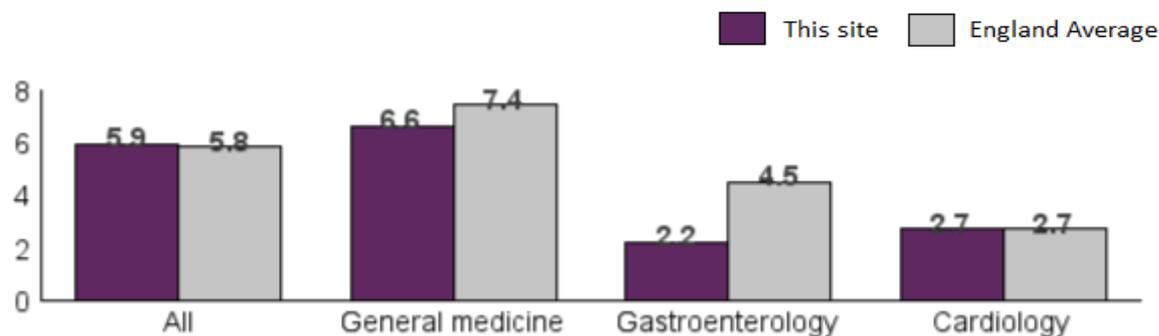
Managers and staff worked to make sure patients did not stay longer than they needed to.

From July 2018 to June 2019 the average length of stay for medical elective patients at Great Western Hospital was 5.9 days, which was higher than England average of 5.8 days. For medical non-elective patients, the average length of stay was 5.3 days, which was lower than England average of 6.0 days.

## Elective Average Length of Stay

- Average length of stay for elective patients in general medicine is lower than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in cardiology is similar to the England average.

## Elective Average Length of Stay - Great Western Hospital



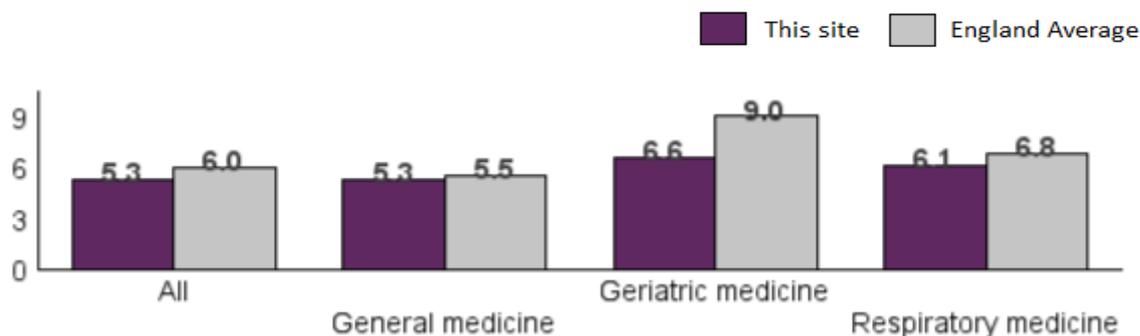
Note: Top three specialties for specific site based on count of activity.

## Non-Elective Average Length of Stay

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is similar to the England average.

- Average length of stay for non-elective patients in respiratory medicine is similar to the England average.

### Non-Elective Average Length of Stay - Great Western Hospital



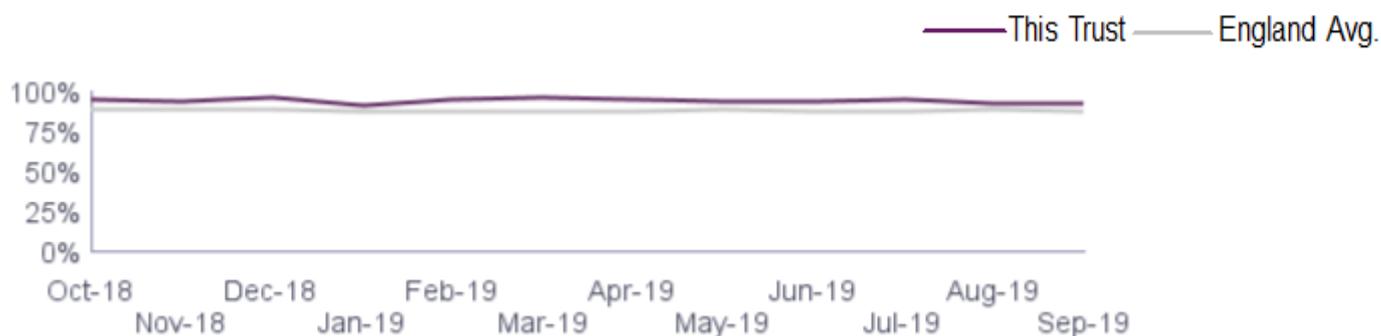
Note: Top three specialties for specific site based on count of activity.



(Source: Hospital Episode Statistics)

### Referral to treatment (percentage within 18 weeks) - admitted performance

From October 2018 to September 2019 the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.



(Source: NHS England)

### Referral to treatment (percentage within 18 weeks) – by specialty

The trust submitted information to a nationally published data base to compare performance against other trusts.

Four specialties performed better than the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Geriatric Medicine	100.0%	96.5%
Thoracic Medicine	96.9%	93.9%
Cardiology	96.0%	80.5%
Gastroenterology	93.3%	92.1%

Two specialties were below the England average for admitted pathway RTT (percentage within

18 weeks).

Specialty grouping	Result	England average
General Medicine	94.5%	96.3%
Rheumatology	66.7%	94.3%

*(Source: NHS England)*

Results for general medicine patients were just below the England average.

Rheumatology results for patients admitted within 18 weeks of being identified as needing admission was below the England average. However, the number of patients was very low, which makes a large difference when displayed as a percentage. The service reviewed reasons for delays to identify any trends and potential for improvement.

### **Patients moving wards per admission**

Managers monitored patients' moves between wards/services to ensure they were kept to a minimum; however, due to bed capacity, moves were frequent. The trust reported the number of patients experiencing additional bed moves during their stay was 496 in December 2019. Additional moves are those excluding moves from assessment units to base wards.

The decision to move patients was often taken for primarily operational reasons and not because there was a clear medical reason or was in the patients' best interests. However, there was a process by which multidisciplinary teams on wards assessed and selected patients who would be suitable to outlie. The operational checklist (dated May 2017) for Medical Outliers (criteria and management of), dated May 2017 set out how appropriate patients should be identified by medical teams at their morning board rounds, as being suitable to outlie in surgical wards when there were no medical beds to accommodate demand. The criteria were: medically fit, not confused and must not have an expected discharge date within the next 48 hours. This information was stored on an electronic system which could be viewed by the site management team, to inform their decision-making. The expectation outlined in the operational checklist, was that, as the hospital de-escalated, outlying patients would be transferred to medical wards unless they had an expected discharge in the next 48 hours. This was to avoid unnecessary handover and assist continuity of care.

From November 2018 to October 2019, within the top two medical wards, 87.1% of patients did not move wards during their admission and 12.9% moved once or more.

*(Source: Routine Provider Information Request (RPIR) – Ward moves tab)*

### **Patients moving wards at night**

Staff moved patients between wards at night.

From November 2018 to October 2019, there were 7,353 patient moves at night within medical care. Patients we spoke with were accepting of the need to move them, although they did not fully understand the reasons for this and complained about disturbed sleep.

*(Source: Routine Provider Information Request (RPIR) – Moves at night tab)*

Staff on Teal ward had undertaken a quality improvement project to reduce the moves of frail older patients. They introduced a recognised frailty scale, to aid the decision-making process around who should be moved to another ward. This had been shared with and adopted by other wards and had helped to reduce the number of severely frail patients being moved for non-clinical reasons.

## **Learning from complaints and concerns**

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with felt able to complain if they needed to. The service clearly displayed information about how to raise a concern in patient areas. Feedback forms were available in each ward area for patients and relatives to complete. Matrons and ward sisters spoke with patients regularly and encouraged them to comment about their care. Matrons used regular audit days to engage with patients and gain feedback about their care.

Staff understood the policy on complaints and knew how to handle them. Ward staff told us how they tried to resolve any issues at an early stage to improve the patient experience of receiving care and treatment. Staff described how they would escalate any concerns they could not resolve.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff gave examples of how they used patient feedback to improve daily practice. The service included patients in the investigation of their complaint. The divisional director of nursing shared with us a complaint from the family of a patient who died in hospital and their wedding ring was lost. The investigation revealed that although there was a process for recording patients' property on admission, there was not a similar 'signing out' process on discharge or death. The family had been invited to assist the trust to develop and introduce a more robust process.

In response to a complaint about patients being unaware they could take their usual medicines, a trial was underway on Dove ward to allow self-administration of Parkinson's medicines so there was no delay for patients needing time critical medicines.

Managers investigated complaints and identified themes. These were discussed at divisional meetings and included timescales for responses after the investigation. From November 2018 to October 2019 there were 242 complaints about medical care. The trust took an average of 22.2 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be closed within 25 days. However, it was reported to the trust board in February 2020 that there were 20 outstanding complaints in unscheduled care in December 2019 and response targets were not being met. The divisional director of nursing had good oversight of complaints and met weekly with the Patient Advice and Liaison Service to review actions needed.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning was shared at board rounds, daily safety briefings and using newsletters. The learning was repeated at these meetings for about two weeks to ensure that all staff on each shift

received the messages. This information was also available in the ward communication book for staff when they returned from annual leave.

### Summary of complaints

A breakdown of complaints by type is below:

Type of complaint	Number of complaints	Percentage of total
Clinical Treatment	68	28.1%
Communications	43	17.8%
Staff	23	9.5%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package	22	9.1%
Other	20	8.3%
Access to treatment or drugs	12	5.0%
Waiting Times	12	5.0%
Appointments including delays	9	3.7%
Privacy, dignity and wellbeing	9	3.7%
End of Life Care	8	3.3%
Patient Care including Nutrition/Hydration	8	3.3%
Integrated Care including delayed discharge due to absence of care package	4	1.7%
Prescribing errors	2	0.8%
Mortuary and post-mortem arrangements	2	0.8%
<b>Total</b>		<b>100.0%</b>

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

### Number of compliments made to the trust

From November 2018 to October 2019 there were 63 compliments at Great Western Hospital about medical care.

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

We reviewed many cards of thanks from grateful patients about the care they had received.

## Is the service well-led?

### Leadership

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

Medical care sat in the unscheduled directorate and was led by a divisional leadership team, comprising a divisional director, associate medical director and a divisional director of nursing. Each had been in post for more than three years and they appeared a cohesive team who met regularly. Each was supported by a deputy and there was clear succession planning in place and opportunities for aspiring leaders. The division was currently looking to develop a leadership programme for heads of service.

The leadership team was highly respected and liked by the staff we spoke with. They were described as being visible and supportive. Matrons and divisional leads were well known to staff and regular visitors to their areas. The divisional leadership team also described good engagement with and support from executive directors. The acting chief executive, chief nurse and medical director were all praised for their “hands-on approach”. The executive directors had developed a ‘buddy system’ with wards and departments. This had been well received by staff. The senior sister on Linnet ward told us their designated buddy was the chief executive, who had supported them to take forward a project to improve patients’ experience when they were cared for on the corridor.

### Vision and strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The leadership team had a clear vision of integrated working across acute, community and mental health services and the development of integrated and streamlined acute medical services. There was a realistic strategy for achieving the priorities and delivering good quality, sustainable care. These followed the trust strategy of four pillars of priority: outstanding patient care; staff and volunteers feeling valued; joining up acute and community services in Swindon; using funding wisely to improve quality of patient care.

The medical care service was working with community and mental health providers to support health provision. Leads informed us they were working with GP surgery staff and community providers to increase understanding of each other’s roles and promote better partnership working. Shared learning was aimed at improving processes between services and providing a seamless service, for example in stroke care and sepsis management.

Service leads used a variety of measures to monitor progress. Projects with community diabetic services were able to measure patient outcomes regarding foot care and management of sepsis

was a focus between acute, ambulance and community services.

## **Culture**

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

All staff we spoke with expressed pride about working in the service. There was a comfortable openness amongst the staff and with leads at all levels and we heard many staff speak of a culture where everybody was treated as equals. Leads expressed a genuine desire to create an open learning environment, using incidents and errors as learning experiences.

Staff felt their views were important and listened to. Many staff were involved in improvement projects where they were able to put their ideas into practice and they felt valued and energised by this.

Teamwork ran through the service and staff supported one another. Staff understood when they moved wards to support another ward which was busier, and we did not hear any complaints about this. Within ward areas we saw how staff consistently worked together and supported each other for the benefit of patients.

There were mechanisms for providing staff with development opportunities which were inclusive for all staff. The training department provided training activities which were specifically aimed at developing skills for the newly recruited staff from other countries. There was a forum for staff who were lesbian, gay, bisexual and transgender. Staff with protected characteristics felt well supported and listened to.

Leads were concerned about staff wellbeing and encouraged staff to focus on this. The trust held wellbeing events for staff to promote self-care. This had included various alternative therapies and supporting staff to access psychological support if they needed it. We saw many 'rehydration stations' for staff to use and maintain their hydration levels during a shift. Leaders had taken a tea trolley around wards and departments to encourage staff to have a drink. We heard about a welfare meeting held each week for matrons where staff could meet with peers and leaders to share experiences and provide support to one another.

## **Governance**

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

Leads of the medical care services followed trust governance processes to monitor and report on quality, safety and effectiveness of services. The division was supported by a governance facilitator. Ward areas fed up to matrons who reported through service level leads, divisional leads, the executive team and ultimately the board. There were standardised information packs

produced each month. Performance was reported on an exception basis to the divisional board, including highlights, concerns, new and emerging risks and shared learning.

Audits were carried out on each ward and reported to matrons each month. Results were recorded on a comprehensive dashboard. These covered a variety of issues relating to patient safety and experience and clearly showed any trends.

Staff took an active part in audits and received feedback on performance within their areas. This was displayed on the ward and areas for improvement highlighted at safety briefings. Staff we spoke with were aware of how well they were performing and areas for improvement.

Each speciality reviewed patient safety issues regarding mortality and patient outcomes. This information was reviewed at divisional level for actions to improve. We saw records of meetings where each division reported to the executive team. Trends were highlighted and shared with other divisions of the trust. We saw meetings were well attended and had good oversight of the areas they were monitoring.

## **Management of risk, issues and performance**

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

The division maintained a risk register, which was reviewed monthly by the divisional management team. Divisional board meetings reviewed all existing and new risks, which were scored as high or extreme. Risks with scores of less than high or extreme were monitored at divisional level with mitigating actions recorded and risks reviewed each month.

We saw detailed discussions documented about reviewing performance and patient outcomes. Departmental meetings and staff meetings identified risks which were escalated to a divisional risk register. Matrons and department leads had access to the risk registers. Risks were assessed according to a framework of impact and likelihood. We saw how actions to mitigate risks had been identified and reviewed. Where all the risks could not be mitigated these were escalated to the trust executive team for further action. We saw risks had been responded to and business plans submitted by divisional leads for actions. For example, staffing levels had been reviewed and methods to cover rota gaps safely had been acted on. Medical staffing had been increased with two 'floating' junior doctors working each day. Risks were reviewed each month and escalated to the trust wide risk register if they could not be fully mitigated.

The service completed regular internal and external audits to monitor quality and safety for patient care. There were monthly safety audits focusing on for example, number of pressure ulcers, patient falls, and hospital acquired infections. Matrons and ward managers met to present results for their areas and discussed how they could improve if this was needed. National audits were reviewed, and specialties reviewed their service using these as benchmarks of quality and effectiveness.

Staff across the division were aware of training available, their responsibilities and how this was

being monitored. Training was discussed at each level of the service and staff were aware of how their specialty area was performing in relation to hospital and national benchmarks. We saw and heard how this provided points of discussion for improving the service.

The service used information to assess and plan for future potential pressures and how to manage them successfully. Winter planning had begun the previous spring and had included reflection on what went well and what needed to improve. This was a continuous process, with much focus and resultant workstreams and quality improvement projects.

## **Information management**

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

Information was used to measure improvement. Systems were used to share information from audits and progress against actions. For example, some wards were maintaining a focus on answering call bells promptly to improve response times and patient care. Changes in practice, such as discharge processes, had audits planned to provide progress reports.

We saw data was submitted to external bodies in line with national standards and how it was used by leads to inform their own practice. Dementia leads were actively monitoring outcomes used by the national audit for dementia programme to enhance the experience of patients living with dementia. Information from the West of England steering group for mortality was shared at mortality and morbidity meetings within the division.

## **Engagement**

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

Service leads were keen to gain staff views and engage with them to improve care and treatment. The service collected staff and patients' views and monitored response rates. Matrons were able to see at ward level the number of responses from patients to the friends and family test. We saw these had been discussed at governance meetings. Staff used additional methods of gathering patient views. The Ambulatory Care and Triage unit had used a questionnaire for all patients cared for there as a trial. This had proved successful in gathering views and was made a permanent feature of the unit. Matrons carried out monthly ward visits where they walked around the ward, spoke with patients and gathered views from staff. Patients told us about feedback they had provided to the matrons at these walkabouts. Patient feedback and actions taken in response were discussed at ward and divisional meetings. Some patients had found ward areas too light at night. The facilities management team were contacted to arrange dimming of lights for the night time. Patient stories were presented at divisional board meetings.

Staff were encouraged to contribute their views to the delivery of the service. There was an annual staff survey which service leads analysed and responded to. Actions identified for

improvement following the 2018 staff survey had been safety at work, health and wellbeing and knowing your managers. There had been a variety of events to improve on survey results. There had been an 'engage to change' event held in December 2019 to gather further views from staff and engage them in contributing their ideas for service improvement. Staff told us how leads were visible and frequently visited wards. Some leads had joined staff at lunchtimes and provided tea and cakes some afternoons. Staff had felt able to contribute views in a smaller group.

## **Learning, continuous improvement and innovation**

**Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

Staff told us they felt able to suggest improvement actions to managers and they would be listened to. We heard of many pilot projects and activities staff were involved with to improve patient experience.

The service shared learning across the organisation. Divisional leads were committed to creating a learning organisation. The newly formed Serious Incident Review and Learning Group was established to capture and learn from any incidents to improve patient care. They shared learning from incidents, complaints and comments across the service and provided examples where care had been improved.

Staff we spoke with were committed to improving services. Specialist nurses supported staff to improve such as in dementia care, sepsis care, stroke care and cancer care. Ward staff acted as champions for these areas of care and supported standards being maintained and improved.

There were a variety of quality improvement projects being undertaken. These took the form of a trial in the first instance and were adapted and embedded in practice if they proved successful.

Staff were able to take time out from their clinical work to meet with peers and share good practice. Staff found these meetings supportive and those who could not attend received feedback about the meeting.

The service operated reward systems for staff who had provided good care or gone the extra mile for a patient. Leads nominated staff for trust led STAR awards. Staff were nominated by patients and/or staff. We heard from a member of staff who had received a STAR award and had felt appreciated and proud of their achievement.

Service leads used a process to monitor quality and safety of the service by reviewing patient deaths in the service. The trust acknowledged they had not managed to review all deaths that needed to be reviewed. There was a focus for each specialty to review deaths in the medical care service. We saw record clinical actions taken and if they were appropriate, and quality of care provided. Learning was shared with divisional leads and ward staff and reported to the trust mortality review group.

Specialties within the service took part in external trials and research. For example, patients could benefit from cardiac telemetry. This was a system of monitoring patients who may have

experienced unexplained fainting and heart palpitations. This allowed patients to be monitored without having to stay in bed with electronic leads attached to a static machine. Patients were able to mobilise around the ward.

The service had adopted 'point of care' analysers. These were systems to test patients for conditions such as influenza, community acquired pneumonia and neutropenic sepsis. Tests gave immediate results and allowed the most appropriate treatment to be prescribed for patients without having to wait for laboratory testing. The system reduced admissions to the hospital.

## Surgery

### Facts and data about this service

The trust's planned care division manages the surgery core service at Great Western Hospital. The surgical service lines sitting under the planned care division are as follows:

- general surgery
- head and neck (ear, nose and throat ('ENT'), ophthalmology, and dental)
- trauma and orthopaedics; and
- urology

The hospital has 134 inpatient beds located across eight wards/departments:

- Aldbourne ward
- Ampney ward
- Cherwell unit
- Meldon ward
- Shalbourne suite
- Surgical assessment unit (SAU)
- Surgical discharge lounge
- Trauma unit

The trust has 15 operating theatres including day case which provides care for people undergoing a range of surgical procedures do not requiring an overnight stay.

*(Source: Routine Provider Information Request (RPIR) – Sites tab)*

From July 2018 to June 2019, the trust had 30,863 surgical admissions. A breakdown of these admissions by type is shown below:

- Emergency admissions - 12,174 (39.4%)
- Day case admissions - 14,811 (48%)
- Planned (i.e. elective) admissions – 3,878 (12.6%)

*(Source: Hospital Episode Statistics)*

On this inspection, we visited all areas listed above. We spoke with over 70 members of staff in various roles, including divisional leaders, senior managers, medical staff, nurses, healthcare assistants, therapy staff and domestic staff.

We spoke with over 10 patients and patient friends and family. We also observed interactions between staff, and between staff and patients.

We reviewed patient records, observed various meetings including multidisciplinary staff meetings, ward rounds and hospital-wide bed management meetings.

We looked at medicines management, checked equipment, medical devices and consumables.

## Is the service safe?

### Mandatory training

**The service provided mandatory training in key skills. The mandatory training was comprehensive and met the needs of patients and staff. Compliance with mandatory training had improved since our last inspection, although further improvement was still required to meet trust targets, particularly in the medical staff group.**

The trust set a target of 80% for completion of mandatory training, except for Information Governance which was set at 95%.

Nursing staff received and mostly kept up-to-date with their mandatory training.

The 80% target was met for 24 of the 25 mandatory training modules for which nursing staff were eligible. The 95% target was met for Information Governance. This was an improvement since our last inspection.

A breakdown of compliance for mandatory training courses as of February 2020 for nursing staff in surgery is shown in the table below:

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Duty of candour	269	276	97.5%	80.0%	Yes
Manual handling - object	269	278	96.8%	80.0%	Yes
Venous thromboembolism	258	267	96.6%	80.0%	Yes
Equality and diversity	268	278	96.4%	80.0%	Yes
Alcohol brief advice	266	276	96.4%	80.0%	Yes
Information governance	267	278	96.0%	95.0%	Yes
Health, safety and welfare	266	278	95.7%	80.0%	Yes
Food and hygiene safety (level 1)	263	276	95.3%	80.0%	Yes
Fire safety (1 year)	236	278	94.9%	80.0%	Yes
Infection prevention (level 1)	263	278	94.6%	80.0%	Yes
Learning disabilities awareness (level 1)	263	278	94.6%	80.0%	Yes
End of life care (level 2)	151	160	94.4%	80.0%	Yes
Learning disabilities awareness (level 2)	259	276	93.8%	80.0%	Yes

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Conflict resolution	259	278	93.2%	80.0%	Yes
Dementia awareness (including privacy and dignity standards)	259	276	93.2%	80.0%	Yes
Slips, trips and falls	256	276	92.8%	80.0%	Yes
Mental health awareness (level 1)	253	278	91.0%	80.0%	Yes
Manual handling - people	247	273	90.5%	80.0%	Yes
Smoking brief advice	242	276	87.7%	80.0%	Yes
Blood transfusion	154	176	87.5%	80.0%	Yes
Infection prevention (level 2)	243	278	87.4%	80.0%	Yes
Medicine management training	241	276	87.3%	80.0%	Yes
Adult basic life Support	238	278	85.6%	80.0%	Yes
NEWS (National Early Warning Scoring System)	233	276	84.4%	80.0%	Yes
Paediatric basic life support	117	141	83.0%	80.0%	Yes
End of life care (level 1)	81	116	69.8%	80.0%	No

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

Medical staff received and mostly kept up to date with their mandatory training. The 80% target was met for 14 of the 20 mandatory training modules for which medical staff were eligible. The 95% target was not met for Information Governance.

A breakdown of compliance for mandatory training courses as of February 2020 at trust level for medical staff is shown in the table below:

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection prevention (level 1)	166	174	95.4%	80.0%	Yes
Duty of candour	153	165	92.7%	80.0%	Yes
Venous thromboembolism	153	165	92.7%	80.0%	Yes
Conflict resolution	160	174	92.0%	80.0%	Yes
Health, safety and welfare	160	174	92.0%	80.0%	Yes
Equality and diversity	159	174	91.4%	80.0%	Yes
Information governance	158	174	90.8%	95.0%	No
Slips, trips and falls	150	172	87.0%	80.0%	Yes
Dementia awareness (including privacy and dignity standards)	149	172	86.6%	80.0%	Yes
Blood Transfusion	136	158	86.1%	80.0%	Yes
Referral to treatment (RTT) (level 1)	79	92	85.9%	80.0%	Yes
Learning disabilities awareness (level 1)	148	174	85.1%	80.0%	Yes
Fire safety (1 year)	147	174	84.5%	80.0%	Yes
Learning disabilities awareness (level 2)	139	165	84.2%	80.0%	Yes
Adult basic life support	143	174	82.8%	80.0%	Yes
NEWS (National Early Warning Scoring System)	130	165	78.8%	80.0%	No

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Manual handling - Object	137	174	78.7%	80.0%	No
Infection prevention (level 2)	137	174	78.7%	80.0%	No
Mental health awareness (level 1)	137	174	78.7%	80.0%	No
End of life care (level 2)	131	174	75.3%	80.0%	No
Paediatric basic life support	122	171	71.3%	80.0%	No

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Senior staff told us that if those they managed had mandatory training courses pending, they would remind them regularly in person or electronically of the need to complete this until it was done. The results of completion rates for mandatory training was also displayed on the quality board in theatres.

Most clinical staff completed training on recognising and responding to patients with learning disabilities and dementia. Training was offered to medical and nursing staff on awareness of learning disabilities and dementia, though not all staff updated their key skills through completion of mandatory training (see tables above). Staff learned about delirium and cognitive impairment, among other things, in these awareness raising courses run by the trust's mental health leads. In the pre-operative ward, staff also received informal in-house training on mental health. We spoke with a nurse who had recently attended a study session and had provided feedback to their team during a meeting about what they had learned on this session.

## Safeguarding

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

The trust set a target of 90% for completion of child safeguarding training and 80% for adult safeguarding and Prevent training. Prevent training seeks to raise awareness of the risks of radicalisation and the roles involved in supporting those at risk.

Nursing staff received and mostly kept up-to-date with training specific for their role on how to recognise and report abuse. The safeguarding targets were met for six of the seven safeguarding training modules for which nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from 22 November 2018 to 21 November 2019 at trust level for nursing staff is shown below:

Training module	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Target	Met (Yes/No)
Preventing radicalisation - Prevent awareness (no specified renewal)	7	7	100%	80%	Yes
Safeguarding adults (level 1)	426	446	95.5%	90%	
Safeguarding children (level 1)	418	446	93.7%		
Safeguarding children (level 2)	416	446	93.3%		
Safeguarding adults (level 2)	384	444	86.5%	80%	
Preventing radicalisation - basic Prevent awareness (3 years)	127	149	85.2%		

Training module	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Target	Met (Yes/No)
Safeguarding children (level 3)	14	18	77.8%	90%	No

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

Medical staff received and mostly kept up-to-date with training specific for their role on how to recognise and report abuse. The safeguarding targets were met for five of the six safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from 22 November 2018 to 21 November 2019 at trust level for medical staff is shown below:

Training module	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Target	Met (Yes/No)
Safeguarding children (level 3)	7	7	100%	90%	Yes
Safeguarding children (level 2)	226	245	92.2%		
Safeguarding adults (level 1)	228	253	90.1%	80%	
Safeguarding adults (level 2)	217	245	88.6%		
Preventing radicalisation - basic Prevent awareness (3 years)	66	77	85.7%		
Safeguarding children (level 1)	224	253	88.5%	90%	No

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff we spoke with were confident to raise concerns to their managers about disrespectful, discriminatory or abusive behaviour or attitudes.

Staff knew how to identify adults and children at risk of, or suffering, significant harm, and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with could tell us what they would do if they had any concerns about a patient's welfare. We were shown records which were completed to refer patients, and a flow chart which helped staff ensure they were following all procedures correctly. Staff told us they were given feedback on any safeguarding referrals made.

## Cleanliness, infection control and hygiene

**The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.**

The theatre department was not always visibly clean. For example, we found dirt on the bottom shelf of a warming cabinet and light dust on shelves in a storeroom in the theatre department.

A self-adhesive absorbent dressing which should be used for patients was used to affix notices to walls throughout the theatre department. This material can curl and become dirty, and when removed, it could leave sticky marks on the walls or take paint off with it, exposing plaster. There were taped notices on a pedal bin in a scrub room in theatres, meaning the bins could not be effectively cleaned. We found adhesive strips at the base of a unit in one of the anaesthetic rooms that was peeling off. In a theatre we visited, the floor had been covered in two colours to

define where staff and trolleys could and could not go for infection control purposes. The sections of covering had joins which, due to wear and tear, had worn away and left small grooves in the floor surface, preventing effective cleaning. All these posed an infection prevention and control risk.

Windows in doors to theatres where laser surgery took place were supposed to be covered for protection. The cover that was supposed to be attached to the studs on the door was partly dangling on the floor, posing an infection prevention and control issue. The covers should be removed to be washed after each session and stored somewhere clean ready for the next use.

A member of the cleaning staff we spoke with, who was tasked with cleaning non-clinical areas, explained they were buddied up with a colleague when they first took on their role. However, they were not aware of how often items such as brushes were cleaned or replaced.

The theatre department did not always have suitable furnishings which were clean and well-maintained. For example, a section of one of the doors from a theatre to the corridor was damaged, exposing rough wood. This material, particularly as it was chipped and exposed, there was an infection prevention and control risk.

The enamel in a metal trolley in an anaesthetic room was chipped and rusty, making it difficult to clean and posing an infection control issue. Swab boards in some of the theatres we inspected had surgical tape attached which was old and curling. We also found a patient transfer trolley with a mattress cracked, making it a challenge to effectively clean. This was an infection control risk.

In one of the scrubs rooms, we found gaps between sinks and access panels behind them. This meant sinks could not effectively be cleaned, which was an infection prevention and control risk.

We found 14 headboards were stacked outside the recovery area. Staff in recovery area took the headboards and attached them to the beds of patients ready to be discharged to a ward. However, we observed the head boards were not cleaned between removal from one bed and being placed on another.

The service had eight laminar flow theatres. These theatres filter the air and create a powerful, calm and uniform unidirectional airflow. The purpose of this was to remove bacteria, viruses and any dust particles from the air flowing in and out of the theatre, creating an isolated clean environment.

Theatres one and two, which shared a preparation room, were laminar flow theatres. A door in theatre one opened into a small lobby which then opened into the shared preparation room. We found these two doors were wedged open during one of our visits to theatres during our inspection. When opening the door to theatre two to enter the joint preparation room, we were able to see staff in theatre one. Operating theatre doors should be kept closed for infection control purposes and to reduce unwanted traffic.

There was a third door into the joint preparation room from the corridor. When we opened the doors from the preparation room to the corridor, the door from the preparation room to theatre two automatically pushed open into the theatre. As mentioned above, operating theatre doors should be kept closed for infection control purposes. Therefore, the automatic opening of the door from the preparation room to theatre two when the doors from the corridor to the preparation room opened posed an infection control risk.

Leaders told us this section of the theatre unit had been tested around the time of our inspection to ensure there was appropriate ventilation. The test found the ventilation to be working correctly.

We found several pressure stabilisers in theatres were protected by a shield. Pressure stabilisers

control the differential air pressures between adjoining rooms. The shielding of these pressure stabilisers made it challenging to visually check the pressure stabilisers as well as potentially making it more difficult to clean them, creating an infection control risk.

Sterilised packs were stocked on solid shelves in a storeroom. This was not in accordance with recommendations that these packs should be stored on gridded shelving to allow dust to fall and prevent condensation if a warm sterilised pack was placed on solid shelves. When we raised this with a member of staff, they explained packs were cooled before being placed on the shelves, thereby mitigating the risk of condensation which could lead to deterioration in the packaging of the sterile trays, thereby compromising the sterility of the equipment. Sterile trays were also stored on low hanging shelves a few centimetres above the floor, posing a risk these could be contaminated by dust from the floor. The storeroom also had carpet flooring which was difficult to keep clean, creating an infectious control risk.

In a preparation room shared by two theatres, we found on two occasions a trolley that had been pre-prepared prior to a procedure that had been left unattended and uncovered. This not only posed an infection risk but risked that the items prepared could also be interfered with.

We also found radiation protection equipment which was not visibly clean. We escalated this to staff on our inspection.

Following our inspection, sterile packs were moved off the floor and staff were reminded of the need to do this through safety briefs. Leaders told us that since our inspection an audit of all theatres had been performed, and a review of works was due to be undertaken in March 2020. Leaders also told us the flooring in this store room adjacent to theatres was going to be changed from carpet to vinyl by the end of March 2020.

Ward areas were mostly visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were seen on equipment when cleaned by staff to indicate it was ready to be used again.

Wards and departments used disposable curtains between patient bed spaces to provide privacy. Disposable curtains we inspected were visibly clean, almost always dated and had been put up within the previous six months.

There were side rooms available, where infectious or immune-suppressed patients could be isolated. This included an isolation room in the main recovery area. However, the effectiveness of these rooms was sometimes compromised by their design. The surgical assessment unit had cubicles that were sometimes used as isolation rooms. However, these cubicles did not have toilets. Staff explained they sought to manage this situation as best as they could by, for example, providing isolated patients in these rooms with commodes and bedpans. Staff acknowledged this was not an ideal situation for patients. Senior staff told us there was a standard operating procedure to avoid (potentially) infectious patients being cared for in the unit. However, operational pressures meant this standard operating procedure was not always adhered to.

On Daisy Ward, we identified an example of patient being moved to an isolation room before the room had been cleaned following the departure of the previous patient. This incident had been appropriately reported. We saw that as soon as this incident had been identified, the patient was moved out of the room and the room was cleaned.

Cleaning records were not always up-to-date and did not clearly demonstrate that all areas were cleaned regularly. We saw records of weekly and monthly cleaning schedules for intubation trolleys, cupboards and other surfaces. These were not consistently completed in all areas we visited, meaning there was a lack of assurance this cleaning always took place. We also identified

failures to consistently document daily cleaning of anaesthetic equipment had taken place.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff observed good hand hygiene practice. They used personal protective equipment when necessary and complied with the 'bare below the elbow' rule. Staff told us they would challenge colleagues who did not observe this rule. We saw all staff cleaned their hands before and after contact with patients. Hand wash basins and hand sanitiser gel dispensers were available for staff, patients and visitors.

We observed a surgical procedure where the team worked well together, hand hygiene was observed, and personal protective equipment used appropriately.

Patients in the surgical assessment unit were screened for methicillin-resistant staphylococcus aureus (MRSA) and other infections on admission. Patients who were admitted to the wards through the emergency department or who were admitted to the wards directly were screened for MRSA and other infections on admission to the wards. Infection control nurses provided support and guidance to staff when required.

## **Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff mostly managed clinical waste well.**

### Recovery 2 and Daisy ward

The design of the environment was not always suitable for the purposes for which it was used. Staff explained the recovery 2 area was safe as an escalation area for patients moved there in accordance with the standard operating procedure. However, they explained it did not provide a good patient experience due to the fact there was no internet, telephone or television in the unit. There were also no toilets in the recovery area, which meant patients had to request to be escorted to and from toilets in an adjoining section (Daisy Ward) of the hospital. Staff explained this not only had a potential impact on patients' experience, it also impacted on staff because it took them away from their other tasks. Patients in recovery 2 were also only allowed visitors for very short periods (5 minutes). However, patients in recovery 2 were provided with hot meals as well as eye masks and earplugs to aid them to rest and sleep.

Leaders said the standard operating procedure was to limit the number of the beds in recovery 2 to be used for escalation purposes to between four and six beds. However, this was often not possible due to operational pressures.

A standard operating procedure set out the criteria for the patients that could be moved to the recovery 2 unit during times of escalation. This included a requirement that a patient was independently mobile. Staff told us that the standard operating procedure was not always adhered to during times of operational pressure and that patients were sometimes moved to recovery 2 who were not appropriate to be there. Staff we spoke with provided examples of patients with a diagnosis of a dementia who had been moved to the day surgery unit. During our inspection, a patient had been placed in recovery 2 in breach of the standard operating procedure setting out the type of patients that can be moved to this part of the hospital. This was escalated appropriately and discussed at weekly divisional matron meetings. Leaders explained the patient had been placed there by accident, and they were looking into how it happened to ensure it did not happen again.

Daisy Ward had been turned into a surgical inpatient ward several years ago. Daisy Ward was intended to be a 23-hour bedded bay. However, operational pressures meant this did not happen

and that it had turned into a 14-bedded inpatient ward supporting gynaecology, urology and emergency patients. Staff we spoke with explained that Daisy Ward was not fit for purpose as an inpatient ward. There was a lack of privacy. The ward was dark, with no natural light. Staff explained the ward also lacked the space needed for patients requiring walking frames or lifts. There were two unisex toilet and shower units for up to 14 patients on Daisy Ward. These toilet and shower facilities were also used for patients in recovery 2.

There was a standard operating procedure setting out the criteria of patients that could be admitted to the ward. Patients were required, among other things, to be independently mobile. Staff reported cases of patients being inappropriately moved to this unit. Staff explained this was sometimes because colleagues involved in the decision to move patients were not fully aware of the criteria for patients to be suitable for Daisy Ward.

Staff explained the process they followed if a patient was moved to a ward or unit for which they were not appropriate. This included escalating the matter to matrons and other senior staff, as well as incident reporting it. We reviewed a sample of incident reports and found an example of a patient who was at risk of falling yet was placed on Daisy Ward. The patient did fall and was assessed again following this fall and moved to a more appropriate part of the hospital.

Divisional leaders explained that one of the challenges facing the service was the different criteria for the use of different areas for escalation, including Daisy Ward, recovery 2 and Shalbourne. They explained that operational pressures meant that they had to balance competing demands and use their judgment to take the most appropriate action, which includes those patients receiving corridor care if the areas are not utilised. This decision-making process usually involved the matron of the day or, if out of hours, an equivalent. They explained staffing was increased if this was considered necessary or appropriate.

### Medical outliers

Due to the lack of beds in wards, many medical patients were placed in other departments' wards (usually in surgical wards). An 'outlier' was defined as a patient admitted to a ward different from the ward on which they should usually be. Aldbourne ward was an elective orthopaedic ward for MRSA screened patients. However, due to the escalation pressures within the hospital it had been changed in December 2019, so it also had outlier trauma patients, medical outlier patients, and other surgical outliers. The nurse in charge had criteria (a standard operating procedure) for patients who should be admitted but told us when the hospital was really busy the criteria were not always adhered to. We found that staff did not always feel trained to look after patients in their care, although they told us that each outlier patient was seen by an appropriate medical team once a day.

### Sterile services

A steam generator and autoclave (sterile) machine used by the hospital's in-house sterile services to sterilise equipment used for surgical procedures had recently come to the end of its life. The service was relying on its remaining steam generator and autoclave (sterile) machines, which were installed at the same time as the machines that had stopped working. There were measures in place to mitigate the consequences of these machines stopping working. These included an arrangement to make use of the sterile services arrangements of a local independent healthcare provider, though leaders told us these measures would nonetheless reduce capacity and come at a considerable financial cost to the trust.

The service was in the process of adopting an initiative from another trust where reclining chairs were used to help day surgery patients recover from their surgery. This system called chair port

could be used to recover patients from stage 1 recovery or following a period of recovery on a trolley or bed. Leaders believed this facility would reduce cancellation rates due to lack of beds. At the time of our inspection, funding had been secured for this initiative.

As recommended by the Association for Perioperative Practice, smoke evacuation/extraction devices were used in theatres to protect patients and staff from surgical smoke emitted during surgical procedures.

Fire extinguishers we inspected were within their service or expiry dates.

The theatre complex was spacious and not cluttered with equipment. Fourteen of the 15 theatres had an anaesthetic room. Theatres and anaesthetic rooms were well equipped.

The service had a fully staffed, 24-hour emergency ('CEPOD') theatre. There was the capacity to open an additional theatre overnight for emergency procedures if this was required.

Staff told us that they carried out daily safety checks of specialist equipment, however, these were not always recorded. Daily checks of the anaesthetic machines were not recorded consistently, meaning there wasn't assurance these checks were always done as required. Furthermore, the sheets used to record these checks did not record the serial number or model of the machine. As a result, although the machines were audited monthly, the information could not be attributed to a specific machine or person.

In theatres, a belt on one of the x-ray protective gowns/aprons was missing, meaning the gown could not offer the protection it would otherwise have offered. We raised this with a member of staff on our inspection who removed the gown in question.

Staff mostly disposed of clinical waste safely. However, some sharps containers were not always signed or dated, which meant there was not always assurance of appropriate responsibility for the correct, and therefore safe, assembly of sharps containers. We raised this with staff on inspection.

Patients could reach call bells and staff usually responded quickly when called. Call bells had been recently installed in the waiting area in the surgical assessment unit for patients and their relatives to call for help if needed from staff. During our inspection, we saw call bells were placed within reach of patients and staff responded to call bells going off quickly. Feedback we received from patients on our inspection mostly supported our observation, though some patients told us of examples where call bells had gone unanswered (see later in this report for more information).

On Aldbourne Ward, we found the use of the shower in the wet room regularly resulted in water seeping into the ward area. We raised this with staff on inspection. Leaders told us the shower had since been risked assessed, with the required works agreed and expected to be completed in April 2020. In the interim, the shower was being regularly inspected.

## **Assessing and responding to patient risk**

**Staff did not always complete and update risk assessments for each patient and remove or minimise risks. The service's process for auditing compliance with the world health organization's surgical safety list did not provide depth of coverage for effective assurance.**

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. The service had implemented the latest version of the National Early Warning Score (NEWS2) to improve recognition and response to patients at risk of deteriorating and recognition of sepsis. Instructions for staff on what to do if they suspected or knew a patient to be suffering from sepsis was set out in observational charts, and senior staff were confident staff in the service were aware of how to escalate patients suspected or known to have sepsis.

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patients were assessed at the point of admission for, among other things, their risk of falling, diet and nutrition and developing pressure areas. These assessments were repeated weekly. Frailty screening was undertaken for patients over the age of 65 years.

Following our previous inspection, we said the trust must ensure venous thromboembolism (VTE) risk assessments were reassessed in line with national guidance. The service sought to ensure patients were risk assessed by medical staff on admission for VTE. Patients were reassessed within three days or earlier if the clinical situation changed.

We looked at 13 patient records during our inspection and found VTE risk assessments and reassessments had been completed. We reviewed the results of the planned care division's monthly audit of VTE risk assessments between June to December 2019. For 5 of the 6 months, the results showed that 100% of patients received a VTE risk assessment.

Nursing assessments, including nutrition assessments, were discussed at meetings. We attended a divisional matron's meeting where out of date nutrition assessments were discussed. There was also discussion of how the service had improved its performance about timely completion of nursing assessments, including the introduction of an electronic patient observation recording system.

Staff knew about and dealt with any specific risk issues. Operating lists were arranged to reflect the complexity and risk of the patients and procedures being undertaken. Safety briefings took place in theatres where any staffing issues, the order of operating lists and the individual requirements of each patient (including their antibiotics requirements, and additional equipment or staff recruitments) were discussed and confirmed. Sterile services were responsive to short notice requests to prioritise requests for preparation of packs.

### Mental health

Staff followed best practice for assessing and monitoring the physical health of people with mental illness. For example, they undertook falls risk assessment for older patients who experienced frailty and poor mobility.

Patients' mental health and emotional wellbeing were assessed daily during morning ward rounds and during regular observations and interactions. We saw staff responding to patients' emotional wellbeing appropriately during this inspection.

Senior staff were able to describe the current risks of the patients with mental health needs on their ward at the time of our inspection. Staff had increased observations for one person who had become unwell. We saw these risks were reflected in the patients' care files.

The ward had support from the lead nurse for alcohol dependency in the emergency department and support from the gastroenterology team if a patient was admitted with alcohol or drug dependencies. They offered appropriate medications to support drug and alcohol withdrawal during their stay.

In the post-operative ward, staff had support from the old age psychiatry team and staff said they were very responsive. Staff gave examples of when patients who were on the ward had deteriorated and had become mentally unwell. With the support of the psychiatry team, they had moved them onto a more appropriate ward, increased staffing levels so they had one to one support and had their operation prioritised. Staff worked alongside the patient's independent mental capacity advocate to organise their recovery in the most appropriate setting. The team were about to start a pilot with the old age psychiatrist to work more frequently on the ward.

## Surgical safety checklist

The World Health Organisation's (WHO) surgical safety checklist was developed with the aim of reducing errors and adverse events and increasing teamwork and communication in surgery. In 2010, the National Patient Safety Agency (NPSA) introduced the Five Steps to Safer Surgery. The Five Steps to Safer Surgery was based on the WHO checklist and involves briefing, sign-in, timeout, sign-out and debriefing, and is now advocated by the NPSA for all patients in England and Wales undergoing surgical procedures.

On this inspection, we observed the surgical safety checklists were mostly performed as expected. Staff were attentive during the surgical safety checklist process. We observed a sign in, time out and sign out with patient participation during a local anaesthetic procedure. This was per the Five Steps to Safer Safety. However, we observed one procedure where the consultant did not participate in the time out.

We attended a team brief in theatre 11. In accordance with National Safety Standards for Invasive Procedures (NatSIPPs) recommendations, all the team participated and felt able to speak up. The team debrief checklist recorded any actions.

The trust's data showed that, between February 2019 to January 2020, the percentage of WHO checklists completed each month varied between 97-100%, with an average completion rate of 99% over the course of the whole 12-month period. Over the same period, the percentage of WHO checklists completed correctly each month varied between 86-100%, with an average correct completion of 91% for the whole 12-month period.

The service audited compliance with the surgical safety checklist by reviewing 10 checklists at random each month. Leaders told us this was only for general anaesthetic procedures and that audit of compliance for local anaesthetic procedures was not carried out.

The low number of checklists audited meant some specialities were audited less often. For example, oral surgery was not audited for most of 2019. This was because the low number of checklists being audited meant some specialities were not as likely to be selected in a random sampling of checklists. This resulted in a risk that service leaders could not have the same level of assurance about compliance with the surgical safety checklist in some specialities. Following our inspection, the trust told us they were planning to increase the number of checklists audited for compliance with the world health organization's surgical safety checklist to 20 per week, beginning the week commencing 2 March 2020.

The results of compliance with the surgical safety checklist was displayed on the quality board in theatres. Notice boards in the theatre department had posters informing staff about the need to stop before you block and other safety issues.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff could name the mental health lead for their department. They were able to contact a specialist mental health professional when required for advice and support.

Staff shared key information to keep patients safe when handing over their care to others. The divisional director of nursing had introduced daily quality and safety huddles.

Shift changes and handovers included all necessary key information to keep patients safe. Ward handovers in the morning and evening were comprehensive, and information was shared about patients' risk keeping them safe.

## **Nursing and other staffing**

**The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to provide the right care and treatment. Managers reviewed and sought to adjust staffing levels and skill mix, and gave bank and agency staff a full induction.**

### Day Surgery

Staff told us the staffing model on the day surgery unit was short by two members of staff. This meant staff were having to work beyond their contracted hours. Staff on the day surgery unit spoke of the negative impact operational pressures were having on staff morale generally, and the possible impact on staff sickness rates which was relatively higher compared to other parts of the division.

Staff on the day surgery unit explained managers visited the unit every morning to get a sense of the situation, and management were aware of the pressures the unit and staff were under. Staff knew how to report concerns about shortages in staff, and we saw examples of this happening. Staff explained management, including the divisional management team, were understanding and supportive of concerns regarding staffing shortages.

The divisional management team were aware of the issues on the day case unit. A business case had been submitted for a new staffing model in the day case surgery unit that if agreed would provide a twilight shift, allowing staff on the day shift to leave work on time.

### Other areas of the service

The surgical assessment unit had an establishment figure of four nursing staff during the day shift. A business case had been submitted at the time of our inspection for an additional nurse during the day shift to meet the needs of the increasing number of patients they were seeing in the unit.

The service was identifying new roles to improve staffing and organisational resilience. This included the introduction of trainee nursing associates in the surgical assessment unit. These roles sought to bridge the gap between the role of a health care assistant and a nurse.

Staff we spoke with in the preoperative clinic explained the clinic was short staffed. The nurse in charge reported this was because nurses working in the clinic needed to be experienced and confident in order to keep patients safe. However, they reported that senior managers and executive leaders were aware of this issue, and empowered staff to make changes to the service. For example, healthcare assistants had been trained to undertake blood tests. Staff in the unit told us leaders including matrons and the divisional director of nursing were supportive of any concerns around staffing.

In theatres, staff told us the complement of nurses plus operating department practitioners was short by approximately 22 members of staff, though the exact figure was pending confirmation of future undertakings by the service to the clinical commissioning group. A business plan was being put together at the time of our inspection for funding for these extra members of staff.

Ampney ward had an establishment level of three nurses and a health care assistant at night. However, staff we spoke with told us the number of health care assistants on the night shift was not sufficient to provide the appropriate level of care and treatment for patients. This had been escalated to the divisional management team.

### Medical outliers

Staff told us surgical wards staffed by surgical nurses were regularly used as escalation areas for medical outliers. By 'medical outliers' we mean patients who are placed in wards in other departments (often surgical wards). This is due to the lack of beds in medical wards.

During our inspection, we found that most patients on Ampney Ward, a surgical ward primarily for the care of urology patients, were actually medical outliers. Nursing staff we spoke with told us medical patients tended to have greater needs. They explained this greater need was not reflected in the staffing levels on surgical wards, which were based on the assumption these wards were for surgical patients. Staff told us this invariably had an impact on the care they delivered to patients and told us examples where this potential under-resourcing caused or contributed to failings in care. This included an example of a medical patient who had a fall during the night shift.

Leaders told us that to deal with increased demand during winter pressures, the service had reduced the number of private patients it was treating. This allowed for the private unit in the service to be used for orthopaedic patients who would normally be treated and cared for in Aldbourne Ward. Aldbourne Ward was then used as an escalation ward for outlying medical patients. This was for a three-month arrangement which was planned to come to an end in March 2020. Leaders explained the ward was nonetheless staffed by surgical nursing staff. The staffing issues on this ward were mitigated through the deployment of extra health care assistants.

#### Fill rates

The number of nurses and healthcare assistants usually matched the planned numbers. According to data provided by the trust, only 2% of annual nursing hours were unfilled (see table below). Feedback we received from staff on many of the wards we visited, including Ampney ward, supported this figure as many staff said they rarely had unfilled hours. However, this was not the case across all areas. For example, leaders told us the fill rates on Aldbourne Ward were relatively low and presented a challenge to the service.

In accordance with guidance from the National Quality Board, a skill mix review was undertaken across all inpatient areas in the planned care division in December 2019. On the back of this review, extra staff have been proposed. Leaders explained extra staff have been placed in areas at risk in the interim. These included an extra health care assistant at night on Meldon Ward. An extra nurse had been placed on the surgical assessment unit during the day to support the demand arising from escalation.

Leaders explained the fill rate for health care assistants required at short notice had been a challenge to fulfil. As a result, the service was expediting the recruitment process of a cohort of health care assistants. As a result, this cohort was expected to all be in post by April 2020.

There were daily quality huddles to review daily staffing levels.

#### Other staffing

Leaders explained recruitment had become an increasing challenge in sterile services. The sterile services department had a vacancy of 8.2. The service was managing this through use of bank staff. The service had also run recent recruitment fairs to attract new staff.

Leaders told us of how creative attempts were made to mitigate recruitment issues by investing in the trust's existing staff. For example, at the time of our inspection, there were only two radiographers in theatres. As a result, three other members of staff had been trained in the use of medical imaging devices.

Leaders also told us a local university had withdrawn an operating department practice course it had previously been running, resulting in challenges in the recruitment of operating department practitioners (ODPs). The service was actively looking at alternative options to recruit ODPs.

The trust offered a bonus as an incentive scheme for staff who took on more shifts.

At the time of our inspection, discussions were ongoing about changes to shift patterns, with the involvement of trade unions.

Matrons did a daily ward round to check staff levels, and redeployed nursing staff to other areas where staffing levels were lower than required. Nursing staff we spoke with told us they understood that this was done to keep patients safe. Staffing issues were discussed at weekly divisional matron meetings, including the need for certain staff to be able to begin an operating list.

Most wards had been given an uplift of three healthcare assistants (HCAs) to cover some of the vacant registered nurses' posts.

The division had introduced advanced clinical practitioners. These were healthcare professionals with the skills and knowledge to allow them to expand their scope of practice to meet the needs of patients better.

The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

Surgery annual staffing metrics							
October 2018 – September 2019					November 2018 – October 2019		
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
<b>Target</b>		8%	13%	3.5%			
<b>All staff</b>	707	6%	10%	4.1%			
<b>Nurses</b>	278	8%	11%	3.9%	22,727 (4%)	25,426 (5%)	9,219 (2%)

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)*

The ward manager could adjust staffing levels daily according to the needs of patients. Additional staff were booked to assist staff on the day surgery unit with additional demands during times of operational pressure.

### Agency staff usage

The service had low and/or reducing rates of bank and agency nurses. On Ampney Ward, staff told us the staffing situation had recently improved, with less reliance in recent months on bank and agency staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

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

## Medical staffing

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

The service usually had enough medical staff to keep patients safe.

Leaders spoke about vacancies in consultant-level medical staff, and the difficulties faced in recruiting to these roles. Leaders told us of vacancies in consultant-level medical staffing in specialities including ear, nose and throat. At the time of our inspection, two upper gastrointestinal surgeons had recently been appointed.

Leaders explained there were multiple reasons for challenges in recruiting to consultant-level vacancies. This included the trust's location between larger teaching hospitals in the area with which they were traditionally competing for potential recruits.

Leaders said that while current consultant staffing levels assured patient safety, they were aware of the need to invest in the consultant workforce to ensure the future of the workforce. Leaders responded to this challenge by being creative and 'growing their own' to fill in any gaps in skills requirement. This included expanding the role of nurses - and providing the necessary training - to take on more tasks in specialities such as ophthalmology, and ear, nose and throat. The service also had introduced advanced clinical practitioner roles in orthopaedics.

The service was working with other trusts in the area to do joint recruitment to share staff rather than compete for a limited pool of potential recruits.

The trauma and orthopaedic service had also adopted consultant of the week model intended to improve patient outcomes, including reducing the length of stay.

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

Staff group	Surgery annual staffing metrics						
	October 2018 – September 2019				November 2018 – October 2019		
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
<b>Target</b>		8%	13%	3.5%			
<b>All staff</b>	707	6%	10%	4.1%			
<b>Medical staff</b>	149	5%	4%	1.3%	6,991 (2%)	7,447 (2%)	17,011 (5%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and

### Medical locum tabs)

The medical staff did not always match the planned number. Five per cent of annual medical hours were unfilled between November 2018 to October 2019 (see table above).

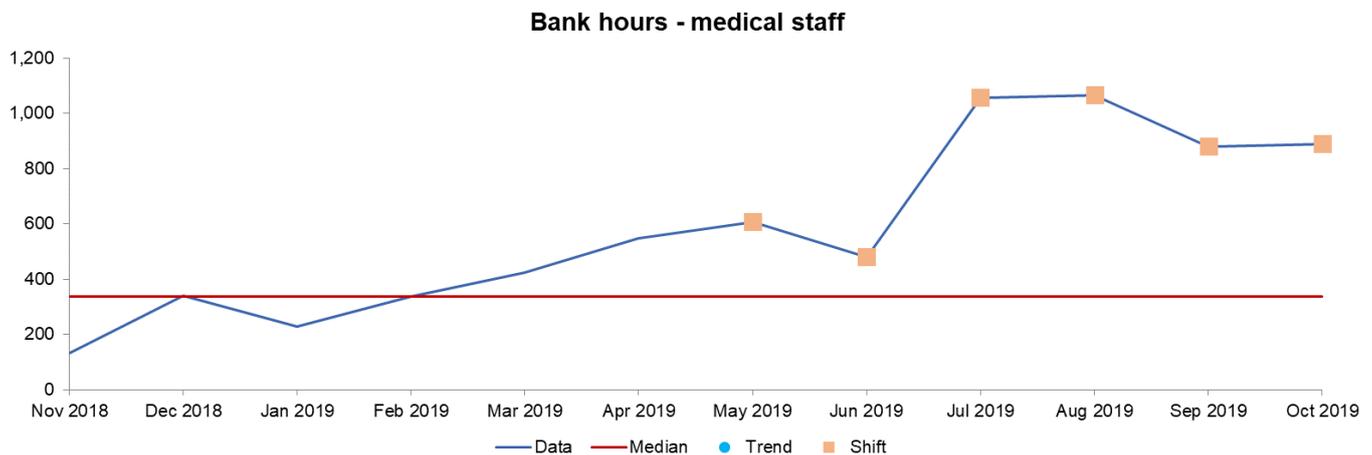
### Sickness rates

The service had low sickness rates for medical staff. The annual sickness rate for medical staff was 1.3% (see table above). This was below (i.e. better than) the trust target (3.5%) and the annual sickness rate for all staff (4.1%).

### Bank and locum staff usage

The service had an increasing rate of bank and locum staff use. Four per cent of annual hours were filled by bank and agency staff between November 2018 to October 2019 (see table above). From May to October 2019, monthly bank use for medical staff showed an upward shift (see graph below).

Managers made sure locums had a full induction to the service before they started work.



(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

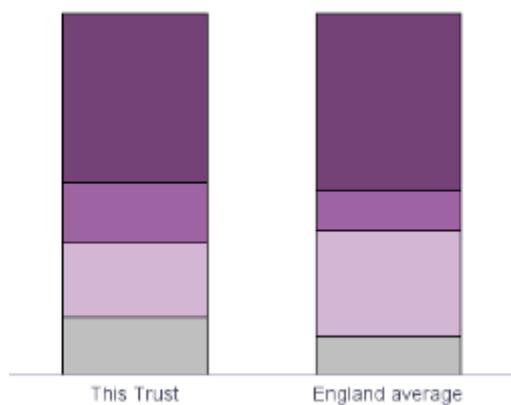
### Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In August 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

### Staffing skill mix for the whole-time equivalent staff working at Great Western Hospitals NHS Foundation Trust

	This Trust	England average
Consultant	47%	49%
Middle career^	17%	11%
Registrar Group~	20%	29%
Junior*	16%	11%



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

*(Source: NHS Digital Workforce Statistics)*

The service always had a consultant on call during evenings and weekends.

## Records

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

Patient notes were comprehensive, and all staff could access them easily. Following our previous inspection, we told the trust it must improve nursing documentation to ensure it was organised and easily accessible to clinicians. This included ensuring patient risk assessments are undertaken and updated as required. Nursing and patient notes we reviewed on this inspection were comprehensive and all staff could access them easily. Patient records we reviewed were legible, complete, signed and dated. All records included an audit trail of decisions made and treatment. They included risk assessments and management plans. Seven-day personalised care planning was evident in the records we reviewed, including falls, manual handling, mobility, nutrition, pain and hygiene and skin integrity.

Staff were able to find the sections in care plans that related to mental health needs and the related risk assessments. Patient records contained all previous notes from their mental health assessments. Staff were able to easily identify where mental health assessments were located in patients' files. When patients were discharged, staff scanned their notes on to the trust's electronic patient record systems.

All information about patients' mental health and wellbeing were stored in paper records that remained with the patient during their stay. There were systems such as the 'forget-me-not' flower next to a patient's name on the board that quickly identified when a patient was living with a diagnosis of dementia. This was to ensure the care of those with the condition was planned and managed accordingly.

We saw that older patients had effective orthogeriatric reviews and mental health later life liaison assessments. Staff noted any cognitive decline and diagnosis information in the patients' care records.

We reviewed eight care records when assessing mental health provision in the surgery service. Records had an alert on the front page to make staff aware of a learning disability or mental

health need. A record in the pre-operative ward had a specific learning disability risk assessment which detailed any reasonable adjustments for that person during surgery.

In the post-operative ward, staff had completed dementia and delirium care plans which prompted staff to follow a list of daily actions to support that patient. General risk assessments were present (to indicate if plans were on track) and updated in all three care plans.

With one patient who had experienced mental health deterioration staff had increased their observation levels accordingly and this had been documented in their care plans. This person also had a 'weekend management plan' to inform staff what they should do after hours.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff on the ward could access mental health risk assessments completed by other teams, such as the emergency department, within the patient's paper care records.

Records were mostly stored securely. Following our previous inspection, we said the service must ensure patient records are stored securely to prevent unauthorised access. On this inspection, we found lockable cupboards were used on the wards to store patients' medical records confidentially. Observation records were stored by patient beds.

The trust had taken steps to improve the security of records, introducing an initiative during 2019 to improve storage of medical records, while raising awareness that it is everyone's responsibility to put records away after use. However, on the Day Surgery Unit, we found patient records placed on a desk by the reception area ready to be picked up by medical staff treating patients. Staff explained that in addition to the receptionist, there was always another member of staff present in this area, thereby ensuring the security of patient records. However, we observed times when this area was not attended by staff and, even when a member of staff was present, they did not always have a line of sight to the records. This meant the security of these records could not be assured.

Staff we spoke with explained there was a workstream to move the central work station in the day case unit where patient records were stored. They explained the funding had been secured for this project and it was with the estates team for an assessment.

We observed computer screens being locked when not in use, and access was password-protected to prevent unauthorised access.

## **Medicines**

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

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. For example, we found anaesthetic induction drugs were drawn up, labelled and administered correctly.

We found gaps in the recording of daily checks in the combined cleaning and temperature monitoring checklist for the drug fridge in an anaesthetic room. This meant there was a risk medication may not have been stored consistently at the correct temperature which could compromise the stability of the medicines stored.

We also found sodium lactate solution stored in a warming cabinet. The temperature indicator on the cabinet indicated the cabinet was at 37 degrees Celsius, though the packs of sodium lactate solution in the cabinet stated these should not be stored above 25 degrees Celsius. We raised this with staff during our inspection. Following our inspection, a standard operating procedure was

developed to provide guidance and instruction to theatre staff on how long this fluid can be placed safely in the warming cabinet. This included monthly audits for assurance that this standard operating procedure was being followed.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. If a patient was admitted with complex medication needs, the doctor reviewed their medication prior to their operation and tailored it during their stay around their needs. Care plans reflected the outcomes of these discussions in their daily notes. It was clear which clinician was responsible for each aspect of care. We saw evidence of medication handovers between teams which also detailed patients' allergies.

We reviewed the controlled drug record and order books in an anaesthetic room and found both to be compliant with legal requirements.

Bank or agency members of staff were not permitted to order or receive controlled drugs. Only permanent members of staff were permitted to do this.

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

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Drug errors were discussed in weekly divisional matrons' meetings. We attended such a meeting during our inspection and witnessed such incidents being discussed. Learning was further disseminated to frontline staff in daily safety briefs.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The team followed a trust policy on the administration of covert medication. If a patient became unwell and needed restraining, due to their behaviour being a risk to themselves or others, staff called the hospital security team and used emergency call buttons around the ward, to support and protect individuals' safety.

## Incidents

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

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, including serious incidents and near misses, in line with trust policy.

## Never Events

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

From November 2018 to October 2019, the trust reported two never events for surgery. The first incident occurred in May 2019 where, after multiple attempts to use spinal anaesthesia, general anaesthesia was performed on the wrong limb. The second incident occurred in September 2019 where a foreign object was removed post operation.

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

Managers shared learning about never events with their staff and across the trust, including learning about never events that happened elsewhere. Each ward staff form had a folder containing shared learning around divisional governance. This complemented learning shared through emails, and divisional and speciality level governance reports.

## **Breakdown of serious incidents reported to STEIS**

### **Trust level**

From November 2018 to October 2019, in accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in surgery which met the reporting criteria set by NHS England. A breakdown of incidents by incident type are below.

<b>Incident type</b>	<b>Number of incidents</b>	<b>Percentage of total</b>
Surgical/invasive procedure incident meeting SI criteria	4	80%
Treatment delay meeting SI criteria	1	20%
<b>Total</b>	<b>5</b>	<b>100%</b>

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

Staff understood the duty of candour. Staff we asked were able to explain this duty and their responsibilities were outlined in policies. The trust's incident reporting system also prompted staff about the duty of candour.

Staff were open and transparent and gave patients and families a full explanation if things went wrong. We reviewed investigation reports into incidents which showed staff had been open and honest with patients, offering an apology when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. The trust's electronic reporting system offered staff the option to request feedback on matters they reported. Feedback was also provided more informally by senior staff. Learning was shared across specialities and service lines through information sharing facilitated by the trust's governance team. In an investigation we reviewed, we saw learning from the incident was shared with staff through monthly governance meetings.

Staff met to discuss feedback from incidents and look at improvements to patient care. There was an ongoing programme of human factors training that was being rolled out in response to never events. Human factors are those things that affect an individual's performance. Human factors training seeks to help individuals understand the things that support or hinder the way people work, thereby improving patient safety.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. As part of our ongoing engagement with the trust and during this inspection, we reviewed investigations into incidents including never events. These investigations were thorough and looked at root causes and contributing factors. Patients and their families were involved in these investigations.

### **Safety thermometer**

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

Safety thermometer data was displayed on wards for staff and patients to see. There were quality boards near the entrances of the wards displaying information about several indicators, including hospital acquired infections, number of falls and pressure ulcers developed in the care of the ward. The quality boards also included information on ward cleanliness, compliance with nutrition screening and call bell response times.

Staff used the safety thermometer data to further improve services.

## Is the service effective?

### Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust's audit team sent out emails periodically to service lines to inform them of new guidance and good practice, as well as to ask for an update from service lines about progress on the implementation of new guidance. A spreadsheet was kept and monitored regularly to track the implementation of new guidance.

Staff had access to national guidelines and good practice, including guidelines on perioperative prescribing for anaesthetists. There were also folders containing guidance for emergencies including anaphylaxis, and local toxicity. Staff were reminded of this guidance through communications in the anaesthetic rooms.

The trust's learning disability team visited wards to update staff on good practise and to ensure staff were following the learning disability pathway.

Staff protected the rights of patients' subject to the Mental Health Act (1983, MHA) and followed the Code of Practice. Doctors working on the post-operative ward had been involved in mental health assessments and had experience of detaining patients under the MHA. Doctors gave examples of supporting patients who were suicidal and working alongside psychiatrists to make sure they were following the correct pathway.

Patients who were detained under MHA normally came into the hospital with a team of mental health professionals or a mental health nurse. Staff worked alongside them to achieve the best possible outcomes for the patients. Staff could access the MHA Code of Practice if they needed to refer to this guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff attended a ward round in the morning to discuss the patients on the ward. Staff could then identify any patients with mental health needs. Patients with dementia had a 'forget-me-not' flower symbol next to their names on the inpatient board, and next to their bed. This meant staff could identify quickly a patient with dementia in a dignified way for them. Mental health specialists, such as the learning disability team and the falls and dementia team within the trust, accompanied staff on their morning ward round if they had identified a patient required specialist mental health support during their stay.

The team had responsive access to psychiatry support five days a week from the old age psychiatry team. If they needed out-of-hours support, they were able to make urgent referrals.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.**

For patients living with dementia, learning needs, or patients whose first language was not English, there was access to an easy to read pictorial menu of the meals available. The menu had easy to recognise signs to identify meat and fish. There was also a wide range of menus available for patients including easy chew, finger food, allergen aware, gluten free, Halal, and vegan.

On the trauma unit, staff held a weekly tea party, which encouraged patients to eat to accelerate healing with the staff, friends, family, and carers. On one day of the inspection, the ward was having a Valentine's day themed party.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients on the trauma unit had access to two nutrition nursing assistants. Their role was to identify barriers to eating, engaging with families, assessing hourly fluids. They provided tips to help older people to eat in hospital and provided information on malnutrition.

Staff fully and accurately completed patient's fluid and nutrition charts where needed. Records we reviewed were mostly completed as required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Records we reviewed were complete and scores were calculated correctly which helped to identify patients at risk of malnutrition.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. Dieticians were available on wards five days a week and were described by ward staff as a 'font of all knowledge'.

At the time of our inspection, there was no clinical lead for nutrition in the dietician team. As a result, the dietitian team consisted of a nurse and a dietitian only. Due to difficulties in recruiting a suitable individual to this role, consideration was being given to appointing an advanced clinical practitioner to the role.

The dietitian team aimed to see patients within 48 hours of referral, though staff explained this was not always possible. Therefore, patients were prioritised according to their clinical needs. Staff explained that due to operational pressures and the need to prioritise the care and treatment of patients, they were not currently auditing how quickly they were seeing patients who had been referred to them.

There were multiple vacancies in the trust's dietician team. Leaders we spoke with explained recruiting suitable individuals to these vacancies had been a challenge.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. Patients waiting to have surgery were not left nil by mouth for long periods.

## **Pain relief**

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

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. An observational tool was used to measure pain in patients who had difficulties communicating, including those living with dementia.

Patients received pain relief soon after requesting it. Patients we asked told us their pain was well controlled, including at night.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this when reviewing prescription records.

The service had a pain team for acute and chronic pain. The team consisted of a team of consultants and nursing staff, with multidisciplinary input from, among others, physiotherapists and clinical psychologists.

The pain team spoke about various strategies for pain management, including management of pain without the use of drugs. This included the benefits of exercise. Courses were run throughout the year for up to ten patients on these different strategies.

The pain team aimed to meet all pain inpatients within 24 hours of a request. However, patients were prioritised based on an assessment of their medical urgency. Vacancies in the pain team were covered by bank staff.

The pain team were undertaking outreach clinics in the community as well to maximise their ability to provide a service to more patients.

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.**

### Relative risk of readmission

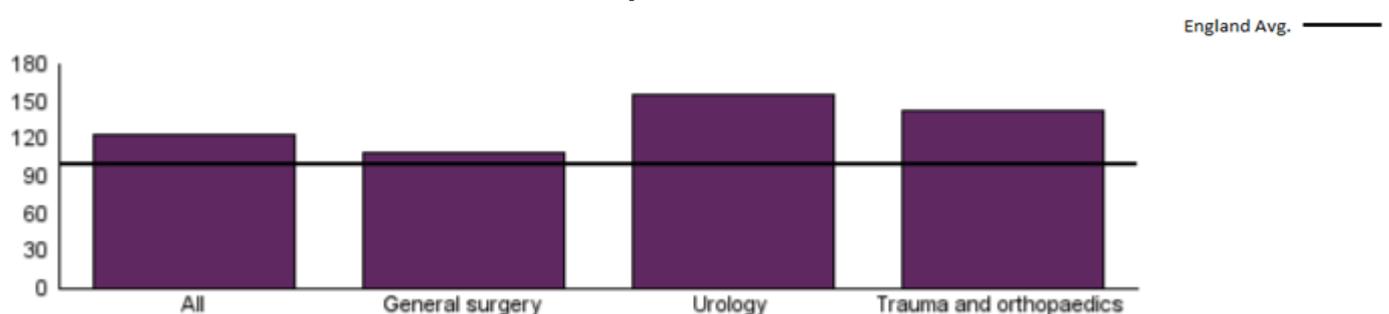
#### Great Western Hospital

The service had a higher than expected risk of readmission for elective (i.e. planned) care than the England average, which was an indicator of the outcome for these patients potentially being substandard.

From June 2018 to May 2019, the following patient groups at Great Western Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average:

- All patients
- General surgery patients
- Urology patients
- Trauma and orthopaedics patients

#### Elective Admissions - *Great Western Hospital*



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 site based on count of activity**

The service had a higher than expected risk of readmission for non-elective (i.e. emergency) care than the England average, which was an indicator of the outcome for these patients being suboptimal.

From June 2018 to May 2019, the following patient groups had a higher than expected risk of readmission for non-elective admissions when compared to the England average:

- All patients
- General surgery patients
- Trauma and orthopaedics patients
- Ear, nose and throat patients

### Non-Elective Admissions - Great Western Hospital



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 site based on count of activity**

(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2018 - 31/05/2019))

### Clinical audits

The service participated in relevant national clinical audits. Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Managers and staff used audit results to improve patient outcomes, including with regards to the National Hip Fracture Database (see below).

Managers and staff investigated audit outliers, implemented local changes to improve care and monitored the improvement over time. The trust was flagged as an outlier with mortality rates between 2 and 3 standard deviation outside the mean, according to the National Emergency Laparotomy Audit. The division successfully reduced the risk score-adjusted mortality rate to 7.9% in the most recently published quarterly data from the audit. This improvement was despite a 25% increase in patients in this quarter (see later in this report for more information).

Managers shared and made sure staff understood information from the audits. Results and learning from audits were shared with staff through governance meetings, among other channels.

### National Hip Fracture Database

The table below summarises Great Western Hospital's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

<b>Metrics (Audit indicators)</b>	<b>Hospital performance</b>	<b>Comparison to other Trusts</b>	<b>Met national standard?</b>
<b>Case ascertainment</b> <i>(Proportion of eligible cases included in the audit)</i>	118.9%	Better	Met
<b>Crude proportion of patients having surgery on the day or day after admission</b> <i>(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</i>	83.9%		Did not meet
<b>Crude peri-operative medical assessment rate</b> <i>(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</i>	96.7%		
<b>Crude proportion of patients documented as not developing a pressure ulcer</b> <i>(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's admission); this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient</i>	93.9%	Similar	
<b>Crude overall hospital length of stay</b> <i>(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</i>	21 days	Within expected range	No current standard
<b>Risk-adjusted 30-day mortality rate</b> <i>(Adjusted scores take into account the differences in the case-mix of patients treated)</i>	5.4%		

*(Source: National Hip Fracture Database)*

Great Western Hospital performed 'better', 'similar' or 'within the expected range' in all metrics displayed in the table above from the 2018 Hip Fracture Database Audit. The trust did not meet the national standards for most of the metrics for which there was a national standard. However, the hospital improved its performance in most of the metrics displayed in the table above compared to how it performed the previous year (2017).

The trust had been involved in the Hip Fracture Quality Improvement Programme (HipQIP), a quality improvement (QI) project involving multiple partners, including other trusts. Based on the latest evidence and best practice, the project sought to provide high-quality hip fracture care using pathways to ensure consistent care. The project involved giving patients additional nutrition, along with other interventions such as early mobilisation, prompt surgery, consistent pain relief and standardisation of care.

The project supported a reduction in mortality rates for patients with hip fractures, dropping from 11.5% to 5.4%.

The service received an award for their new approach to care, which significantly reduced mortality rates and improved the quality of life for patients who have suffered a broken hip. In December 2019, the hospital held an open event inviting other trusts to attend to learn more about the positive results of this QI project.

In the latest (2019) Hip Fracture Database results, the trust's 30-day mortality rate increased (i.e. deteriorated) to 6.6%. This was slightly higher (i.e. worse) than the average mortality rate for these injuries of 6.1%.

The trust had an action plan to continue to improve its performance in this audit. This action plan noted the recent deterioration in the trust's 30-day mortality rate for hip fracture patients. Trust leaders told us all inpatient hip fracture deaths underwent a structured review as well as being discussed at mortality and morbidity meetings at speciality (trauma and orthopaedic) and trust levels. They explained no theme had yet been identified for the deterioration in this indicator. However, the matter was under continued review.

### Bowel Cancer Audit

The table below summarises Great Western Hospitals NHS Foundation Trust's performance in the 2018 National Bowel Cancer Audit.

<b>Metrics (Audit measures)</b>	<b>Trust performance</b>	<b>Comparison to other Trusts</b>	<b>Met national standard?</b>
<b>Case ascertainment</b> <i>(Proportion of eligible cases included in the audit)</i>	93.5%	Good	Good is over 80%
<b>Risk-adjusted post-operative length of stay &gt;5 days after major resection</b> <i>(A prolonged length of stay can pose risks to patients)</i>	77.2%	Worse than national aggregate	No current standard
<b>Risk-adjusted 90-day post-operative mortality rate</b> <i>(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</i>	3%		
<b>Risk-adjusted 2-year post-operative mortality rate</b> <i>(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</i>	17.4%	Within expected range	
<b>Risk-adjusted 30-day unplanned readmission rate</b> <i>(A potential risk for early/inappropriate discharge is the need for unplanned readmission)</i>	10%		
<b>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection</b> <i>(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some</i>	60.9%		

procedures this can be reversed at a later date)

(Source: National Bowel Cancer Audit)

When compared to other trusts, Great Western Hospitals NHS Foundation Trust performed 'good' or 'within expected range' compared to other trusts for five of the metrics displayed, including the proportion of patients who died within 90 days or two years of surgery.

The trust's performance in most of the metrics improved compared to its performance in the previous year (2017).

The trust had an action plan to improve its performance in this audit.

### National Oesophago-gastric Cancer Audit

The table below summarises Great Western Hospital NHS Foundation Trust's performance in the 2018 National Oesophago-gastric Cancer Audit.

<b>Metrics (Audit measures)</b>	<b>Trust performance</b>	<b>Comparison to other Trusts</b>	<b>Met national standard?</b>
<b>Trust-level metrics</b> <i>(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</i>			
<b>Case ascertainment</b> <i>(Proportion of eligible cases included in the audit)</i>	>90%	Better	No current standard
<b>Age and sex adjusted proportion of patients diagnosed after an emergency admission</b> <i>(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</i>	15.6%	Similar	
<b>Risk adjusted 90-day post-operative mortality rate</b> <i>(Proportion of patients who die within 90 days of their operation)</i>	Not eligible	Not eligible	
<b>Cancer Alliance level metrics</b> <i>(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)</i>			
<b>Crude proportion of patients treated with curative intent in the Cancer Alliance</b> <i>(Proportion of patients receiving treatment intended to cure their cancer)</i>	54.8%	Better	No current standard

(Source: National Oesophago-Gastric Cancer Audit)

Great Western Hospital NHS Foundation Trust performed 'similar' or 'better' in comparison to other trusts in all the metrics displayed above in the 2018 National Oesophago-gastric Cancer Audit.

The trust saw a deterioration in its performance in one of the metrics: the proportion of patients

diagnosed after an emergency admission, up from 14% in 2017 to 15.4% in 2018. Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late-stage cancer and therefore poor rates of survival. The audit recommends overall rates over 15% could warrant investigation.

Following the audit report in 2018, the service created an action to validate data on a monthly basis, to be followed up with a quarterly report, which would be shared with the clinical team. The monthly validation was completed and the quarterly report was in progress at the time of our inspection.

### National Emergency Laparotomy Audit

The table below summarises Great Western Hospital's performance in the Fourth National Emergency Laparotomy Audit published in 2018. The audit reports on the extent to which key performance measures were met and grades performance as follows:

- **RED** (<50% of patients achieving the standard)
- **AMBER** (50% - 80% of patients achieving the standard)
- **GREEN** (>80% of patients achieved the standard)

<b>Metrics (Audit measures)</b>	<b>Hospital performance</b>	<b>Audit's Rating</b>	<b>Met national standard?</b>
<b>Case ascertainment</b> <i>(Proportion of eligible cases included in the audit)</i>	100%	<b>GREEN</b>	Met
<b>Crude proportion of cases with pre-operative documentation of risk of death</b> <i>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</i>	88%		
<b>Crude proportion of cases with access to theatres within clinically appropriate time frames</b> <i>(Proportion of patients who were operated on within recommended times)</i>	91%		
<b>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre</b> <i>(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</i>	86%		
<b>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to surgery post-operatively</b> <i>(Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</i>	100%		
<b>Risk-adjusted 30-day mortality rate</b> <i>(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</i>	16%	Worse than expected	No current standard

(Source: National Emergency Laparotomy Audit)

Great Western Hospital achieved the national standard for all metrics (displayed in the table above) for which there was a national standard in the Fourth National Emergency Laparotomy Audit published in 2018. The hospital achieved a 'green' rating in all metrics displayed in the table above except the metric for the proportion of patients who died within 30 days of admission. In this metric, the hospital was rated 'worse than expected'.

Service leaders explained that by working across disciplines and service lines, the division had successfully reduced the risk score-adjusted 30-day mortality rate to 7.9% (down from 16% as quoted in the table above) in the most recently published quarterly data from the audit. This improvement was despite a 25% increase in patients in this quarter. Leaders explained this improvement was achieved, at least in part, through surgeons and anaesthetists reviewing – with a view to improve – the pathway for patients, resulting in a lower (i.e. improved) mortality rate for patients.

### National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises Great Western Hospitals NHS Foundation Trust's performance in the 2018 National Ophthalmology Database Audit.

<b>Metrics (Audit measures)</b>	<b>Trust performance</b>	<b>Comparison to other Trusts</b>	<b>Met national standard?</b>
<b>Trust-level metrics</b> <i>(Measures of hospital performance in the treatment of cataracts)</i>			
<b>Case ascertainment</b> <i>(Proportion of eligible cases included in the audit)</i>	38.5%	-	No current standard
<b>Risk-adjusted posterior capsule rupture rate</b> <i>(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)</i>	0.3%	Positive outlier	
<b>Risk adjusted visual acuity loss</b> <i>(The most important outcome following cataract surgery is the clarity of vision)</i>	0.6%	Within expected range	

(Source: National Ophthalmology Database Audit)

The trust was a 'positive outlier' in one of the metrics in the 2018 National Ophthalmology Database Audit: posterior capsule rupture (PCR) rate. The frequency of PCR is a widely accepted indicator of surgical quality. As an adverse operative event, it results in a significantly higher risk of harm to the eye and may affect vision recovery.

The trust performed 'within expected range' in the other metric displayed in the table above from the 2018 National Ophthalmology Database Audit.

The trust's performance in the audit deteriorated in the 2019 National Ophthalmology Database Audit, where the trust scored 0.8% for PCR and VA Loss. However, this was still lower (i.e. better) than the overall rates of 1.1% for PCR and 0.9% for VA Loss based on the average rates for consultant surgeons.

## National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The table below summarises Great Western Hospital's performance in the 2018 National Joint Registry.

	<b>Metrics (Audit measures)</b>	<b>Hospital performance</b>	<b>Comparison to other hospitals</b>	<b>Met national standard?</b>
<b>Trust-level</b>	<b>Case ascertainment (hips, knees, ankles and elbows)</b> <i>(Proportion of eligible cases within the trust that were submitted to the audit)</i>	95.5%	Better	Met
	<b>Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)</b> <i>(Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</i>	90.2%	Similar	Did not meet
<b>Hospital level: Hips</b>	<b>Risk-adjusted 5-year revision ratio (for hips excluding tumours and neck of femur fracture)</b> <i>(Proportion of patients who need their hip replacement 're-doing')</i>	1	Within expected range	Met
	<b>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture)</b> <i>(Proportion of patients who die within 90 days of their operation)</i>	0.8		Did not meet
<b>Hospital level: Knees</b>	<b>Risk-adjusted 5-year revision ratio (for knees excluding tumours)</b> <i>(Proportion of patients who need their knee replacement 're-doing')</i>	1.2		Met
	<b>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours)</b> <i>(Proportion of patients who die within 90 days of their operation)</i>	1		

(Source: National Joint Registry)

Great Western Hospital performed 'better', 'similar' or 'within expected range' compared to other trusts in the metrics displayed in the table above from the 2018 National Joint Registry. The hospital met the national standard for four of these six metrics.

### Accreditation and other external quality assessments

The service's in-house sterile services unit was an accredited decontamination unit, certified as meeting the requirements of EU Directive 93/42/EEC and ISO 13485. At the time of our inspection, the sterile services department had recently had its accreditation renewed.

Many of the specialities in the division had gone through 'Getting It Right First Time' (GIRFT), an NHS Improvement programme designed to improve the quality of care by reducing unwarranted variations. There was evidence of learning from these reviews and ongoing work to meet the outstanding issues identified in the reviews.

## Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Simulation training in the trust's simulation suite was offered to staff in the service every month to improve patient safety. This training sought to encourage team cohesiveness and communication skills, in addition to clinical skills.

Breakfast teaching sessions for anaesthetic staff were also arranged on a monthly basis. On the month of our inspection, the session covered advanced recovery skills.

The service worked with the trust's academy facility to use monthly half-day governance sessions to update staff skills through completion of mandatory training.

Monthly updates were provided on various issues, including manual handling. The service was also seeking to introduce quarterly planned care staff forums as a further arena to promote learning.

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

## Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. From 12 November 2018 to 13 November 2019, 85.3% of staff in surgery received an appraisal compared to the trust target of 80%. This was an improvement compared to what we found at our previous inspection when we reported 79.4% of staff within surgery had received an appraisal (from May 2017 to April 2018).

The breakdown by staff group can be seen in the table below:

Staff group	12 November 2018 to 13 November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Allied health professionals	1	1	100%	80%	Yes
Additional clinical services	167	186	89.8%		
Administrative and clerical	75	84	89.3%		
Nursing	262	296	88.5%		
Add prof scientific and technic	28	33	84.8%		
Medical and dental	126	173	72.8%		No

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

The planned care division, within which the surgery core service sat, scored lower (5/10) (i.e. worse) for the quality of appraisals compared to the trust as a whole (5.2/10) in the 2019 NHS Staff Survey. The average score for organisations taking part in the survey was 5.5/10.

Leaders explained the compliance rate for appraisals among medical staff was (at least in part) due to an administrative issue with having the appraisals recorded on the trust system. They explained it took longer to reflect that an appraisal had taken place. We were assured that all medical staff were appraised.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We spoke with a member of staff in theatres who explained they were due to go on a catheterisation and cannulation course. They explained they felt more motivated because of the career opportunities available to them.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. In addition to yearly appraisals, we heard examples of more regular informal meetings held by managers to check in with staff they managed.

Staff sought and received specific support, advice and training from the old age psychiatry team and other mental health leads within the trust to enable them to manage issues arising from mental health conditions.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. Managers monitored poor performance through the appraisal process or through support from the human resources team.

## **Multidisciplinary working**

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw good examples of multidisciplinary working at the preoperative clinic. This was a nurse led clinic, supported by anaesthetists. Nurses we spoke with told us that the anaesthetists were responsive to any requests for support. Anaesthetists also ran teaching sessions for nurses.

Multidisciplinary ward rounds took place across the wards we visited, including Ampney ward and the Trauma ward. During the morning ward round, staff from the falls and dementia teams joined the ward team to provide advice and support for patients requiring specialist advice on good practice.

Staff worked across health care disciplines and with other agencies when required to care for patients. We attended a board round which was well attended by occupational therapists, a clinical practitioner, an ortho-geriatrician, junior doctors, the integrated discharge team, an administrator and charge nurse. Everyone attending contributed to the discussion of each patient, including whether patients were medically fit for discharge, pain management, comorbidities, home circumstances, equipment and support required, as well as patients being held under the Mental Capacity Act. Patient experiences were also discussed, including moving patients out of a private room into a bay where they would be able to have more social interaction.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

## **Seven-day services**

**Key services were not always available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards, including weekends. They were supported by junior doctors. Patients were reviewed by consultants depending on the care pathway.

A review of the service's performance against the seven-day standards had been carried out. This assessment found two areas of non-compliance with the standards – namely, the lack of 24-hours a day, seven days a week access to magnetic resonance imaging (MRI) and interventional radiology. The service was looking to address this non-compliance by working with other local trusts which could provide these services, though we were not told if and when such an arrangement would be in place.

There was safe provision of physiotherapy and occupational therapy for patients following surgery. There was joint working between physiotherapy and occupational therapy giving comprehensive assessments of mobility and independence and medical fitness for discharge.

Allied health professionals worked five days per week, with core hours from 8am to 5pm. We noted during the inspection a weekend service was provided for patients who needed support to be mobilised to get home.

## **Health promotion**

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

The service had relevant information promoting healthy lifestyles and support on the wards/units. The service promoted healthy lifestyles and signposted patients to sources of information and support, for example in relation to substance and alcohol abuse and smoking. There were information leaflets available in reception waiting areas and on notice boards on wards.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients gave their consent for operations at the pre-operative clinic, and staff understood that patients required capacity to give consent. They understood that where required, patients may need capacity assessments, and they would liaise with the mental health team on site and anaesthetists. We saw that best interest forms were completed, and saw that multidisciplinary meetings were held.

Staff followed a two-stage test set out on the trust's mental capacity act form to determine whether patients had capacity. The staff we spoke with explained they repeated these tests for patients who were temporarily coming out as lacking capacity according to this test because they were, for example, delirious. Staff were notified a week before the expiration of deprivation of liberty authorisations to repeat and consider patient capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. All patients who could give informed consent to their surgery completed consent forms, based on guidance issued by the Department of Health. The consent form ensured that staff followed a flowchart which measured a patient's ability to consent to a specific surgical intervention. By completing the form, staff were obliged to assess capacity and follow the

principles of the Mental Capacity Act. Staff had to check if there was a power of attorney in place, if the patient had made any advance decisions, if they had instructed an independent mental capacity advocate and the details of any best interest decision meetings. This form was retained in patients' notes. Consultants would not commence surgery before this form had been filled out.

When reviewing patients' care records, we saw that information about a patient's mental capacity had been recorded and the best interest decision had been reached involving the most appropriate people. However, on the Trauma Unit the documentation of the Mental Capacity Act assessment lacked clarity. For example, it was documented that a patient did not have capacity as they were "not alert enough to retain information". We did not see evidence of ongoing capacity assessments for further treatment. All paperwork had been sent to the people involved in the decision.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. In the records we reviewed, we found consent was sought and documented on the day of a procedure even where consent had been obtained previously as well.

On the morning of the patients' operation, staff read through the consent form again with the patient who lacked capacity and discussed the outcomes and risks associated with the operation. Patients we spoke to who had mental health needs said staff had discussed the expected outcomes and associated risks with their operations.

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

Staff received and mostly kept up to date with training on the Mental Capacity Act and Deprivation of Liberty Safeguards. While most nursing staff kept up to date with training in the Mental Health Act, medical staff did not achieve the trust's target (80%) for completion of training in the Mental Health Act.

The trust set a target of 80% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The target was met for all MCA/DOLS training modules for which nursing staff were eligible. For medical staff, the target was met for one of the two MCA/DOLS training modules for which they were eligible.

A breakdown of compliance for MCA/DOLS training modules from 22 November 2018 to 21 November 2019 at trust level for nursing staff is shown below:

Training module	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	407	441	92.3%	80%	Yes
Mental Health Act	392	442	88.7%		

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

A breakdown of compliance for MCA/DOLS training modules from 22 November 2018 to 21 November 2019 at trust level for medical staff is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	215	249	86.3%	80.0%	Yes
Mental Health Act	177	249	71.1%	80.0%	No

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

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Senior staff on the post-operative wards had good understanding and had received training on the deprivation of liberty safeguards (DOLs). We saw that DOLs forms had been completed in patients' care notes where appropriate. In addition, staff documented treatment escalation plans and do not resuscitate forms where relevant. This documentation formed an essential part of care planning before surgery.

## Is the service caring?

### Compassionate care

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

**People were mostly treated with kindness, dignity, respect and compassion.** The patients we spoke with during this inspection were positive about the care and treatment they received. We observed positive interactions from the multidisciplinary team with their patients.

We saw kind and compassionate interactions between staff and patients. Staff introduced themselves to patients in a friendly and professional way and spoke to patients with respect and encouragement. Curtains were always used to ensure patient privacy. We saw that all patients on wards and bays had an assigned nurse and healthcare assistant which was noted on a whiteboard.

The comments we received and saw from patients included:

- “Care has been lovely – all nurses have been lovely, they always pull the curtains around when they examine me.”
- “My daughter lives a long way from the hospital, and they let her visit me at any time of the day when she is here.”
- “I saw the consultant the day after my operation and they answered all my questions.”
- “My pain has been managed extremely well.”

However, we were also told by one patient they had not been washed and dressed until midday, and they would not have been like this at home.

On Aldbourne ward, we found a bay of five beds where the bedside televisions and payphones were not working. A patient stated they were bored and would have like to have access to the television to help pass the time. Another patient also had no access to a personal phone and had borrowed another patient's phone to contact their relatives. They told us this had been flagged with staff. However, we could not find this had been reported by staff to be fixed, and no incident report had been made. When we raised this issue with staff, we were told it would be “several

days” for this to be sorted as the bedside televisions and phones were provided by an external company.

Staff made sure people’s privacy and dignity was always respected. For example, we saw nurses closing curtains around patients when delivering personal care and treatment. All patients we spoke with were positive about the way staff maintained their privacy and dignity. Patients had access to chaperones if required and information about how to access a chaperone was displayed clearly in treatment rooms. The service had a chaperone policy and staff were aware of their responsibilities. We observed a surgical procedure where the patient's dignity was preserved with an incontinence pad that covered the proposed operation site. The pad was removed at the last moment before preparing the patient for the procedure.

Staff responded in a compassionate, timely and appropriate way to people experiencing physical pain, discomfort or emotional distress. Most patients told us their pain had been well managed and had been reviewed every day by the pharmacist or doctor.

Patients we spoke with told us staff were caring and supportive. They said they had been treated well and they trusted the opinion of their doctor. For patients with mental health needs, they said they had been given enough information about their stay to keep them safe.

Patients had access to their care plans as they were located at the end of their beds. Two patients we spoke to were not sure what was going to happen to them next. We asked staff to speak to them and reassure them about this and they did this straight away.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Positive feedback from patients was displayed on wards. For example, we observed privacy and dignity, with curtains around beds used. We saw doctors and nurses speaking with patients – always introducing themselves, bending down to make eye contact, giving patients time to ask questions, and making sure patients understood their responses.

We saw staff went out of their way to improve the experience of patients during their stay.

Patients said staff treated them well and with kindness. Nurses would buy patients their favourite biscuits. On the trauma unit, the patients were given gifts on Christmas day (such as soaps, flannels, books and chocolates). This was reflected in the feedback from patients who told us that when they spoke to staff, they were extremely helpful.

We were also given examples where end of life patients’ pets had been brought into the wards. However, patients also told us that they recognised that there were staff shortages on wards which meant that there were times in the day, particularly during the morning, when it was more difficult to get staff attention. One patient told us about another patient who had been in the toilet for over 20 minutes as staff were too busy to respond to the call bell.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff to be understanding and non-judgemental when interacting with patients who had mental health needs. Staff showed they possessed the required knowledge and skills to support them in our conversations with them. Staff provided many examples of supporting patients with mental health needs. For example, in the preoperative clinic, staff were made aware of a patient living with dementia who was very anxious about coming into hospital. Staff coordinated the patient’s appointment so all the health professionals would see the patient in the one room to reduce the patient’s anxiety. They received very positive feedback from the patient’s

relatives. We also noted that when nurses were concerned about a patient, they would phone them to ensure they had got home safely, and to recap any key messages. Patients were given the opportunity to visit the hospital and see the day surgery unit and recovery area prior to the day of their operation. They had the opportunity to speak to staff and ask questions in advance.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients had access to multi-faith chaplaincy services 24 hours a day, seven days a week. The chaplaincy team came from Christian traditions and were able to support people of all faiths and none. They were also able to contact any of the world faiths represented in the area to arrange for someone to support a patient's individual needs.

## **Emotional support**

### **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. Families and carers of patients who were in hospital for an extended time were given a 'carers passport'. The passport provided access to a range of benefits including free drinks, discounted parking and food when in hospital. The hospital also held a carer's café each week, staffed by volunteers to offer information and support.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff we spoke with on the wards spoke passionately about supporting patients who became distressed. On Meldon ward, a room had been identified which was kept clear and calm for patients and their families to use, away from the general ward and discharge area.

For patients who were anxious about surgery, their relatives or carers were allowed to stay with them until they had been given their anaesthetic in the anaesthetic room and would then be allowed to be in the recovery area when the patient awoke, to reduce the patient's stress.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients who receive life-changing diagnoses were given appropriate emotional support, including access to further support services. For example, nurses could signpost patients to Macmillan nurses.

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

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw staff explaining things to patients in a way they could understand. The patients spoken with felt well informed as to their diagnosis and care plans, they felt the management of their care and treatment had been discussed with them as much as possible. Surgical patients were offered an opportunity to attend the pre-operative clinic. For orthopaedic patients, this included a morning session and an opportunity for patients to meet clinicians in advance of their stay in hospital, as well as a preoperative nurse who would be the point of contact until they were admitted. Patients were offered advice for preparing for surgery, which included advice on fitness, nutrition and wellbeing. Patients were then told about what to expect regarding their stay in hospital, including pain management. Patients were then given information about enhanced recovery, eating and drinking, getting mobile and daily goals.

Patients we spoke with confirmed they had enough information about the risks and benefits of their surgery. Patients we spoke with feel listened to, respected and have their views considered.

Nurses on the wards kept patients well-informed of timings and delays to going to theatre. Patients we spoke with were happy with the way nurses kept them updated on when they were going to theatres. However, patients we spoke with were not always informed about when they would be going home or what support they would need at home. Nurses told us that information about patient's discharge was not always available and were often changed because of delayed transfers of care (where a patient is ready to be discharged from hospital but is unable to because of a lack of a package of care in the community).

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients we spoke with felt listened to, respected and had their views considered. Information was clearly displayed in all ward areas which showed how patients could complain or provide feedback on their treatment. Staff we spoke with told us they actively encouraged feedback, and wanted to deal with any patient's concerns immediately, so they could improve the patient's experience or treatment before they left hospital.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test (FFT) survey. FFT results were displayed in ward areas and the theatre complex. Staff could give examples of how they used patient feedback to improve the quality of care they provided.

## Is the service responsive?

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

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, the demand for beds was overtaking capacity and affecting the ability to provide single-sex accommodation.**

Managers planned and organised services, so they met the changing needs of the local population. The service worked with stakeholders to understand whether and how the service could meet the needs of the local population. This included an ongoing review of the impact of the local area's population growth would continue to have on the service. The service sought to work with local NHS trusts and independent health care providers to develop resilience and capacity in order to meet the needs of the local population. This included, for example, collaborating with a local NHS trust to jointly recruit and share medical staff.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. However, facilities and premises were not appropriate for the services being delivered. The waiting area on Meldon ward was split into male and female waiting areas. However, depending on how many patients of each sex there were in any day, there could be times where male and female patients would be together. However, we saw patients in the waiting areas were not put into gowns until about 10 minutes prior to their surgery, in order to maintain their dignity. There was also an area which was curtained off for patients who were distressed.

Leaders acknowledged mixed-sex breaches were a common occurrence in the surgical assessment unit and the recovery 2 area, and that one of the biggest challenges facing the service included the need to provide single-sex accommodation in these two areas. A plan had been put together to ensure single-sex accommodation on the surgical assessment unit, though this meant a reduction in bed capacity. At the time of our inspection, leaders told us this plan was

going to the trust board for approval.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff had access to advice and support from the mental health liaison team and the old age psychiatry if a patient decided to either discharge themselves or refuse treatment.

Managers monitored and took action to minimise missed appointments. Nurses in the preoperative clinic had reduced the number of patients with anaemia or diabetes who could not proceed with planned procedures. They had improved patient pathways so they could identify these patients earlier and worked with community and other hospital teams to improve patients' health prior to being admitted for surgery.

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

**The service was mostly inclusive and sought to take account of patients' individual needs and preferences. Staff often made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Patients with additional needs would be booked earlier in the list in order to have their surgery sooner. Staff liaised with the learning disability team and carers to meet patients' needs. Staff could meet patients and their families or carers in the car park and bring them straight to theatre if necessary. We also observed patient needs being discussed as part of ward handover discussions and documented within their patient records. Discussions included supporting patients on the wards and supporting them as they transitioned to their home environment. Staff on the day surgery unit had gone through the mental health first aider course. They gave examples of the adjustments made and lengths they went to where patients were identified as having a mental health problem, including the example of a patient living with panic attacks and anxiety. If a person was admitted to the ward with a mental health need that was causing them or others distress, staff consulted the old age psychiatry team or the adult psychiatric liaison team to complete an assessment and move them to a more appropriate place on the ward.

In the pre-operative ward, people were invited to come and walk around the ward prior to their admission to familiarise themselves with the environment. Staff working on the ward made specific adjustments for people with autism during their pre assessment period, spending time going through the process step by step.

Patients we spoke to said they had reasonable amounts of privacy and could request to draw their curtains if they wanted to. However, patients said they did not have much access to activities or had been asked if they would like a befriender. We saw that most patients did not have anything to keep them occupied whilst on the ward.

Wards were generally designed to meet the needs of patients living with dementia. Signage for toilets and showers on some wards were 'dementia friendly' with large colourful pictures, though the environment of some areas could be improved to meet the needs of patients living with dementia, by improving signs and use of high contrast colours. All ward areas we visited had information boards with information for and on living with dementia. Wards had dementia link nurses to act as a resource for dementia information and help deliver holistic care to patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. For patients with dementia, staff supported them to fill out a booklet on their admission, called 'All About Me'. Staff used this booklet to collect information

about the person's preferences around eating, drinking and personal hygiene. Patients also stated things that made them happy or upset, the way they preferred to communicate and information about their life so far. Where dementia patients had 'this is me' leaflets, staff on the day surgery unit went through these to ensure they were better aware of the individual needs of these patients.

Staff in the pre-operative ward followed the learning difficulties pathway when completing pre assessments. For example, staff offered patients an appointment over the phone, so they did not have to travel in to the hospital before they had to. During their assessment, they discussed any reasonable adjustments needing to be made. Staff informed the learning disability team of the date the patient was admitted. Staff recorded if the patient required a side room, so they had space to relax. The ward could accommodate a care team if they accompanied the patient. Staff gave examples of a patient who had a learning disability and was scared of moving from the ward into theatre on the hospital trolley. Staff knew that he had a favourite film that used to calm down with, so set it up on an electronic tablet for him to watch whilst he was being transported.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff understood how to access extra support for patients living with dementia. Staff spoke confidently about the additional support they would give to patients living with dementia including supporting them to orientate themselves within the environment and involving those close to the patient. Staff we spoke with knew how to contact the dementia team for additional support, or advice.

The trauma unit had a computer on wheels which gave patients access to movies, television series, music poetry, relaxation exercises and pictures. This computer could also access games such as bingo, and these were used by staff dementia champions on the ward to support patients. Prizes of chocolates and biscuits were given to patients.

The service had information leaflets available in languages spoken by the patients and local community. Clinicians had access to an interpretation service 24 hours a day and had access to an online facility to translate languages. Patient leaflets could also be translated but this would take three to four days to create. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There was also a wide range of menus available for patients including easy chew, finger food, allergen aware, gluten free, and vegan.

## **Access and flow**

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

The hospital was located in a part of the country that had seen, and was projected to continue to see, significant population growth, creating added demand for services. Furthermore, leaders in the planned care division explained the service had seen above expected growth in terms of demand in a number of specialities, including urology. According to modelling by NHS Improvement, the planned care division (in which the surgery core service sat) was short by 60 to 70 beds to meet the demand expected to arise from the growth in the local population.

The trust used the NHS performance tool 'operational performance escalation level (OPEL) to respond to increased pressures in demand or surges. The OPEL level was set based on triggers and was updated every two hours, seven days a week. At the time of our inspection, the trust was in OPEL four, the NHS's highest level of pressure escalation.

The planned care division's resources were often spent supporting other parts of the hospital, particularly unscheduled care. This was in addition to the existing increase in demand facing the planned care division as discussed above and the fact that the service was short of beds to meet demand. We saw the pressures facing the division during our inspection. This included one of the surgical wards, Aldbourne ward, which cared for orthopaedic patients, being formally 'flipped' from a surgical ward to an escalation ward for medical outliers. Leaders explained this had happened in previous years and was part of the trust's plan to manage winter pressures. One of the areas that was historically used as a recovery area for patients who had undergone an operation – the recovery 2 area – had also in the last few years been used as an escalation area for patients.

Staff we spoke with across the service identified demand and capacity as the biggest challenge facing the service. For example, staff we spoke with in theatres explained the biggest issue they were dealing with were obstacles to efficient patient flow through the hospital, and that this was mainly caused by the use of recovery 2 as an escalation area. Staff explained this had sometimes affected theatre lists being carried out on time.

#### Patient flow (i.e. the transition of a patient through the hospital)

At both trust and service level, steps were being taken to respond to the demands on the service. For example, a trust-wide bed meeting took place twice a day to discuss, among other things, bed availability and pressure areas in the hospital. These were attended by senior nurses across surgical services.

Patient flow was also discussed at flow meetings which took place daily in theatres. These meetings were attended by a colleague from the bed management team, the intensive care unit, a theatre coordinator and the recovery coordinators. We attended one of these meetings during our inspection. All those expected to attend were not able to attend and the meeting was regularly interrupted due to calls and late starts, impacting on its usefulness. The meeting was nonetheless an opportunity to discuss actual or possible cancellations, the operating lists, and any issues that are forecasted such as bed availability. Decisions were taken and actions take away from this meeting.

The service had developed a full hospital protocol for surgery. Leaders intended for this protocol to ensure surgery was given an appropriate consideration alongside medical care when responding to operational pressures in the service.

#### Theatre scheduling and utilisation

Bookings for planned (also known as 'elective') procedures were made through the service's elective booking team. The service was using a paper system to book patients for procedures, though discussions were underway to move to an electronic system. Heads of service met weekly with their assigned booking clerk from the elective booking team to discuss issues with waiting lists, among other things.

Once a patient was booked for a procedure by the elective booking team, they were then invited to a pre-assessment session. Leaders explained there were plans to allow patients who were planned to undergo a day case procedure to have their pre-assessment on the day of booking. This was not happening at the time of our inspection due to staffing issues. However, leaders explained there was a recruitment plan to make this possible going forward. Leaders explained this would help reduce the number of trips patients had to make to the hospital, making for better patient experience as well as improving flow through the hospital.

There was a weekly meeting of the surgical planning group where issues (such as theatre lists

and patients with a long wait for treatment) were discussed. This was attended by a wide group of stakeholders in surgical services including sterile services. The service had implemented the '6-4-2' theatre management process to improve the planning and scheduling of operating lists, whereby the theatre programme was reviewed weekly and looking six weeks ahead. This process reviewed whether each speciality was scheduling the appropriate number of theatre lists to meet its activity assumptions, whether clinicians were available, and whether operating lists were scheduled on time.

On the day surgery unit, staff also went through the theatre list on Thursdays, for a review of the following week's schedule.

The service had a theatre transformation project to improve theatre utilisation and scheduling. The project had four workstreams, each of which had quantifiable deliverables, an understanding of the challenges and a set of milestones with deadlines to track progress:

1. **Surgical planning:** Performance was being studied to learn how scheduling could be changed to improve utilisation and flow. For example, patients were being booked in to come in at different times to see what impact that had on performance.
2. **Pre-assessment:** The service had a comparatively low rate of cancellations due to patients being deemed unfit for surgery, and leaders claimed this was due to the service's effective pre-assessment process. However, leaders explained they were looking at how they could make the pre-assessment process more efficient. This included better use of technology, including carrying out pre-assessments through audio and video calls rather than always in person as was the case at the time of our inspection.
3. **Day surgery:** Leaders acknowledged the service had a comparatively high (worse) proportion of day case procedures that resulted in patients being admitted overnight. As part of the theatre transformation project, leaders were looking at how they could improve performance in this area. This included looking at good practice and national guidance on post-surgical recovery to determine the most suitable time to operate on an individual.
4. **Operational delay and patient flow:** This workstream involved different parts of the planned care division working together to understand and improve those issues that were getting in the way of procedures being undertaken in theatres.

The project had a committee chaired by the divisional director for the planned care division, which met monthly. Leaders explained improvements had been made in reducing late starts and overruns, and that their focus at the time of our inspection was in four areas: cancellations on the day, late starts, underruns, overruns and did not attend rates, for all of which key performance indicators had been agreed. As a result of this work, the service had seen theatre utilisation improve from around the high 70s percentage to around 84%. However, leaders acknowledged there was a dip in theatre utilisation in January 2020 due to winter pressures.

The service had a process to ensure privately funded work did not undermine the work done for NHS funded patients. There were 10 sessions a week dedicated to privately funded work. Any requests for those slots allocated for privately funded work to be 'flipped' with slots allocated for NHS funded work had to be approved by the divisional director.

Leaders told us all their standard operating procedures were being reviewed and revised at the time of our inspection.

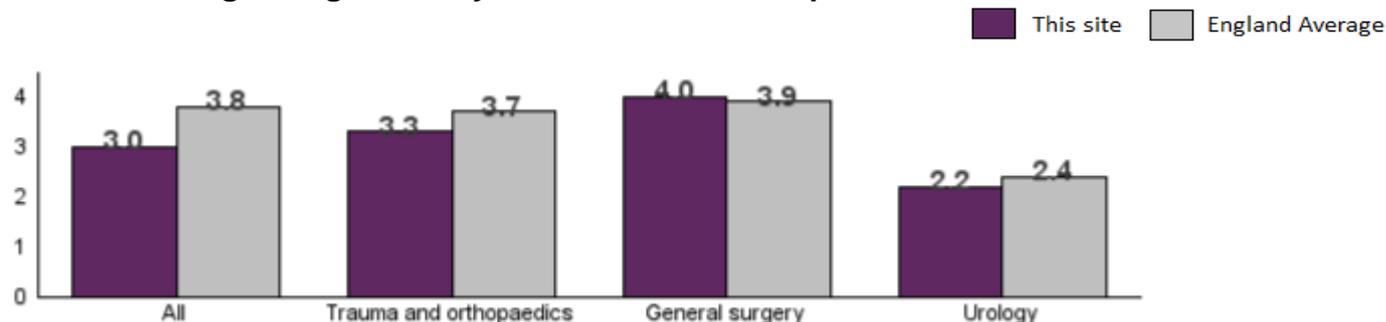
### **Average length of stay**

Managers and staff worked to make sure patients did not stay longer than they needed to. Length of stay was discussed at weekly divisional matron meetings with action points taken away by individual members of staff.

## Elective patients

From July 2018 to June 2019, the average length of stay for patients having elective surgery at Great Western Hospital was 3 days. This was shorter than the average for England, which was 3.8 days. The average length of stay for patients having elective trauma and orthopaedics surgery or elective urology surgery at the hospital was also shorter than the average for England. However, the average length of stay for patients having elective general surgery at the hospital was longer than the average for England. See graph below.

### Elective Average Length of Stay - Great Western Hospital

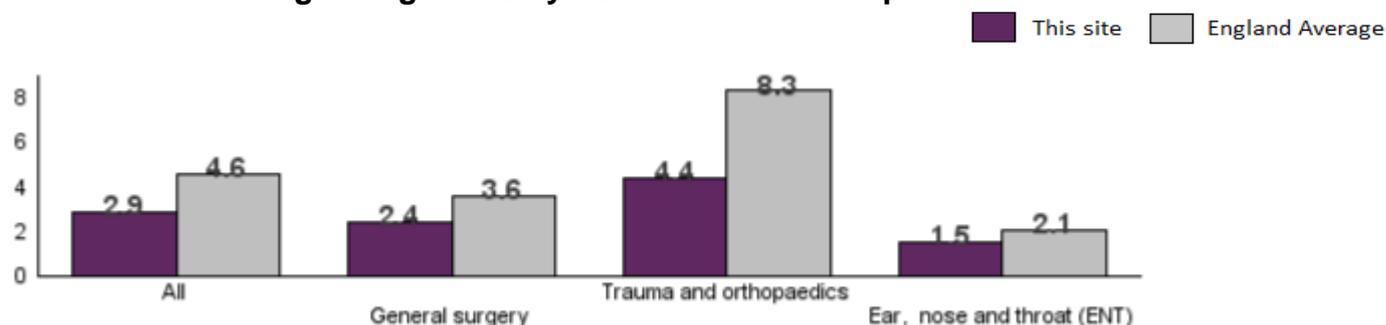


*Note: Top three specialties for specific site based on count of activity.*

## Non-elective patients

From July 2018 to June 2019, the average length of stay for patients having non-elective surgery at Great Western Hospital was 2.9 days. This was shorter than the average for England, which was 4.6 days. The average length of stay for patients having non-elective general surgery, trauma and orthopaedics surgery, and ear, nose and throat surgery at the hospital was all shorter than the average for England. See graph below.

### Non-Elective Average Length of Stay - Great Western Hospital



*Note: Top three specialties for specific site based on count of activity.*

## Surgical outliers

Managers worked to minimise the number of surgical patients on non-surgical wards (also called 'surgical outliers'). As mentioned above, an 'outlier' is defined as a patient admitted to a ward different from the ward on which they should usually be. While surgical wards were often used as escalation areas for patients from other disciplines (primarily, medical patients), leaders explained surgical patients were rarely ever placed on non-surgical wards.

## Enhanced recovery

The service ran enhanced recovery programmes to improve outcomes for patients. By improving patient outcomes, the service sought to reduce lengths of stay and increase capacity within the service to meet growing demand. This included an enhanced recovery programme for colorectal patients. The multidisciplinary programme sought to help speed up the recovery of patients'

bowels, get them back on their feet and moving around more quickly following an operation and reducing fatigue, all of which was designed to reduce the risk of complications following surgery.

### Discharge patients

The divisional director of nursing led daily quality and safety huddles in which, among other things, the discharge of patients from the hospital were discussed. These huddles were also an opportunity to discuss the opening and closing of escalation beds.

Staff we spoke with on the surgical wards told us they regularly used the surgical discharge lounge.

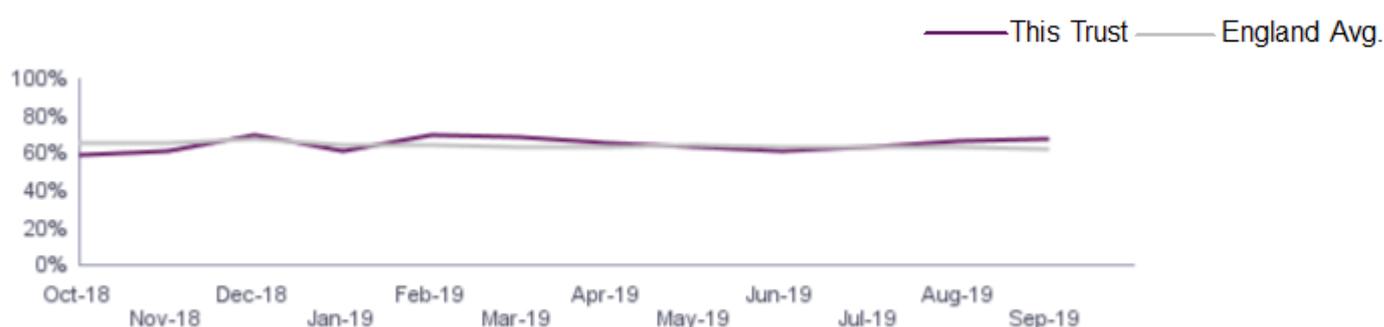
Staff told us staffing could sometimes be an obstacle to more effectively discharging patients from hospital. On Ampney ward, for example, staff told us the charge nurse, who had the role of ward coordinator, still had equal caring responsibilities to other nurses on the ward. This impacted on the charge nurse's ability to join doctors on daily ward rounds. As a result, the charge nurse sometimes had to read patient notes afterwards to find out which patient could be discharged and what needed to be done to ensure the discharge would be possible. Staff explained this impacted on the efficiency of discharge on the ward.

Staff also told us that getting staff to sign off electronic discharge summaries was sometimes a barrier to timely discharging of patients, though they explained this had recently improved.

### **Referral to treatment (percentage within 18 weeks) - admitted performance**

Managers monitored waiting times. However, patients could not always access services when needed or receive treatment within agreed timeframes and national targets.

From October 2018 to September 2019, the trust's referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average.



(Source: NHS England)

### **Referral to treatment (percentage within 18 weeks) – by specialty**

One specialty was above (or better than) the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
General surgery	85.7%	71.9%

Five specialties were below (or worse than) the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<b>Specialty grouping</b>	<b>Result</b>	<b>England average</b>
Urology	64.9%	74.3%
Ophthalmology	59%	61%
Ear, nose and throat	58.4%	59.7%
Trauma and orthopaedics	40.9%	57.9%
Oral surgery	31.2%	54%

Leaders explained their current priorities included reducing referral to treatment times (RTT). Leaders discussed the progress made towards improving the referral to treatment times in the service. However, leaders acknowledged they still needed to make progress with their list of patients who needed to be treated by given dates to start treatment within maximum waiting times. The service had a recovery plan to improve referral to treatment times. This plan was overseen by an oversight group which was chaired by the trust's chief operating officer, and which met weekly to discuss the size of the waiting list.

Leaders identified ear, nose and throat, urology, and trauma and orthopaedics as specialities that were most challenged in terms of referral to treatment time (RTT) waiting lists. They explained the steps being taken to improve performance in these areas. For example, with ear, nose and throat, leaders said part of the reason for the RTT performance was due to recent staffing issues. However, leaders explained vacancies had been filled in this area, and that they expected to see an improvement in the RTT figures going forward. With urology, they explained that going forward initial screening of patients were to be carried out by a local primary healthcare provider with which the trust had recently entered into a partnership. This was intended to free up capacity in the service and enable it to improve its RTT performance for this speciality. All non-cancer treatments were being seen by services provided in the community in partnership with the trust. This has been in place for 18 months.

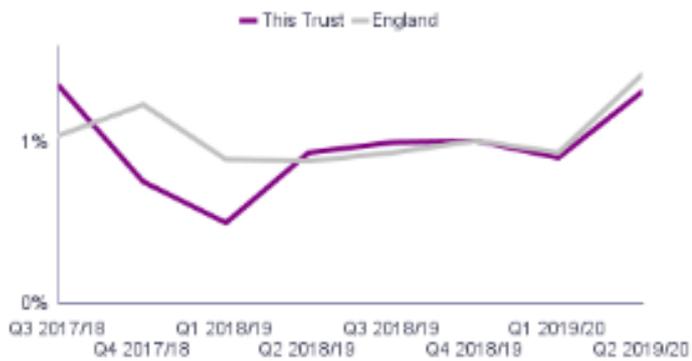
Leaders explained the trauma and orthopaedic referral to treatment data had been adversely affected by the trust's prioritisation on cancer waiting lists, which meant that trauma and orthopaedics were not prioritised in the same way. However, action had been taken to improve the RTT figure with regards to this speciality. This included recently fully recruiting to anaesthetic vacancies. Additional funding was also being sought for joint work in this area with another local NHS trust, as well as a business case which had been developed for another consultant. At the time of our inspection, these were with the trust board for approval.

Initiatives had been introduced to reduce length of stay to free up capacity in the hospital so that it is in a stronger place to improve the service's referral to treatment times. For example, 'hot clinics' had been introduced for general surgery and urology patients, run out of the surgical assessment unit, to provide quick access to specialist services to avoid delay and improve flow in the hospital.

## **Cancelled operations**

### **Cancelled Operations as a percentage of elective admissions - Great Western Hospitals NHS Foundation Trust**

From Q2 2018/19, the percentage of cancelled operations\* at the trust has been similar to the England average (see graph below).

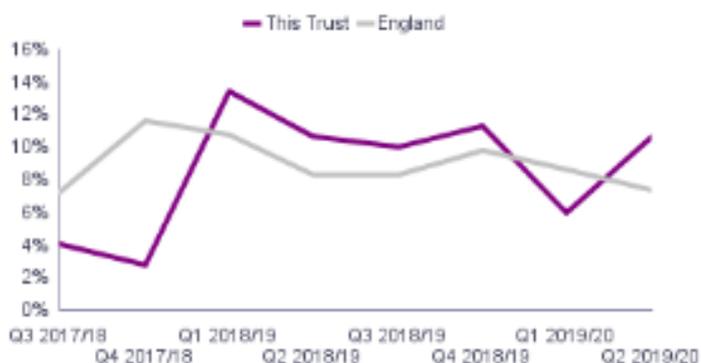


(Source: NHS England)

\*Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

### Percentage of patients whose operation was cancelled and were not treated within 28 days - Great Western Hospitals NHS Foundation Trust

Between Q1 2018/19 to Q2 2019/20, the trust's performance was generally worse than the England average. There was improvement in Q1 2019/20 where the trust's performance was better than the England average, but the trust's performance deteriorated in Q2 2019/20. See graph below.



(Source: NHS England)

Managers worked to keep the number of cancelled operations to a minimum. The service had a policy of not cancelling procedures where the patient had been waiting for 35 weeks or longer without the authorisation of the divisional director.

Leaders explained all cancellations involved clinical input to ensure there was an appropriate assessment of the risk of such cancellations. The cancelled operation was rebooked for a time that was deemed clinically appropriate.

The most common reasons for cancellations were operational issues such as bed availability. Other reasons included staffing. Leaders said staffing issues in critical care had an impact on cancellations due to a mixture of vacancies and staff on parental leave. There were challenges with recruiting staff to the intensive care unit. More recently, vacancies among anaesthetists had an impact on cancellations, though this had since improved following a successful recruitment campaign.

The service was commissioned by the local clinical commissioning group (CCG) to carry out a certain number of hours of surgical activity. Leaders explained that, pending negotiations with the

clinical commissioning group as to the amount of work the service was going to be commissioned to deliver, a business case had been prepared for more staff in the theatre department. Leaders said the department was potentially short by 22 whole team equivalent members of staff to deliver this work.

Gaps in theatre lists caused by the cancellation of planned procedures due to operational pressures were used where possible for emergency procedures.

Leaders told us cancellations did sometimes take place due to staffing issues in anaesthetics, though these were limited to cancellations of individual procedures rather than whole operating lists. Staff were proactively moved around to maintain the appropriate skills and ensure the safety of patients.

When patients had their operations cancelled at the last minute, managers sought to make sure they were rearranged as soon as possible and within national targets and guidance. There was a standard operating procedure for cancellations on the day of a procedure. Where a procedure had to be cancelled on the day, the manager of the day or theatre coordinator liaised with the elective booking team to meet with the patient and provide a letter apologising for and explaining the cancellation.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

With cancellation on the day, leaders distinguished those that could be anticipated from those that were due to operational pressures and were working on reducing those that could be anticipated.

Managers and staff worked to make sure that they started discharge planning as early as possible. The service had a new stranded patients initiative. The Emergency Care Improvement Programme defines stranded patients as those with a length of stay of seven days or more. A stranded patient review is a snapshot audit of a health setting (for example, an acute trust or whole health system) on a single day, to find out what patients are waiting for and how many could be treated in a different setting. It identifies what the clinical plan is for each stranded patient, and what the next steps will be on the day of review.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. We saw evidence of regular communication with patients' care homes documented in their care plans. We saw internal transfer handover sheets and acute care referral forms with any psychiatric referrals detailed in patients' care plans.

Staff worked alongside the patient's independent mental capacity advocate to organise their recovery in the most appropriate setting.

### **Patients moving wards per admission**

From November 2018 to October 2019, within the top two surgical wards at the trust, 81.6% of patients did not move wards during their admission, and 19.4% moved once or more.

*(Source: Routine Provider Information Request (RPIR) – Ward moves tab)*

### **Patients moving wards at night**

From November 2018 to October 2019, 2,840 patients moved wards at night within surgery.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.**

Patients, relatives and carers knew how to complain or raise concerns. Patients we asked told us they knew how to complain or could find out how to if needed.

The service clearly displayed information about how to raise a concern in patient areas. We saw leaflets on wards, and in corridors outside wards, including on how to access the Patient Advice and Liaison Service (PALS), a service created to provide advice and support to NHS patients and their relatives and carers.

Staff understood the policy on complaints and knew how to handle them. Managers were required to undertake training before being assigned complaints to handle. This including training on using the trust's electronic complaints system as well as training on complaints handling itself.

The service had a policy of allocating no more than three active complaints at any one time to a manager to ensure they could manage these complaints. Support was also offered as needed to complaint handlers, including junior complaint handlers.

Leaders explained all complaints responses were reviewed by the divisional operational director or divisional director of nursing before being sent out to the complainant.

Managers investigated complaints and identified themes. All complaints were logged with PALS, whether raised 'formally' or 'informally' (e.g. in person on a ward), to ensure effective oversight and monitoring.

At the time of our inspection, the service had no reopened or overdue complaints.

## Summary of complaints

From November 2018 to October 2019, there were 132 complaints about surgery at Great Western Hospital. The trust took an average of 23.5 days to investigate and close complaints. This was in line with their complaints policy which states complaints should be closed within 25 days. A breakdown of complaints by type is below:

Type of complaint	Number of complaints	Percentage of total
Clinical Treatment	58	43.9%
Communications	13	9.8%
Staff	13	9.8%
Other	9	6.8%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package	9	6.8%
Appointments including delays	7	5.3%
Patient Care including Nutrition/Hydration	6	4.5%
Waiting Times	5	3.8%
Access to treatment or drugs	4	3%

End of Life Care	2	1.5%
Privacy, dignity and wellbeing	2	1.5%
Integrated Care including delayed discharge due to absence of care package	2	1.5%
Prescribing errors	1	0.8%
Mortuary and post-mortem arrangements	1	0.8%
<b>Total</b>	<b>132</b>	<b>100%</b>

### Number of compliments made to the trust

From November 2018 to October 2019, 55 compliments were recorded about surgery at Great Western Hospital.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints were acknowledged within 24 hours during weekdays, whether by PALS or, where appropriate, a senior member of staff in the hospital.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, on one ward a complaint had been made where a call bell had gone unanswered which meant that a patient had been left in a wet bed. This had been raised with the nursing team who were alerted to respond more quickly to call bells.

We observed complaints and compliments discussed at weekly divisional matron meetings.

## Is the service well-led?

### Leadership

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

The surgery core service was managed by the trust's planned care division, which was one of five division's in the trust. The planned care division was led by a triumvirate comprising of an associate medical director, divisional director and divisional director of nursing.

The divisional director and divisional director of nursing had recently been appointed at the time of our inspection, with the associate medical director in post for a longer period.

The service had recently appointed a deputy divisional director, and had plans to recruit a deputy director of nursing. Divisional leaders explained this was to ensure more effective leadership.

The divisional leaders explained they were using the fact many of them were new in their roles as an opportunity to look at the service with fresh eyes to see how things can be improved.

The same triumvirate structure was in place to lead each of the service lines beneath the divisional leadership team. This triumvirate structure allowed for multiple perspectives and expertise to play a role in the leadership of the different service lines and the planned care division as whole.

Divisional leaders understood the challenges facing the services and were taking steps to address these challenges. Divisional leaders identified the following as the main challenges facing the service:

- Capacity: The planned care division's resources were often spent supporting other parts of the hospital, particularly unscheduled care. Leaders were confident the service was getting better at managing this while reducing its impact on the day to day activity
- Cancellation of procedures: The service was taking action (as discussed earlier in this report) to reduce cancellations.
- Referral to treatment times (RTT): The service had recovery plan towards which it was making progress.
- Staffing challenges: This extended to medical, nursing and other groups of staff (as discussed earlier in this report). The service was investing in staff and taking a creative approach to address this challenge.

Leaders discussed initiatives being undertaken to create resilience in service leadership. The trust was running a heads of service development programme in a bid to 'grow its own' leaders and ensure sustainability and resilience in the organisation's leadership capacity. Leadership development opportunities were also extended to staff from different professions and grades, including allied health professionals.

Junior staff were regularly invited to and attended meetings they would not otherwise attend to encourage wider staff understanding of and engagement with issues affecting the service. Senior staff explained that encouraging attendance by more junior members of staff would ensure these colleagues would be able to act up as appropriate in the event they may be required to do so, as well as to inspire them to pursue development opportunities.

Leaders were visible and accessible. The divisional leadership team were doing weekly walkarounds in the different areas of the service to increase their visibility and accessibility to staff.

Staff we spoke with on wards spoke very positively about leaders. One matron was described as "best in the trust... visible, supportive, and listens with good grace".

The divisional leadership team explained they were well supported at trust level, with regular formal and informal opportunities to meet trust leaders. This included monthly one to one meetings.

## **Vision and strategy**

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

The divisional leadership team explained they were taking the opportunity as a mostly new team to look at the service's existing strategy to see how it could be improved.

There was a strategy going forward, including the extension of certain specialities based on waiting list demand and patient safety.

Leaders worked with stakeholders to understand whether and how the service could meet the needs of the local population. This included an ongoing review of the impact of the local area's population growth would continue to have on the service. The service sought to work with local NHS trusts and independent health care providers to develop resilience and capacity in order to meet the needs of the local population. This included, for example, collaborating with a local NHS

trust to jointly recruit and share medical staff.

Staff we asked were aware of the trust's values service, teamwork, ambition and respect. Staff explained these values guided everything they did as a service.

The trust was developing an annual work plan and internal key performance indicators that would reflect the national and local priorities and local needs of mental health service provision. However, staff we spoke with were not aware of the local mental health agenda.

## **Culture**

**Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, operational pressures and staffing shortages had detrimental effects on staff.**

Staff mostly felt supported, respected and valued. Leaders praised the quality of work and commitment of staff. Staff demonstrated cooperative, supportive and appreciative relationships during our inspection. It was evident from our conversations with staff they valued and respected their colleagues. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. We saw staff proactively support each other and communicate in a respectful way.

Staff were recognised through monthly and yearly awards, which were arranged and hosted by the trust. Patients and their friends and families were invited to nominate staff who had gone 'above and beyond for patients every day'.

The culture in the division centred on the needs and experience of people who used services. Staff spoke positively about patient focus and told us they wanted to provide "over and above" care every day, despite the operational pressures facing staff and the service more generally. They were proud of their team working and felt supported and reassured by feedback from patients.

Staff mostly felt positive and proud to work in the planned care division. Although staff were aware of the challenges facing the service, especially staffing and capacity shortages, all staff we spoke with were passionate about their jobs. Staff told us they liked working at the trust.

- A member of staff on the wards told us, "The best thing about the ward is the team and the people, we dig in and help out when it's tough. The staff make the job easier."
- Another member of staff on the wards with whom we spoke explained there was a sense of "camaraderie" among staff, and that their manager was "great" and "very supportive."
- A staff member in theatres told us they "loved" their job, and that they enjoyed the teamwork and were passionate about looking after patients and protecting patient dignity.
- Another staff member in theatres explained they were due to go on a catheterisation and cannulation course. They said they felt more motivated because of the career opportunities available to them.

Action was taken to address behaviour and performance inconsistent with the care group's vision and values, regardless of seniority. We witnessed examples of staff challenge each other for conduct falling below what was expected. For example, we identified examples of staff challenging colleagues, including consultant surgeons, for not documenting completion of the surgical safety

checklist. Staff we spoke with felt confident about speaking up about disrespectful, discriminatory or abusive behaviour or attitudes.

The culture in the planned care division sought to encourage openness and honesty, including with people who use services, in response to incidents. Safety performance information such as the latest number of falls and pressure ulcers were presented in the surgical wards we visited for the information of patients and their family and carers.

Staff received training on, and understood, the duty of candour. We saw examples of staff applying the duty of candour in response to incidents.

Leaders and staff understood the importance of staff being able to speak up about issues and to make suggestions for improvement without fear of retaliation. Leaders encouraged staff to speak up through a range of routes, including electronic incident reporting. Leaders we spoke with were confident that staff would feel about to speak up as necessary. Senior staff explained they had an 'open door' policy, and they were confident staff would feel able to approach them with concerns or to make suggestions for improvement.

Staff we asked knew about the trust's freedom to speak up guardian, who provided independent and impartial support to workers to speak up. We saw the trust's freedom to speak up network advertised to staff through a variety of mechanisms during our inspection, including on banners and computer screensavers.

Leaders stressed the importance of staff safety and wellbeing in their discussions with us on inspection. However, this was sometimes affected by operational pressures. For example, due to the impact of operational demands on the day case unit, the staff there were regularly working beyond their contracted hours. Staff on the day care unit, which had a higher sickness rate compared to the division more generally, told us this undermined their work-life balance.

The environment and furnishings were not always conducive towards a positive work environment. For example, the sterile services department had no natural light. Leaders explained the environment had a potential impact on staff wellbeing and staff being able to do their job. The staff kitchen in the theatre complex also had cabinets that were chipped and work surfaces that were lifting, making it difficult to clean.

## **Governance**

**Staff were clear about their roles and accountabilities and had regular opportunities to meet and discuss the performance of the service. However, leaders did not always operate governance processes in accordance with trust policy.**

Service lines received monthly quality governance reports, which they used to identify themes and learning. Leaders explained they sought to ensure the wide dissemination of these quality governance reports. Service lines also had their own governance meeting, which fed into the divisional performance meetings and the divisional governance oversight committee.

We reviewed minutes from service line level clinical governance meetings where topics such as safeguarding, serious incidents and never events and training were discussed. The minutes produced by the service lines following these meetings were not standardised across the service. We also did not see evidence of an action tracker in use for general surgery and urology clinical governance meetings, which made it difficult to track proposed actions.

At the divisional performance meetings, the triumvirate leadership team within each service line were invited in turn to attend and discuss their report. These included discussions about incidents,

patient feedback, trends, finance, and appraisals and other staffing metrics. The highest rated risks were also discussed at monthly performance meetings. Clinical leads explained they felt constructively challenged and supported by divisional leaders in these meetings.

Divisional performance meetings were not minuted. However, there was an action tracker to review progress on agreed actions. Divisional leaders acknowledged this posed a challenge in terms of those not in attendance being able to confirm what was discussed but decided not to be actioned – and therefore not added to the action tracker.

Every month, a week after meeting the different service lines within the division, the divisional leadership team met with the trust leadership team to give an account of the division's performance as a whole. The issues discussed at this meeting were similar to those discussed at the divisional level (such as finance, staffing metrics, incidents etc). The divisional leadership team explained they too felt supported and constructively challenged by trust leadership. However, our review of output from these minutes showed that, similar to divisional performance meetings, these meetings were not minuted. An action tracker was used instead to monitor progress on agreed actions. As mentioned earlier producing effective minutes provide accountability by ensuring important comments made in a meeting are not forgotten and prevent any future disagreement about what participants said. Minutes are also helpful for people who were unable to attend a meeting by allowing them to see what was discussed.

The planned care division had a divisional governance oversight committee chaired by the divisional associate medical director, which held monthly meetings with service lines to monitor and review service line governance priorities. These were also used to update service lines on trust or divisional governance processes or investigations.

The service and the trust sought to make governance everyone's business. This included trust-wide half-day governance sessions took place 10 times a year. These sessions included discussions of mortality and morbidity meetings, clinical audits, never events and serious incidents, and lessons learnt. Speakers, including those from other professional groups and those external to the trust, were invited to speak at clinical governance sessions.

## **Management of risk, issues and performance**

**Leaders and teams used systems to manage performance. They mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

The division followed the trust wide serious incident process, which had changed since the last inspection. A serious incident review and learning group had been established. Attendees included the senior leadership team, clinicians, senior nurses. This work sought to improve staff understanding of risk, including the appropriate escalation, management and scoring of risks. The division was now focusing on ensuring that messages were being shared and understood with nursing and theatre staff.

The divisional board monitored each serious incident and a quality report was produced and shared with the executive team. The quality report also included the highest rated risks which were discussed every month at the divisional meeting. The senior leadership team told us there was now a lot more challenge of risks.

The highest scoring risk on the divisional (and trust) risk register concerned the sterile services department. Specifically, it concerned the remaining steam generators and the autoclave (sterile) machines and how they could stop working (as discussed earlier in this report). These risks had been on the register since 2015 and 2016, respectively. The scores for these risks had recently

been increased following the failure of a steam generator and autoclave machine which were installed at the same time as the remaining machines. The high score reflected the fact the failure of these machines would cause significant disruption to the surgical service at the hospital, as well as the fact that the remaining machines were also at the end of their lives and are at risk of stopping working as the ones that died recently. There were measures to mitigate the consequences of these machines stopping working, though leaders told us these would come at a considerable financial cost to the trust.

Service lines held regular mortality and morbidity meetings, which were an opportunity for clinicians and others to examine adverse events, complications, and errors that may have led to illness or death in patients. However, we found that minutes from these meetings were not standardised, thereby potentially reducing their ability to support learning.

## **Information management**

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

Medical records were mostly stored in locked trolleys with key pads. This was the case in all areas we visited except the day surgery unit, where the records of patients waiting for procedures were placed on a desk near the reception area to be picked up by medical staff. This meant there was a possibility confidential information about patients could be available to unauthorised individuals.

Information stored electronically was secure. We observed computers being locked when not in use and these were password protected to prevent unauthorised access to them.

Staff had access to the trust's intranet and other networks, and they knew how to navigate these to find the information they required. Staff knew how to access trust policies and care pathways. Staff we asked were able to demonstrate how they would access information or search for guidance. Staff we asked had secure access to relevant electronic information. Staff had an email account and received updates and information from managers.

There was a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Information was used to identify, assess, prioritise, inform and monitor areas of performance. This information was used for assurance, as well as to drive and measure improvements.

There were effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. When issues with data were identified, action was taken. For example, the service had undertaken work to improve understanding and effective scoring of risks.

Performance data was discussed within service lines, as well as at divisional and trust level.

Information technology systems were used effectively to monitor and improve the quality of care. Staff spoke positively about the introduction of the recording of patient observations electronically, as well as electronic prescription and administration of medication.

## **Engagement**

**Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, staff were not always aware of staff engagement activities or receive feedback on actions taken following staff engagement**

## **initiatives.**

Leaders sought to actively engage with staff to understand where and how improvements could be made to the service. Leaders in the planned care division adopted a staff engagement programme from another division in the trust called IDEAS. The IDEAS programme involved holding drop-in sessions as well as a baking challenge to encourage interest and participation. At the time of our inspection, hundreds of ideas had been submitted as part of the IDEAS programme.

A dashboard had been put together composed of ideas collated from staff feedback. We saw examples of 'quick wins' service leaders had implemented based on ideas from staff, including providing a tablet computer for staff in the trauma team to improve administrative processes.

The IDEAS programme had not yet been rolled out across all areas of the division. Leaders said the plan was to complete the rollout of the programme across the planned care division by May 2020. Divisional leaders explained they encouraged staff to put their names to ideas they shared as part of this programme so they could go back to them for more information and to involve them in realising their ideas.

Staff we asked were not always aware of staff engagement activities undertaken in the division. Some staff we spoke with also told us although there were opportunities for them to make suggestions for improvement, they often did not receive feedback on what, if anything, was done with this information. They explained there was a need to improve communication and feedback regarding what if anything was done with feedback sought from staff engagement.

There were various channels utilised to disseminate information from the board to the frontlines, including matrons' meetings, weekly huddles and the surgical newsletter. The service had increased the frequency of a newsletter sent out to staff from quarterly to monthly.

Leaders told us that as a service, they had worked on how they listened to and learned from patients. Leaders spoke about steps being taken to better engage with patients. For example, the patient journey and feedback - both positive and critical - were discussed at weekly matron meetings.

We saw posters throughout the service, including in the surgical assessment unit, inviting patients and their friends, family and carers to feedback on their experience. There were also well-prompted Friends and Family Test leaflets, posters and feedback forms throughout the service during our inspection. Patients and their relatives and carers were also signposted to trust's patient advice and liaison service for advice and support.

Events for the families and carers of patients were also organised, including a weekly carer's cafe offering advice and guidance.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. Leaders worked with external partners to deliver services to meet the needs of the population it was serving. We saw examples of staff learning from other organisations and multiple examples of active collaboration (as illustrated throughout this report).

## **Learning, continuous improvement and innovation**

**Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

As mentioned earlier in this report, the trust had been involved in the Hip Fracture Quality Improvement Programme (HipQIP). The project sought to provide high-quality hip fracture care

using the latest pathways to ensure consistent care. The project involved giving patients additional nutrition, along with other interventions such as early mobilisation, prompt surgery, consistent pain relief and standardisation of care. The project supported a reduction in mortality rates for patients with hip fractures, dropping from 11.5% to 5.4%. Clinicians received an award for their new approach to care, which significantly reduced mortality rates and improved the quality of life for patients who have suffered a broken hip. In December 2019, the hospital held an open event inviting other trusts to attend to learn more about the positive results of this quality improvement project.

Service leaders explained that by working across disciplines and service lines, the division had also successfully reduced the risk score-adjusted mortality rate to 7.9% in the most recently published quarterly data from the National Emergency Laparotomy Audit.

## Maternity

### Facts and data about this service

Great Western Hospital provides a range of antenatal, intrapartum and postnatal maternity services in the hospital in Swindon and the wider community.

Acute maternity services comprise of a high-risk labour ward with two dedicated obstetric theatres, a bereavement suite and a combined ante and postnatal ward with six neonatal transitional care beds. There is an alongside midwifery led birth unit; a total of 48 beds.

Services include antenatal clinics, ultrasound scanning, a day assessment unit and intrapartum and postnatal provision. Midwifery led antenatal and postnatal care is also provided by community midwifery teams. Staff work in their dedicated areas but also rotate from the community to hospital to maintain their skills. There are specialist midwives leading in different areas, such as staff education, safeguarding, bereavement support and the service had just recruited a research midwife. For those women who wish to have a home birth, perinatal midwifery led services are provided by the community midwifery teams.

Doctors and midwives are supported by maternity care assistants and healthcare assistants, to provide care for women and their babies. Women have access to other specialist support services within the trust as required.

We observed care provided by staff and spoke with 21 women about their care and treatment. We spoke with 48 staff, including a range of medical, midwifery, administrative and domestic staff. During our inspection we reviewed seven sets of clinical records of women who had received maternity services and reviewed data provided to us by the trust. We also reviewed the trust's performance data.

A breakdown of maternity services wards at Great Western Hospital is below,

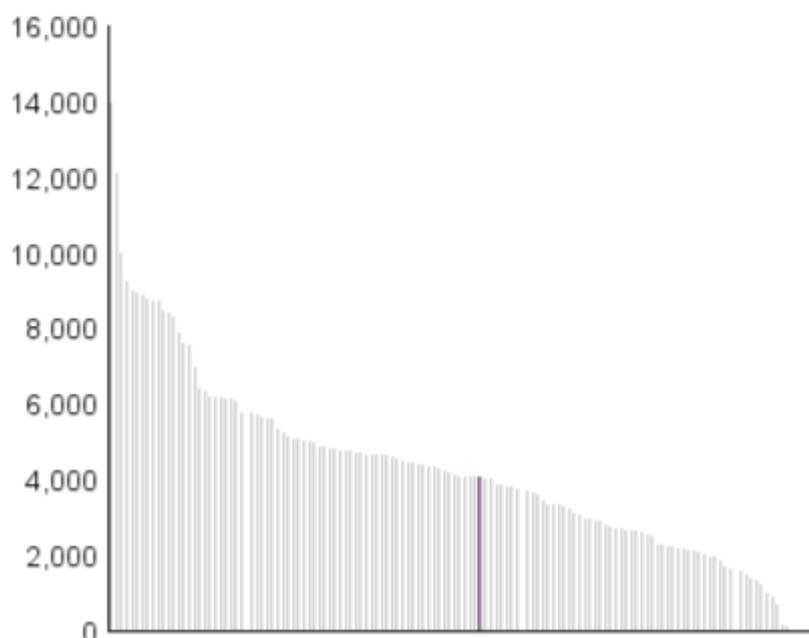
Team/ward/satellite name	Description of team/ward/satellite and services provided	Number of beds
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Delivery Suite	Provides high risk intrapartum care. There are 12 delivery rooms one of which has a pool room. All rooms have en-suite facilities. Included was a room designated as a bereavement delivery room. There are also two assessment rooms.	12
White Horse Birth Centre	Provides low risk intrapartum care. There are four delivery rooms, two of these with birth pools and en-suite facilities. There is also a bay with two beds for post-natal women.	6
Obstetric theatres	Two dedicated theatres, one operates five mornings a week for elective surgery and the other is only used in the event of an emergency.	
Antenatal and Postnatal care on Hazel ward	30 bedded ward (includes 18 side-rooms) providing antenatal and postnatal care to women. Also includes six neonatal transitional care beds.	30
Community midwifery teams	In addition to community work, community midwives are on call to support the unit and the homebirth team. They also provide NIPE screening (neonatal and infant physical examination) both in the unit and in the community.	
Antenatal Obstetric Clinics	Antenatal obstetrics clinics run Monday to Friday with five clinic rooms. Specialist clinics such as diabetic, preterm birth clinic, maternal medicine, multiple births, postnatal, raised BMI and fetal medicine clinic.	
Antenatal Day Assessment Unit (DAU)	There are three assessment beds for antenatal assessments and a counselling room.	4
Antenatal screening	This service is provided Monday to Friday with allocated rooms for consultation, scanning and phlebotomy.	
Specialist Midwives and teams	Safeguarding, risk and safety, smoke stop, infant feeding, Professional Maternity Advocate, digital, bereavement, birth matters, practice development and student support.	

From July 2018 to June 2019 there were 4,036 deliveries at the trust.

A comparison of the number of deliveries at the trust with the national totals during this period is shown below.

**Number of deliveries at Great Western Hospitals NHS Foundation Trust – Comparison with other trusts in England.**



(Source: Hospital Episode Statistics (HES))

A profile of all deliveries and gestation periods from July 2018 to June 2019 can be seen in the tables below.

<b>Profile of all deliveries (July 2018 to June 2019)</b>			
	<b>GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST</b>		<b>England</b>
	<b>Deliveries (n)</b>	<b>Deliveries (%)</b>	<b>Deliveries (%)</b>
<b>Single or multiple births</b>			
Single	3,920	98.0%	98.6%
Multiple	80	2.0%	1.4%
<b>Mother's age</b>			
Under 20	90	2.3%	2.9%
20-34	3,025	75.6%	74.5%
35-39	725	18.1%	18.5%
40+	160	4.0%	4.1%
<b>Total number of deliveries</b>			
Total	4,000		571,848

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

"To protect patient confidentiality, figures between one and seven have been suppressed and replaced with "\*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed. Values (including totals) greater than seven have been rounded to the nearest five with the delivery rate calculated with the rounded figures. This does not apply to the 'other/unrecorded' method of delivery as patients are not identifiable. Please note that because row/column totals will be calculated and then rounded, the total of rounded values may differ from the rounded total, and row/column percentages may sum to more than 100%, as in row E above."

(Source: Hospital Episode Statistics (HES))

## Is the service safe?

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

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

### Mandatory training

The service provided mandatory training in key skills and most staff had completed it. Compliance had improved since our last inspection, although some further improvement was needed to ensure trust targets were consistently met, particularly in the medical staff group.

### Mandatory training completion rates

Midwifery staff received and mostly met trust targets for mandatory training. The 80% target was met for 22 of the 24 mandatory training modules for which registered midwifery staff were eligible. The 95% target was met for Information Governance.

A breakdown of compliance for mandatory training courses as of February 2020 for registered midwifery staff is shown below:

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Alcohol Brief Advice	6	6	100.0%	80.0%	Yes
End of Life Care Level 2	10	10	100.0%	80.0%	Yes
Information Governance	201	206	97.6%	95.0%	Yes
Duty of Candour	199	204	97.5%	80.0%	Yes
Infection Prevention (Level 1)	199	206	96.6%	80.0%	Yes
Venous Thromboembolism	192	199	96.5%	80.0%	Yes
Health, Safety and Welfare	198	206	96.1%	80.0%	Yes
Manual Handling - Object	197	206	95.6%	80.0%	Yes
Adult Basic Life Support	192	203	95.0%	80.0%	Yes
Manual Handling - People	187	198	94.4%	80.0%	Yes
Equality and Diversity	193	206	93.7%	80.0%	Yes
Fire Safety 1 year	190	206	92.2%	80.0%	Yes
Conflict Resolution	190	206	92.2%	80.0%	Yes
Learning Disabilities Awareness Level 1	182	206	88.3%	80.0%	Yes
Food and Hygiene Safety Level 1	179	204	87.7%	80.0%	Yes
Learning Disabilities Awareness Level 2	178	204	87.3%	80.0%	Yes
Slips, Trips and Falls	177	204	86.8%	80.0%	Yes
Dementia Awareness (including Privacy & Dignity standards)	170	204	83.3%	80.0%	Yes
Smoking Brief Advice	5	6	83.3%	80.0%	Yes
Mental Health Awareness Level 1	171	206	83.0%	80.0%	Yes
Infection Prevention (Level 2)	167	204	81.9%	80.0%	Yes

Training module name	February 2020				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Medicine management training	165	204	80.9%	80.0%	Yes
Conflict Resolution Advanced	38	51	74.5%	80.0%	No
Blood Transfusion	63	90	70.0%	80.0%	No

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

Medical staff received but did not meet trust targets for mandatory training. We requested the latest training data from the trust for medical staff. The 80% target was met for 18 of the 26 mandatory training modules for which medical staff were eligible. The 95% target was narrowly missed for Information Governance.

A breakdown of the latest compliance figures for mandatory training courses as of February 2020 for medical staff in maternity is shown below:

Training module name	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	92.8%	80.0%	Yes
Corporate induction	95.2%	80.0%	Yes
Dementia Awareness Training	85.7%	80.0%	Yes
Duty of Candour	90.4%	80.0%	Yes
End of Life Care Level 2	78.5%	80.0%	Yes
Equality, Diversity and Human Rights	85.7%	80.0%	Yes
Fire Safety	47.6%	80.0%	No
Health, Safety and Welfare	85.7%	80.0%	Yes
Infection Prevention (Level 1)	92.5%	80.0%	Yes
Fire Safety 1 year	91.5%	80.0%	Yes
Conflict Resolution	91.0%	80.0%	Yes
Equality and Diversity	91.0%	80.0%	Yes
Learning Disabilities Awareness Level 1	86.6%	80.0%	Yes
Food and Hygiene Safety Level 1	86.3%	80.0%	Yes
Learning Disabilities Awareness Level 2	84.9%	80.0%	Yes
Medicine management training	84.3%	80.0%	Yes
Slips, Trips and Falls	82.5%	80.0%	Yes
Mental Health Awareness Level 1	82.1%	80.0%	Yes
Information Governance	92.0%	95.0%	No
Dementia Awareness (including Privacy & Dignity standards)	78.0%	80.0%	No
Infection Prevention (Level 2)	75.4%	80.0%	No
Smoking Brief Advice	75.0%	80.0%	No
NEWS (National Early Warning Scoring System)	75.0%	80.0%	No
Blood Transfusion	70.8%	80.0%	No
Conflict Resolution Advanced	67.4%	80.0%	No
Paediatric Basic Life Support	0.0%	80.0%	No

The mandatory training was comprehensive and met the needs of women and staff. Midwifery and medical staff also undertook further role-specific training called practical emergency obstetric

training (PROMPT). This included neonatal life support and emergency situations in maternity for example, breech delivery and shoulder dystocia (this is when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body).

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received monthly reports from the electronic staff record (ESR) demonstrating training compliance and including details of staff booked on training courses and staff not attending courses booked.

Midwifery staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. Specific training on mental health was not mandatory for staff. However, mental health leads within the trust provided bespoke training for staff as and when it was required. Newly qualified staff attended a perinatal mental health study day which was updated every year and new staff had training in learning disability and autism during their induction.

The maternity unit had access to input from a specialist perinatal mental health community team five days a week who delivered training to the team. Midwives and junior doctors had an annual mental health training day, which included attendance and training from perinatal psychiatrists about severe post-natal depression. Staff feedback found this to be a rewarding teaching session.

## Safeguarding

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

### Safeguarding training completion rates

Midwifery staff received training specific for their role on how to recognise and report abuse. Staff had a good awareness of the signs of safeguarding and the actions they should take to keep people safe. The trust set a target of 90% for completion of child safeguarding training and 80% for adult safeguarding and PREVENT (preventing radicalisation) training.

A breakdown of compliance for safeguarding training courses from 22 November 2018 to 21 November 2019 at trust level for registered midwifery staff in maternity is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Preventing Radicalisation - Prevent Awareness - No Specified Renewal	1	1	100.0%	80.0%	Yes
Safeguarding Children (Level 1)	380	402	94.5%	90.0%	Yes
Safeguarding Children (Level 2)	374	398	94.0%	90.0%	Yes
Safeguarding Children (Level 3)	356	388	91.8%	90.0%	Yes
Safeguarding Adults (Level 1)	364	402	90.5%	80.0%	Yes
Safeguarding Adults (Level 2)	324	398	81.4%	80.0%	Yes
Preventing Radicalisation - Basic Prevent Awareness - 3 Years	163	201	81.1%	80.0%	Yes
Safeguarding Children (Level 3)	114	166	68.7%	90.0%	No

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional)					

In maternity the safeguarding targets were met for seven of the eight safeguarding training modules for which registered midwifery staff were eligible. However, the trust provided the most recent safeguarding children figures at level 3 (additional) for midwives. This showed that midwifery staff across the community (68.3%), day assessment unit (73.9%), Hazel ward and delivery suite (31%) and specialist midwives (65%) did not meet the 90% target for safeguarding children level 3 (additional).

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

Medical staff in maternity received training specific for their role on how to recognise and report abuse. Medical staff had a good awareness of the signs of abuse in adult and children and the actions they should take to keep people safe. At our last inspection in 2015, medical staff did not achieve the trust's target of 90% across all three safeguarding children's mandatory training levels. At this inspection, the trust provided the latest training figures which were much improved, with medical staff achieving the trust target at all levels.

Safeguarding Children (Level 1)	90.4%	90.0%	Yes
Safeguarding Children (Level 2)	90.4%	90.0%	Yes
Safeguarding Children (Level 3)	100%	90.0%	Yes
Safeguarding Adults (Level 1)	85.7%	80.0%	Yes
Safeguarding Adults (Level 2)	83.3%	80.0%	Yes

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

If a patient was assessed to be at risk of suicide or self-harm, there were arrangements to enable them to remain safe. The maternity unit had a good working relationship with the psychiatric liaison team in the hospital. Staff knew how to make an urgent referral to psychiatry and said they responded within their target timeframe of four hours. Staff said that usually, two members of the team came up to assess the patient and formulate a care plan. Staff could also request a registered mental health nurse to provide one to one support when needed.

Staff were aware of the Mental Health Act regarding doctor's and nurse's holding power. They knew when and how they could be used and how to get urgent advice. The team had access to specialist advice from the psychiatric liaison team and the perinatal team if they were working with a woman detained under the Mental Health Act. Staff were able to access the Mental Health Code of Practice on line for guidance.

Safeguarding needs were identified during the antenatal booking process to identify women at risk and the Local Authority would be notified where necessary. Within the community midwifery teams there were five safeguarding link midwives to provide support and resources to colleagues

and the women they cared for. The lead safeguarding midwife communicated with the trust-wide safeguarding team to assess the risks of women and disseminated any key messages to colleagues. Where midwives identified concerns, they were able to access advice and support. The lead midwife for safeguarding attended regular internal and external multi-agency risk assessment conferences.

Where child protection concerns were identified the lead midwife for safeguarding would liaise with the relevant Local Authority. There were procedures to protect children who were to be placed in the care of the Local Authority.

Learning from safeguarding serious case reviews was disseminated to staff through newsletters and mandatory training. As a result of a serious case review, child protection procedures were improved, and the service felt confident to challenge decisions made externally.

There were processes to recognise female genital mutilation (FGM) and staff had appropriate support from the safeguarding team. Staff had access to the safeguarding policy which included reference to FGM and there was a specific FGM policy. All staff undertook training for FGM, although they had rarely experienced this. Extra FGM training sessions were offered to staff

## **Cleanliness, infection control and hygiene**

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were arrangements for deep cleaning and staff we spoke with demonstrated knowledge of different cleaning techniques.

Hand hygiene audits were undertaken monthly. Results were not displayed on wards, so staff, women and visitors could not see performance data. Trust hand hygiene results for maternity demonstrated 100% compliance between August 2019 and January 2020, except for September 2019 for Hazel ward when zero compliance was noted as no audit was completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw all staff were bare below the elbow in clinical areas and PPE was used appropriately. Staff followed aseptic non-touch techniques in theatre to prevent contamination of key equipment. We also observed staff washing their hands and using the hand gel between patient contact. All clinical areas had a good supply of gloves and aprons, including long gloves for manual removal of placenta and use in the birthing pool.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We found 'I am clean' stickers on equipment. These were used after cleaning to indicate the item was clean and ready to be used again.

National guidelines were followed for the screening of women admitted to the maternity services. Women who worked in health or a caring environment were considered high risk and were screened for methicillin resistant staphylococcus aureus (MRSA) in line with relevant criteria. All hospital acquired infections, for example, MRSA, were investigated to look for key themes. We

reviewed trust data which demonstrated there were no cases of MRSA between October and December 2019 from screening of 279 women.

Ward areas were clean and had suitable furnishings which were clean and mostly well maintained. We observed cleaning during the inspection and staff and women told us they regularly saw cleaning staff. Furnishings were able to be cleaned suitably. On the delivery suite we found some mattresses on the delivery beds which were frayed and worn. This presented an infection control risk to women. However, when brought to the attention of the senior nurse, we were informed that three new mattresses had already been ordered.

There was a good supply of clean linen and linen was frequently replaced. Dirty linen was discarded in designated bags to ensure laundry services were aware of any specific risks.

## **Environment and equipment**

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

The service had enough suitable equipment to help them to safely care for women and babies. At the last inspection in 2015, we found some equipment did not have up-to-date maintenance checks on Hazel ward and the delivery suite. At this inspection, equipment we observed had an up-to-date safety maintenance check and expiry dates were clearly visible.

There was neonatal resuscitation equipment, including a separate emergency trolley. Each room on the delivery suite was equipped to care for women and their babies and included resuscitaires, oxygen, nitrous oxide (a gas used for pain relief in labour) and cardiotocograph monitors.

However, we noted seven out of eleven delivery rooms (one room had the nitrous oxide permanently capped off) did not have a scavenger unit (removes nitrous oxide from the room as studies have linked chronic occupational exposure to specific health problems, including reproductive risks). The trust had recognised this as an issue; staff were exposed to a level of nitrous oxide above the exposure limit set out in control of substances hazardous to health regulations (2002). This was on the corporate risk register under estates and facilities management. The trust had taken steps to mitigate the risk by monitoring staff, offering vitamin B12 testing to all staff, risk assessments for pregnant midwives and staff could move their place of work from the delivery suite to minimise their exposure. New ventilation was being planned for the delivery rooms.

There were clean and well-equipped obstetric theatres, on the same floor and attached to the central delivery suite. There were two dedicated obstetric theatres. Theatre 1 had an elective caesarean list Monday to Friday mornings and theatre 2 was only used in case of an emergency.

Women could reach call bells and staff would respond quickly when called. Staff ensured women who had limited mobility, particularly immediately following birth or section, had call bells to hand.

The design of the environment followed national guidance. There was appropriate room for women to be cared for safely, fire exits were clearly marked and exit pathways were not blocked.

However, the trust recognised a risk to patient safety on the White Horse Birth Centre. There were delays in maintenance and repairs within the birth centre. There was no maintenance contract as

original building work was completed by an external company for financial reasons. This was being monitored through the risk register.

Staff followed the Prevention and Management of Baby/Child Abduction Policy, although the policy was not in date and was under review by clinicians and security staff.

Babies were electronically tagged and were generally kept with their mums at the bedside. During our inspection we heard an activated tag and observed all doors to the maternity unit lock, so no-one could leave. However, staff did not undertake baby abduction drills to test its effectiveness and relied on the baby security tagging system.

Security on wards and the central delivery suite was maintained by means of security intercoms and CCTV. Members of staff gained entry through a card swipe system.

All areas of the maternity service had access to specialist emergency equipment and staff carried out daily safety checks of the equipment. We observed fully completed daily and weekly checks on emergency resuscitation trolleys. The trolleys were sealed shut with a tamper-proof seal. This ensured all the equipment would be available in an emergency.

Clinical waste was managed well across the maternity services and staff disposed of clinical waste safely. Different types of waste were segregated and managed according to the risk of infection. Sharps boxes were labelled appropriately, not overfilled, closed and tagged to prevent access to discarded sharp items.

## **Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff mostly identified and quickly acted upon women at risk of deterioration.**

Risk assessments were completed and updated, and action was taken to remove or minimise risks. This included comprehensive risk assessments for women at the time of their first antenatal appointment. These included BMI (body mass index), smoking, gestational diabetes, pre-eclampsia, mental health issues and pre-existing health problems or vulnerable circumstances.

Risk assessments were continually evaluated throughout a woman's pregnancy. Where women were identified as being at higher risk, or if their risk had increased during pregnancy, they were referred for consultant-led care.

Staff knew about and dealt with any specific risk issues. Women received a risk assessment for venous thromboembolism (VTE) and bleeding at booking, in labour and during post-natal care in line with national guidance.

Cardiotocography (CTG) (recording the fetal heartbeat and the uterine contractions during pregnancy - more commonly known as an electronic fetal monitoring) had pre-printed stickers, which were all completed in the records we reviewed. The reason for the CTG was documented, signed, findings summarised and when a 'fresh eyes' approach was used. This meant there was a double check of the results, which were open to interpretation. The service had recently applied for funding for a CTG midwife to further improve care.

Staff used a nationally recognised tool to identify women at risk of deterioration but did not always escalate them appropriately. There were processes to identify and respond to changing risk, deteriorating health of women. There were procedures to aid decision-making and staff could tell

us of circumstances when they had escalated concerns and the support they had received. The maternity early obstetric warning system (MEOWS) was used to monitor women's health and wellbeing and to identify deterioration using physiological parameters. Guidelines required staff to measure and document a full set of observations using the MEOWS on all women admitted to the maternity unit, on transfer to another ward and those visited in their postnatal period in the community. Every time a set of observations was performed, they were recorded on the MEOWS chart and recorded in the women's notes. Most records we reviewed documented correct scoring.

However, we found a woman, who was post-operative, who had a raised MEOWS score due to a high temperature, that had been escalated to a doctor, but correct action was not taken as per trust policy. This meant the patient had missed the opportunity for a sepsis screen and could have developed post-operative puerperal sepsis, missing the vital "golden hour" for immediate treatment with antibiotics. Trust policy had not been followed and there had been no input from the trust sepsis team. We brought this to the attention of the senior midwife and action was taken.

Staff shared key information to keep women safe when handing over their care to others. We observed shift changes and handovers. They included all necessary key information to keep women safe. Staff used SBAR (Situation, Background, Assessment and Recommendation) report style for handover. There was a further bedside handover introducing women to the midwife who would be caring for them.

There was also a separate SBAR handover sheet when transferring women from antenatal care to delivery suite or the birth centre and transfer from the delivery suite to the ward.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff had access to mental health support from the psychiatric liaison team until 10 pm. Out of hours support was from the night mental health liaison service and the on-call psychiatrist. The psychiatric liaison service had a clear protocol of support they would provide, to whom and between which hours. This was displayed in the ward office so staff knew who to contact and when.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff used a risk screening form completed at the booking visit to identify any pre-existing mental health conditions. This was reviewed at 36 weeks. If issues were known, staff created a maternal mental health plan. Specialist mental health midwives met with women with known mental health conditions to create a mental health birth plan.

Staff gave examples of responsive support from the psychiatric liaison team. Staff told us about one woman who experienced postnatal psychosis out of hours and would not consent for required therapy. The psychiatric liaison team reviewed the woman within an hour and completed a full mental health assessment and arranged a follow up appointment the next day.

### **Theatre safety**

There were arrangements to ensure that checks were made before and after surgical procedures. During our inspection we observed a good standard of safety briefings in the obstetric theatre prior to a procedure. We observed the World Health Organisation (WHO) checklist, used to identify risk factors, undertaken prior to a procedure. The use of the checklist is a requirement of the National Safety Standards for invasive procedures, introduced by NHS England in 2015 to improve patient outcomes. The maternity WHO checklist compliance from July 2018 to September 2019 showed a

downward trend from 97% to 89%. The trust planned to increase the WHO checklist audit to 20 per week trust-wide, week commencing 2 March 2020.

There was a process to call for emergency assistance in theatres. Midwifery staff were clear confident when to contact a consultant if required.

## **Mental Health**

The service had 24-hour access to mental health liaison and specialist mental health support. Staff told us the mental health team were very proactive in responding to referrals. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

## **Triage**

There was a formal system to assess (triage) women in the antenatal, intrapartum and postnatal period who telephoned the reception desk on the delivery suite with concerns. A receptionist would answer the call, and any available midwife could take the call and complete a Situation, Background, Assessment and recommendation (SBAR) advice record. Between 7.30am and 8.15pm, the woman could be directed to the day assessment unit, their community midwife or GP or given advice to stay at home.

However, there was not always a receptionist on duty, 24 hours a day on the delivery suite. We examined duty rosters from October 2019 to February 2020 and found 85 reception shifts had not been filled. Of these, 66 (77.6%) were night shifts and 19 (22%) were day shifts. This meant there could be a delay in answering the phone and the door when a woman arrived. Women could potentially present with a serious condition and experience a delay. This was not recognised as a risk on the divisional risk register. Following our inspection, the trust told us they were actively recruiting for more reception staff and in the meantime, staff were working additional shifts and the trust assured us that all shifts were covered.

When women attending out of hours entered the delivery suite, they were shown to the waiting room by the receptionist and waited for a midwife who would take the woman to an assessment or delivery room and complete a full assessment of mother and baby. In most cases, women would have phoned ahead and therefore would be expected and the night coordinating midwife would have allocated a midwife in advance or would attend when able. However, there was a reliance on the receptionist to tell the coordinating midwife if the woman looked unwell or needed immediate assistance. This had been recognised by the trust and was being addressed. The trust told us there had been no incidents reported over the past year for out of hours' patients coming to harm as a result of the current triage process in the delivery suite.

The unit had a whiteboard to keep track of woman that had telephoned and who had been invited in. The trust was working with a university and another NHS maternity unit to develop the "Swindon Maternity Assessment and Triage" (SMAT) for delivery suite. This was planned in order to assess all women within 15 minutes of presentation and see them in order of clinical need. A dedicated waiting room had been introduced and a triage assessment room had been identified. Six members of staff had received additional training and support. This training was being cascaded to band 6 and 7 midwives. The new system included standardised symptom-specific algorithms to allocate clinical priority and the immediate care and further investigations of the eight most common reasons for attendance;

Once implemented there would be a band 6 or 7 midwife allocated to triage on each shift. The plan was they would take calls and aim to perform the initial triage within 15 minutes. Data collected at the beginning of the quality improvement project demonstrated that only 48% of women were seen within 15 minutes of arrival and therefore the overarching aim was to initially see at least 60% of women within 15 minutes.

It was anticipated that this more robust triage system, would be implemented by the end of March 2020.

## Midwifery staffing

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

The service usually had enough nursing and midwifery staff to keep women and babies safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. At our last inspection in 2016, midwifery staffing levels did not comply with the Health and Social Care Act (2008) Code of Practice on staffing. At this inspection we found the situation to be improved.

A midwifery establishment review was undertaken in December 2019 using a workforce tool called Birth-rate Plus as a standard for safe maternity staffing, in line with National Institute for Health and Care Excellence (NICE) (NG4) 2014. This showed that the service remained understaffed by 3.99 whole time equivalent (WTE) for managerial posts. The trust had recently appointed a band 8A Governance Midwife, which reduced the vacancy rate to 2.99 WTE. The service also had 5.85 WTE registered midwifery staff vacancies across the acute sector and the community. The trust was actively recruiting to fill these posts. When these posts were filled, it would provide 24-hour, seven-day week cover for the new triage service on delivery suite, which was due to start on 31<sup>st</sup> March 2020.

The number of midwives, maternity support workers and healthcare assistants on shifts on the unit usually matched the planned numbers and there was no breach of the midwife to birth ratio of more than one to 35. This was an improvement from our last inspection in 2016.

The table below shows a summary of the midwifery staffing metrics in maternity compared to the trust's targets, where applicable:

Maternity annual staffing metrics							
October 2018 – September 2019					November 2018 – October 2019		
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
<b>Target</b>		8%	13%	3.5%			
<b>All staff</b>	214	2%	11%	4.4%			
<b>Registered midwives</b>	159	-2%	10%	4.4%	13,935 (5%)	021 (<1%)	7,270 (1%)

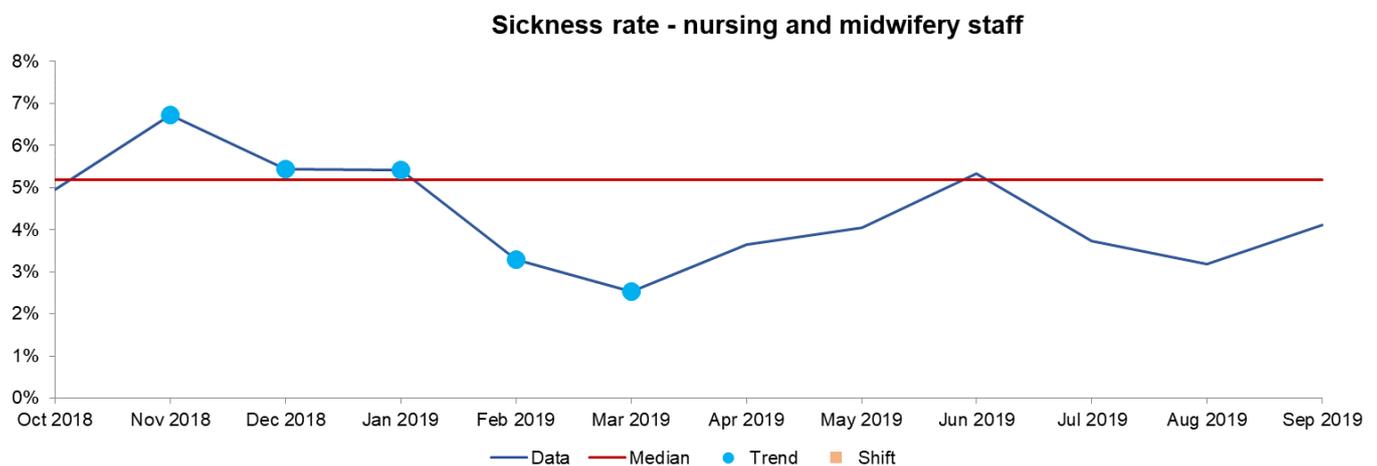
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Midwifery staffing rates were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover or bank use.

Managers limited their use of bank staff. Substantive staff often covered unfilled shifts. Due to reduction in sickness levels and for 'hard to fill shifts' the trust offered a financial incentive, consequently, the service had not used agency midwives for the past year.

## Sickness rates

The service had low sickness rates for midwifery staff. Managers attributed this to robust but supportive sickness management, and the professional midwifery advocates supporting staff.



Monthly sickness rates over the last 12 months for registered nurses showed a downward trend from November 2018 to March 2019.

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

## Midwife to birth ratio

From July 2018 to June 2019 the trust had a ratio of one midwife to every 24.9 births. This was similar to than the England average of one midwife to every 24.6 births. This was an improvement from the last inspection in 2016.

(Source: Electronic Staff Records – EST Data Warehouse)

## Medical staffing

**The service did not always have enough medical staff in accordance with the guidance from the Royal College. However, there was no evidence to suggest care and treatment was**

**not provided safely. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

The service usually had enough medical staff to keep women and babies safe and always had a consultant on call during evenings and weekends. The consultants on the maternity unit consistently provided 60 hours per week on site and a further 98 hours per week on call. This met the Royal College of Gynaecologists and Obstetricians Good Practice Guidelines (2010). Consultant cover was planned between 8.30am to 7pm on weekdays and 8.30am to 2pm on weekends. On-call consultant cover was available from 6.30pm to 8.30am and 2pm to 8.30am on weekends, was provided by a rota of 11 consultants. However, consultants often stayed later at weekends if needed. The senior registrar based on Labour ward also provided advice and support to staff on Hazel ward if required.

The delivery suite had a dedicated anaesthetic consultant and registrar providing senior anaesthetic cover during the day and an on-call anaesthetist at night.

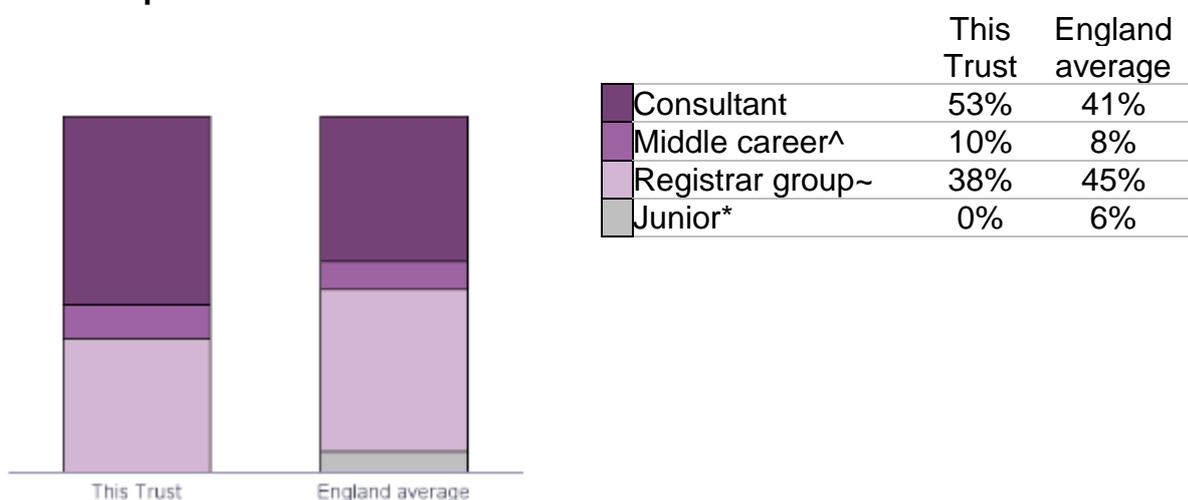
The trust had recently appointed a new consultant to start in March 2020 but still had two whole time equivalent vacancies. Managers could access locums when they needed additional medical staff and consultants also provided extra cover when required to ensure a safe service.

There was regular consultant presence and regular ward rounds performed. Junior medical staff told us they felt supported. There were arrangements for supporting and managing medical staff to deliver effective care and treatment in line with Royal College of Obstetricians and Gynaecologists training schedules.

### Staffing skill mix

The service usually had a good skill mix of medical staff on each shift and reviewed this regularly. In August 2019, 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 24.7 whole time equivalent staff working in maternity at Great Western Hospitals NHS Foundation Trust.



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

\* Junior = Foundation Year 1-2

*(Source: NHS Digital Workforce Statistics)*

## **Records**

**Staff kept detailed records of women's care and treatment. However, records were not always clear, up to date, stored securely and not always easily available to all staff providing care.**

Women's notes were comprehensive, but staff could not always access them easily. During our inspection in 2015, we found the trust needed to remove duplication and increase accessibility to records.

At this inspection, we reviewed seven sets of clinical records and found notes were still a mixture of paper and electronic records. There was duplication and inconsistency between hand held notes and the maternity IT system and records as loose sheets of paper. We saw evidence of a woman who had in-depth documentation on the maternity IT system, but the midwife only saw this when she logged on to complete her discharge process.

Antenatal and admission records for women were electronic but paper records were used for women admitted for induction of labour. Delivery care records were paper while post-natal care was documented electronically and printed for women's hand-held notes for community midwives. Consultants and registrars did not currently use the electronic system so struggled to access notes. This meant records were not always easily accessible to a range of healthcare professionals during pregnancy, labour and the postnatal period. For example, patient information could be potentially missed by clinicians as patient care episodes were in more than one location. This was a risk recorded on the divisional risk register. The trust was in the process of training medical staff to use the electronic system. The trust recognised this as a risk and monitored progress through the risk register.

The trust had invested in a digital midwife to progress the local maternity system plans to prepare for a paperless electronic system. However, her workload was high and the action plan to introduce a paperless electronic system had been delayed by volume of work to be done.

Community midwives were contacted when a woman was discharged, and an electronic discharge summary sent to the GP.

Psychiatric mental health services and the perinatal team also experienced issues around accessing information on electronic system and paper copies. They used another electronic record system which not all maternity staff had access to. The hospital used paper notes while the patient was admitted.

Babies' records were not always stored securely. When a baby was born, they had their own set of notes. These were loose sheets of paper kept in plastic wallets which were not stored securely.

## **Medicines**

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

Staff did not always store and manage all medicines and prescribing documents in line with the provider's policy. Medicines were stored securely in locked trolleys and doors were locked to

treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely and managed appropriately. Regular balance checks were performed in line with trust policy. However, on delivery suite we found anaesthetic medicine and insulin stored in an unlocked fridge. Although the treatment room had restricted access, this included non-clinical staff. We also found emergency "Grab boxes" with terbutaline on the work surface in the treatment room. This was not in line with trust policy. When brought to the attention of senior staff, the anaesthetic medicines were removed, a new locked fridge was ordered for safer storage of medicines such as insulin and the terbutaline grab bags were stored in a locked medicine cabinet.

Digital locks were in use for all medicine cupboards, which were newly installed. Access codes were planned to be changed regularly. This meant that staff did not have to look for or carry keys and were able to access medicines more quickly.

Stock medicines were regularly checked by pharmacy technicians and expired, or unused stocks were removed and returned to pharmacy in a secured bin. Expired controlled medicines (including patient's own drugs) were removed by the ward pharmacist in the presence of the midwife in charge.

Prescribing guidelines were available on trust intranet and 'Microguide' was available for antimicrobial guidance to ensure women were prescribed antibiotics in accordance with local antibiotic formularies. Pharmacists were involved in training and induction of new and junior medical staff and non-medical prescribers.

Medicines fridge and treatment room temperature records showed medicines were stored at the correct temperatures.

Medical gases such as oxygen and nitrous oxide cylinders were checked and found to be in date, either full or nearly full and stored in accordance with regulation requirement.

Controlled medicine cupboards were checked and there were no discrepancies in medicines present.

Staff reviewed women's medicines regularly and provided specific advice to women and carers about their medicines. A pharmacist visited daily to review prescriptions and advise medical staff when doses needed to be revised. Patient's allergies were documented on prescription charts.

The service had systems to ensure staff knew about safety alerts and reported medicine incidents properly. Staff knew how to report incidents or near misses through the trusts electronic reporting system. Staff felt confident in raising a medicine incident should they need to. Managers investigated medicine incidents and shared lessons learned with the whole team and the wider service. They gave us examples of medicine errors they would report as an incident and how they would respond to the person involved.

However, we found an example where medicine administration had not been completed, reported or investigated. For example, an intravenous antibiotic dose of 1.2 grams was prescribed. A single 1.2-gram vial was not available, and staff had noted it was not administered and recorded as "not available". However, two 600 mg vials were available to be used to as a 1.2-gram dose but were not.

When a woman who was dependent on alcohol or illegal drugs was admitted, they were offered medicines to assist their withdrawal and associated side-effects. The specialist midwife for mental health and substance misuse helped women with dependence issues. There were detoxification guidelines to follow when caring for intravenous drug users. The safeguarding team and the

mental health lead midwife had experience of supporting women who had misused various substances. Staff could offer prescribed medicines to ease withdrawal.

There was discussion with relevant women about their mental health or epilepsy medicines and the factors to be considered during the ante and post-natal periods, including while breast feeding. Women already on mental health or epilepsy medication were seen at the ante natal clinic and a care plan was devised if it was thought the medication would pass through the placenta to the baby. Staff completed neonatal abstinence syndrome scoring for a week before the plan was made. The maternity unit had a specific policy on medication while breast feeding, which staff discussed with women. This usually meant a longer stay in hospital after the birth. For example, if the patient was taking antidepressants, their minimum stay post-delivery would be 48 hours, up to five days to enable close observation of mother and baby.

## Incidents

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

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. They were familiar with the incident reporting procedure and told us it was easy to use, and they were encouraged to use it. They were able to describe the range of events which should be reported in line with trust policy. This included, for example, unintended outcomes such as third-degree perineal tear and 'near misses'. Managers and staff felt there was a good reporting culture; all midwives understood their responsibility to report concerns or mistakes.

Learning was shared with staff about incidents. Staff received feedback from incidents which they had reported and those which had occurred in the maternity service. For example, the unit produced posters called LASER (Learning After Significant Event Recommendations) for all staff. Other types of communication of learning included safety briefings, email, governance newsletter, 'hot topics' on the PROMPT study day and lunchtime teaching sessions.

Staff met to discuss incidents and look at improvements to women's care. There was evidence that changes had been made as a result of incidents. This occurred at handover and the safety huddle in order to look at improvements to women's care. The governance team produced a monthly newsletter which included learning from incidents, root cause analysis, Healthcare Safety Investigation Branch (HSIB) investigations, serious incidents, lessons from governance activities, learning from audits and updates from national programmes such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

There was a weekly multidisciplinary incident review meeting which all clinical staff were invited to. Trends and themes were discussed at the monthly maternity governance meeting. The risk midwife told us a recent theme was identified which related to incorrect labelling of blood samples. The service had worked with the blood bank to find solutions and had issued advice to staff through the maternity newsletter.

We reviewed safety incidents in maternity from November 2019 – January 2020. The top three reported incidents were; major postpartum haemorrhage, postpartum haemorrhage of less than 1500 millilitres and readmission of mother and baby. Learning and themes from incidents were discussed at departmental governance meetings.

## **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.

The trust did not report any never events in maternity from November 2018 to October 2019.  
(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity due to 'maternity/obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)' which met the reporting criteria set by NHS England November 2018 to October 2019.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. We saw several examples where duty of candour was applied. Women were invited to be involved in the investigation of the incident and to receive a copy of the final investigation report.

Managers debriefed and supported staff after serious incidents. Staff received feedback from investigation of incidents which they had reported and those which had occurred in the maternity service. However, staff were not able to describe any feedback or learning from incidents which had occurred outside of their service.

Staff told us they were offered emotional and practical support when this was required. We reviewed two investigation reports which were thorough and appropriate and resulted in clear action plans which ensured learning arising from the incidents was put into practice.

## **Safety thermometer**

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

The service continually monitored safety performance. The service did not use a maternity safety thermometer. However, they collected safety information which was displayed in all ward areas on performance boards. We observed zero cases of MRSA, healthcare acquired infections including Escherichia coli (common human bacteria), falls and pressures areas for January 2019. Safety information was reviewed and discussed at the monthly clinical effectiveness committee.

## **Is the service effective?**

## **Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence-based practice, but they were not always up to date. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.**

Staff followed mostly up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The trust told us all the intrapartum guidelines were in one document and were in the process of being separated into individual guidelines. They were all currently under review as they expired in 2018.

We reviewed the following policies, standard operating procedures, guidelines and care pathways: emergency gynaecology for early pregnancy unit, antenatal booking and ongoing antenatal care, tongue tie pathway and management of diabetes. All had clear pathways for treatment, referenced to the appropriate Royal College of Obstetricians and Gynaecologists guidelines and NICE clinical guidelines.

We attended handover meetings and observed staff routinely refer to the psychological and emotional needs of women, their relatives and carers.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. The unit had an ante natal working party which audited the use of NICE guidance. Staff also had support and advice from the Trust's NICE guidance lead. The trust clinical psychologist also offered advice around NICE guidelines for anxiety and depression, cognitive behaviour therapy and supported decision making.

## **Nutrition and hydration**

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

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs and would access dieticians when requiring advice. Staff fully and accurately completed women's fluid and nutrition charts where needed. There was plenty of choice from the menu and women told us the food was good. Snacks and drinks could be purchased from vending machines outside of meal times.

Women were given a choice of food and drink to meet their cultural and religious preferences. Menus displayed vegetarian and vegan options and women could request additional choices dependant on their religious, cultural and other needs.

Women were supported to feed their babies. Staff were reassuring, supportive and knowledgeable. The service had an infant feeding specialist midwife and a small team of maternity care assistants and trained volunteers who were available most times to assist with feeding. Staff took time to discuss feeding options available, including breast and bottle feeding. The service had achieved UNICEF baby friendly initiative status after a recent assessment. The UNICEF Baby Friendly Initiative supports breastfeeding and parent and child relationships by working with public services to improve care standards. Accreditation lasts for 18 months before it needs to be reassessed again.

Written information was readily available for breast feeding. We saw information boards, on all wards, displaying illustrations and photographs of breastfeeding positions and methods. We observed staff assisting women to feed their babies. Women who could not breastfeed were supported to express milk.

Staff provided guidance for women to express milk. We saw expressed milk stored in a secure milk fridge, correctly labelled and only containing breast milk. The service used a website by breast feeding network for guidance on storage of human breast milk. For the future, this guidance will be included in the next revision of the infant feeding and relationship building policy.

## **Pain relief**

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

Women usually received pain relief soon after requesting it. Pain relief was available to women at all times during their stay. Staff responded quickly to requests for pain relief and were understanding of women's pain, including at the time of labour. We saw a woman requesting pain relief and a midwife responding to this request. There were two delivery suite anaesthetists available to provide timely access to epidurals.

The trust protocol was for women to wait no more than an hour for an epidural. If this was not achievable the trust on-call Consultant Anaesthetist was required to attend. Staff told us women, dependant on the anaesthetist workload, could "wait several hours" for an epidural to be placed. However, the latest trust audit in November 2019 showed the median time between request and receiving the epidural was 60 minutes. This was in line with trust policy.

Staff prescribed, administered and recorded pain relief accurately. There were a range of pain relief methods available during labour. Women received both written and verbal information about pain relief options available to them during antenatal classes, when they discussed their birth plan with a midwife and during labour. Most delivery rooms were equipped with piped nitrous oxide gas (a form of pain relief safe to use in labour) and oxygen. Cylinders of nitrous oxide and oxygen were also accessible and also available for homebirths.

Women who underwent a caesarean section were given advice about pain relief and were provided with a week 's supply of analgesia to take home. They were encouraged to contact their GP if they needed a further prescription.

There was a birthing pool, supported by an up to date policy, which could be used for pain relief in one of the rooms on the delivery suite. The birthing pool was not available when the room was in use by another woman. In the White Horse birthing centre, there were two rooms with birthing pools which were regularly used.

During our last inspection we were not assured of the cleaning process. During this inspection we saw clear laminated cleaning instructions kept by each pool and were told the birthing pool was cleaned after every use, by the midwifery team.

## **Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited**

## under relevant clinical accreditation schemes.

Managers carried out a comprehensive audit programme and used information from the audits to improve care and treatment. There was a service audit team who oversaw the local and national maternity audits and we saw evidence of the extensive audit programme.

The service participated in national and local audit, so it could benchmark performance and patient outcomes against other providers and identify areas for improvement. Audit results were shared at a number of meetings and the monthly clinical governance meetings. We reviewed the audit programme including UKOSS (UK Obstetric Surveillance System), NMPA (National Maternity and Perinatal Audit), MMBRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), NPID (National Pregnancy in Diabetes Audit) and HSIB (Healthcare Safety Investigation Branch). Audits included results and action plan arising.

We were told of local audits and actions resulting from these. For example, the service undertook an audit on the effectiveness of the use of EOBS (observations recorded electronically), rather than the use of MEOWS, during a period of time. The service found that there was an area of risk when the woman transferred from the delivery suite to the postnatal ward, that the observations were not being recorded routinely. Audit results were discussed with the maternity governance team and it was agreed to revert back to paper based MEOWS. On re-audit the service assured themselves that the risk had been eliminated.

Managers and staff used the results to improve women's outcomes. The maternity performance dashboard was reviewed by the service. It demonstrated a number of performance metrics including; types of delivery including assisted delivery, smoking related indicators, rates of breast feeding, morbidity and mortality. However, it was basic, and outcomes were not able to be compared with the national average.

## National Neonatal Audit Programme

The table below summarises Great Western Hospital's performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<b>Metrics (Audit measures)</b>	<b>Hospital performance</b>	<b>Comparison to other hospitals</b>	<b>Meets national standard?</b>
<b>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?</b> <i>(Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)</i>	89.4%	Within expected range	Did not meet
<b>Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?</b> <i>(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later</i>	63.5%	Within expected range	No current standard

develop cerebral palsy)			
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(Source: National Neonatal Audit Programme)

### National Maternity and Perinatal Audit Programme

The table below summarises Great Western Hospital performance in the 2018 National Maternity and Perinatal Audit Programme against measures related to maternity care.

<b>Metrics (Audit measures)</b>	<b>Hospital performance</b>	<b>Comparison to other hospitals</b>	<b>Meets national standard?</b>
<b>Trust-level case ascertainment</b> <i>(Proportion of eligible cases included in the audit)</i>	102.4%	N/A	Met
<b>Antenatal measures (before birth, during or relating to pregnancy)</b>			
<b>Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date</b> <i>(Babies who are small for their age at birth are at increased risk of problems before, during and after birth)</i>	52.6%	Within expected range	No current standard
<b>Intra-partum measures (during labour and birth)</b>			
<b>Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery</b> <i>(For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)</i>	44.1%	Within expected range	No current standard
<b>Case-mix adjusted overall caesarean section rate for single, term babies</b> <i>(The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)</i>	27.6%	Within expected range	No current standard
<b>Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7</b> <i>(The Apgar score is used to summarise the condition of a new born baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5-minute Apgar score of</i>	0.9%	Within expected range	No current standard

<i>less than 7 has been associated with an increased risk of problems for the baby)</i>			
<b>Case-mix adjusted proportion of vaginal births with a 3<sup>rd</sup> or 4<sup>th</sup> degree perineal tear</b> <i>(Third- or fourth-degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)</i>	N/A	N/A	No current standard
<b>Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml</b> <i>(Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)</i>	N/A	N/A	No current standard
<b>Post-partum measures (following birth)</b>			
<b>Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit</b> <i>(Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)</i>	N/A	N/A	No current standard

*(Source: National Maternity and Perinatal Audit Programme)*

### Standardised Caesarean section rates and modes of delivery

From July 2018 to June 2019 the total number of caesarean sections was similar to the England average. The standardised caesarean section rates for both, elective sections and emergency sections, were similar to the England averages.

Standardised caesarean section rate (July 2018 to June 2019)					
Type of caesarean	England	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	National comparison
Elective caesareans	13.1%	515	12.9%	97.9	Similar to expected
Emergency caesareans	16.7%	675	17.0%	100.7	Similar to expected
Total caesareans	29.8%	1,195	29.9%	99.5	Similar to expected

*Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.*

*Delivery methods are derived from the primary procedure code within a delivery episode.*

*This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.*

(Source: Hospital Episode Statistics (HES))

In relation to other modes of delivery from July 2018 to June 2019 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<b>Proportions of deliveries by recorded delivery method (July 2018 to June 2019)</b>			
<b>Delivery method</b>	<b>GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST</b>		<b>England</b>
	<b>Deliveries (n)</b>	<b>Deliveries (%)</b>	<b>Deliveries (%)</b>
Total caesarean sections <sup>1</sup>	1,195	29.9%	29.8%
Instrumental deliveries <sup>2</sup>	480	12.0%	12.3%
Non-interventional deliveries <sup>3</sup>	2,330	58.1%	57.9%
Total deliveries	4,000	100%	100% (n=571,848)

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

1 Includes elective and emergency caesareans

2 Includes forceps and ventouse (vacuum) deliveries

3 Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episode Statistics (HES))

### Maternity active outlier alerts

As of 11 December 2019, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES))

### MBRRACE-UK Perinatal Mortality Surveillance Report

The table below summarises Great Western Hospital's performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016.

<b>Metrics (Audit measures)</b>	<b>Trust performance</b>	<b>Comparison to other trusts with similar service provision</b>	<b>Meets national standard?</b>
<b>Stabilised and risk-adjusted perinatal mortality rate</b> (The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK's death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)	4.95	Up to 10% lower than the average for the comparator group	No current standard

(Source: MBRRACE-UK)

### Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The service employed a practice development midwife to oversee the training for all midwifery nursing and support staff. Staff rotated between the hospital and the community midwifery teams to maintain their skills.

NHS Resolution no longer recognised inhouse training for NIPE (Training for New-born Infant Physical Examination). The trust stopped all staff who had completed the inhouse training from undertaking NIPE. This examination was mainly undertaken by paediatricians, birth centre midwives, senior band 7 midwives and community midwives who were suitably qualified. In future this will no longer be an issue for newly qualified staff as NIPE training is to be incorporated into the midwifery degree. This will mean all midwifery staff will be suitably accredited in the future.

Managers gave all new staff a full induction tailored to their role before they started work. New staff attended the trust induction and a local induction tailored to their place of work. This included departmental requirements, access to electronic systems and obstetric emergency situations.

Staff felt supported with training and supervision. All newly qualified midwives undertook a 12-month preceptorship programme. This programme supported the newly qualified midwives to build confidence and consolidate learning gained as a student. Managers identified training needs for their staff and gave them the time and opportunity to develop their skills and knowledge.

Managers supported midwifery and medical staff to develop through regular, constructive clinical supervision of their work. The service had several professional midwifery advocates, who were experienced practising midwives. They provided supervision and support. Staff could access this supervision through group meetings and one to one contact with the advocates.

Training needs for medical staff were identified and all grades of medical staff told us they were encouraged and given opportunities to develop.

### Appraisal rates

From 12 November 2018 to 13 November 2019, 80.8% of required staff in maternity received an appraisal compared to the trust target of 80%. This was an improvement from the last inspection in 2015.

The breakdown by staff group can be seen in the table below:

Staff group	12 November 2018 to 13 November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Administrative and Clerical	9	11	81.8%	80.0%	Yes
Midwifery Registered	162	202	80.2%	80.0%	Yes
Additional Clinical Services	43	52	82.7%	80.0%	Yes

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

## **Multidisciplinary working**

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. Doctors, midwives and allied health professionals reported good working relationships with each other and there was mutual respect for each other's professions. Midwives told us if they needed a medical opinion, they were able to get this without delay. Maternity staff worked very closely with the neonatal and paediatric staff.

High risk pregnant women were closely monitored through a high risk antenatal multidisciplinary meeting held monthly to discuss fetal medicine patients. They maintained an online tracker and chronology if women were referred to specialist services elsewhere. We saw a clinic which monitored high risk pregnancies with a consultant and sonographer working closely together.

Through a Quality Improvement project, the service had introduced a daily perinatal safety huddle, which involved the neonatal consultant/registrar, senior nurse from the Neonatal Unit, Delivery Suite coordinator, obstetric consultant, Hazel ward coordinator, Day Assessment midwife and Community Midwifery bleep holder and a representative from the safeguarding team. They discussed safety issues, access and flow and any safeguarding concerns. All multidisciplinary staff were invited to participate in risk meetings.

Staff worked across health care disciplines and with other agencies when required to care for women. The unit worked closely with NHS maternity units in Bristol and Oxford to provide more specialist care for women and babies.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. For example, the specialist screening midwife (who was funded by Public Health England but contracted to the trust) regularly met with an obstetrician, sexual health representative, a medical consultant and health visitors to discuss women to ensure good multidisciplinary care.

Staff referred women for mental health assessments when they showed signs of mental ill health or depression. These mental health assessments for women were completed by the psychiatric liaison service within the hospital. Women that were returning to the community were followed up by the community midwife and mental health service.

Staff worked across health care disciplines and with other agencies when required to care for women. Staff had a good working relationship with the psychiatric liaison team and the perinatal team. The specialist community perinatal team was employed by the local mental health trust and were commissioned to provide support to the team. We also observed close working relationships with the special care baby unit and other external agencies such as the local authority.

## **Seven-day services**

**Key services were available seven days a week to support timely care.**

Consultants led daily ward rounds on all wards, including at weekends and out of hours. Women were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Obstetricians were available at all times, as well as scanning and diagnostic services. Routine ultra-sound scans were available Monday to Friday.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Community midwives carried out midwife-led antenatal clinics Monday to Friday and saw women at home and in community hubs seven days a week. They also provided an on-call service out of hours. Midwives provided care in the antenatal day assessment unit, seven days per week, to women who required care either as an outpatient or for triage assessment for admission to antenatal services. Advice was available for women from midwives on the delivery suite through the 24-hour telephone line.

## Health promotion

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

Throughout the service health promotion information and leaflets were widely available and displayed on notice boards and in waiting rooms. These included leaflets regarding; diet, immunisation, breastfeeding, diabetes and bereavement. Also, the trusts' website had information leaflets available to be downloaded and available in other languages.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service promoted emotional well-being and provided signposting to counselling services and domestic abuse support. The maternity section of the trust's website included links to external sites women could access.

The service promoted healthy life style choices to women during their pregnancy. Women were encouraged to maintain a healthy diet and there was written information and practical support to help them with this. The maternity section of the trust's website included eating well in pregnancy. The website contained advice on healthy eating in pregnancy and while breastfeeding. A midwife ran a "Health in Pregnancy" clinic and classes for women.

Specialist advice was available to women who smoked. There was a stop smoking midwife who supported women at home in a non-judgemental way and gave them achievable goals to work towards. In accordance with the NICE guidance *Smoking: stopping in pregnancy and after childbirth*, women were offered carbon monoxide tests and could be referred to a specialist midwife. Midwives were encouraged to engage with partners and other family members, who were smokers, to support them also.

We reviewed the monthly audit results of 'smoking at delivery'. This demonstrated, between the period of April 2019 and January 2020, the number of women who were still smoking at time of delivery was an average of 10.35%. This was above the current national ambition of 6%

There was specialist advice available to women who were alcohol or substance dependant. There was a service mental health and substance misuse team. Women were encouraged to contact their GP, or the midwife, for advice and support and could be referred to other organisations for specialist support.

There was screening and monitoring of women with diabetes or those at risk of developing gestational diabetes. A multidisciplinary diabetes clinic was held weekly to support these women. We observed the multidisciplinary diabetes clinic and heard advice on what to do next.

Women were encouraged and supported to breastfeed their babies. Women were given written and practical advice by midwives, and breastfeeding support workers, and had access to

information posters and leaflets. Women were supported to harvest (collect and store) colostrum (first breast milk after birth) if they were likely to have difficulties feeding their baby in the first few days after birth.

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

**Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women’s consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff gained consent from women for their care and treatment in line with legislation and guidance. Staff received training on the Mental Capacity Act (2005) during their induction and completed training on Deprivation of Liberty safeguards as an e-learning course. Staff could also access help and support from the psychiatric liaison team.

Staff clearly recorded consent in the women’s records and that they consented to treatment based on all the information available. Staff discussed the procedure, outcomes and risks for elective caesareans with women in the antenatal clinic. Any risks were reviewed by the anaesthetist and the doctor went through the consent form with the patient, documented in confidential files. The doctor checked the patient’s consent again in the morning of the operation during the ward round.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff accessed guidelines on assessment under the mental capacity act through their internal system and by following the trust policy. If staff thought that a woman lacked mental capacity to make a decision about their care or aspects of their care, they would seek advice from their senior midwife and the mental health midwife. Staff would also alert the consultant obstetrician who was the lead for mental health in maternity.

Staff recorded mental capacity assessments in the women’s paper notes, which were stored in a locked cabinet. The paper records were colour coded, so staff knew which section to record the information in.

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

Midwifery staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards exceeding the trust target.

The trust set a target of 80% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training modules from 22 November 2018 to 21 November 2019 for registered midwives in maternity is shown below:

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Consent, Mental Capacity Act 2005 and Deprivation of Liberty	344	396	86.9%	80.0%	Yes

Training module name	22 November 2018 – 21 November 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguards					
Mental Health Act	322	396	81.3%	80.0%	Yes

In maternity the target was met for all the MCA/DOLS training modules for which registered midwives were eligible.

The trust supplied the latest data for all the MCA/DOLS training modules for which medical staff were eligible, showed compliance rate of 92.86%.

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

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. We spoke with 24 members of staff regarding consent, capacity, deprivation of liberties, Gillick competence and Fraser Guidelines. Staff had knowledge of the relevant consent and decision-making requirements of legislation and guidance. This included the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

For mental health difficulties, staff were aware of and knew how to approach the perinatal mental health specialist midwife for advice and support. If staff lacked confidence in assessing vulnerable patients, they knew who to contact for assistance.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Care records showed that consent to midwifery/medical assessment in the hospital were completed accurately. This meant staff could be assured that consent was obtained appropriately.

When women could not give consent, staff made decisions in their best interest, taking into account the woman's wishes, culture and traditions. Staff always had access to up-to-date, accurate and comprehensive information on women's care and treatment. Staff had access to electronic and paper records systems that they could all update.

## Is the service caring?

### Compassionate care

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

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were committed to supporting women during pregnancy, labour and postnatally to ensure women, and their families, had a positive experience. Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

The birth matters service was caring and supportive for women. There was woman focussed care through the birth matters clinic for women with subsequent pregnancies.

Staff were committed to supporting women during pregnancy, labour and postnatally to ensure women, and their families, had a positive experience. Feedback from women, their partners and

family, at the time of our inspection was very positive. Partners were welcome to stay overnight following delivery to promote bonding. Staff demonstrated empathy towards women, their partners and family, who had experienced baby loss before, during or after birth.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Women said staff treated them well, with kindness, dignity and respect. We observed staff introduce themselves by name to women and their partners. Staff described their role and discussed their care and what would happen next. Recent feedback from women included "What an incredible team.", "An incredible midwife...truly amazing at her job.", "...you shared our joy and our challenges". "I was so anxious on the first night, but you were brilliant", "The blessing we are taking away is your dedication and knowledge you shared", "Thank you so much. You were supportive, softly spoken and was just brilliant" and "At no time did we have any doubts she was in safe hands". Women we talked to told us "Words cannot express how brilliant the midwives are", "Aren't they fabulous!", "They were great!" and "I couldn't have asked for better care".

However, staff struggled to maintain the privacy and dignity of women attending the day assessment unit, which was an open unit with three trolleys, separated only by curtains. It was also difficult having telephone conversations in private. The midwives used the private room to speak to women when it was not being used for glucose tolerance testing. An alternative for midwives was to use a scanning room when available.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgemental attitude when caring for or discussing women with mental health needs. Women we spoke with felt listened to and understood by staff. We heard staff explaining treatment options to women and making decisions together. Staff followed policy to keep women's care and treatment confidential. We observed compassionate care from the midwives to the patient who had a mental health condition. They showed understanding and empathy around their presentations and demonstrated a good level of knowledge around their roles and responsibilities.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. One woman told us she had been offered a female staff member at all times during her care and labour in keeping with her cultural beliefs.

There was support for women with transient psychological symptoms ('baby blues') or infant attachment problems. If a woman presented with transient psychological symptoms, they would receive support from the mental health practitioner midwife who would recommend a minimum of a 48 hour stay on the ward to sleep and bond with their baby. Staff referred women who were being discharged to external support groups for extra support.

### **Friends and Family test performance**

Due to low the low number of responders, we were unable to accurately calculate the trusts response rate and compare this to the England average. This was due to a change in provider who collated the responses.

The trust provided the latest report dated December 2019. It showed a 100% satisfaction rate with the delivery suite, Hazel ward and the birth centre although the response rate was low.

### **CQC Survey of women's experiences of maternity services 2018**

The trust performed better than other trusts for one of the 19 questions in the latest CQC maternity survey in 2018. The trust performed similar to other trusts for the remaining 18 questions.

<b>Area</b>	<b>Question</b>	<b>Score (0-10)</b>	<b>RAG</b>
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	9.1	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	8.2	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.3	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.7	About the same
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	9.3	About the same
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.8	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	9.0	Better
	If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time	9.1	About the same
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.6	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.9	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.5	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.1	About the same
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	6.9	About the same
	Looking back, was there a delay in being discharged from hospital?	4.7	About the same
	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	7.5	About the same

Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	7.9	About the same
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.9	About the same
Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	7.6	About the same
Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.9	About the same

*(Source: CQC Survey of Women's Experiences of Maternity Services 2018)*

## **Emotional support**

**Staff provided emotional support to women, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.**

Staff supported women and families who experienced the loss of a baby and there was a bereavement lead. Staff supported high risk women through their pregnancies; this included pregnant women who had previously experienced the loss of a baby. They supported women in labour and following a loss, worked with families to ensure the precious time they spent with their babies was as they wanted. This included supporting them, for example, to bathe and dress their baby, and making baby's handprints and footprints for memory boxes provided to them. We were told of examples of women supported to follow their cultural or religious choices for their baby and all staff worked together to ensure the dignity and respect of these choices.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The service had a specialist bereavement midwife and all midwives received education to care for women in the event of a stillbirth or unexpected death in-utero. Women and their families were cared for sensitively away from areas where women had delivered their babies. Midwives and the chaplaincy team, if appropriate, supported these women and families including those who had experienced the loss of a baby previously.

Cooled cots (a cooling unit that allowed families to spend extra time with their baby by regulating its temperature) were provided and could be placed in a cot or even a pram. This allowed parents to stay with their babies before their funeral.

All women who were bereaved were supported with postnatal care. The bereavement midwife offered support dependant on individual needs and parents chose the level of support they wanted. A consultant obstetrician held a clinic for women when they had experienced pregnancy loss and subsequently became pregnant again.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff comforting a woman who required reassurance by assisting her to a quiet area.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. When asked about women's emotional needs, staff

spoke about women in a compassionate way. We observed care given to a woman by midwives and medical staff, and involvement of those close to the woman, to ensure she was emotionally supported.

Women gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. We saw many written examples of positive patient feedback displayed on the maternity unit.

## **Understanding and involvement of women and those close to them**

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

Staff made sure women and those close to them understood their care and treatment. Women told us they felt well informed throughout their pregnancy and during the birth of their baby. Most fathers told us they felt welcomed and included in their partner's pregnancy and the birth of their child.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. All women we talked to told of positive experiences.

Staff supported women to make informed decisions about their care. They told us they were encouraged to ask questions and seek support when they needed it. Women were encouraged to make advanced decisions about their care. Women told us they felt their decisions were respected and, where possible, followed.

Staff made sure women and those close to them understood their care and treatment. Women regularly had a doula (someone without formal obstetric training to provide guidance and support during labour) present and were encouraged to individualise care plans for the birth of their baby. Staff would discuss anxieties to ensure the best possible experience for women.

Staff supported women to make informed decisions about their care. In the community the midwives understood, and could give many examples, of care for women of different cultures. Community midwives were proud to tell us of examples of care which involved those close to women and the complexities of the cultural expectations.

Staff talked with women, families and carers in a way they could understand. We observed interaction between a consultant, a woman and her partner. The consultant discussed the ultrasound results with them and answered their questions in a calm, respectful manner.

## **Is the service responsive?**

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

**The service planned and provided care in a way that met the needs of local women and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the needs of the local population. The trust had well established care pathways for all stages of pregnancy, delivery and post-natal care. The day assessment unit opened 8 am – 8 pm and out of hours women rang the delivery suite for advice and support.

Flu vaccines were provided by midwives in antenatal clinics. This meant all women were offered vaccination. The vaccine for whooping cough was delivered in the community.

Managers ensured that women who did not attend appointments were contacted. Women who did not attend their appointments were contacted by midwives and were offered an alternative appointment.

Facilities and premises were appropriate for the services being delivered. The antenatal and postnatal ward was next to the delivery suite and the birthing centre. There were issues with ventilation and scavenger units for nitrous oxide on delivery suite. This was on the corporate risk register under estates and facilities management and the trust had plans to provide the correct ventilation systems.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. The trust mental health team were very proactive in responding in emergency situations. Staff offered support, completed or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

The service had systems to help care for women in need of additional support or specialist intervention. Staff gave an example of supporting a patient who was referred for a mental health assessment. The midwife organised a private consultation room and additional support for the woman during the assessment.

The service also referred pregnant women under 20 years old to the Family Nurse Partnership in the community funded by National Health Service England. This was a home visiting programme for first-time young mums and families giving them help and support for two years after delivery.

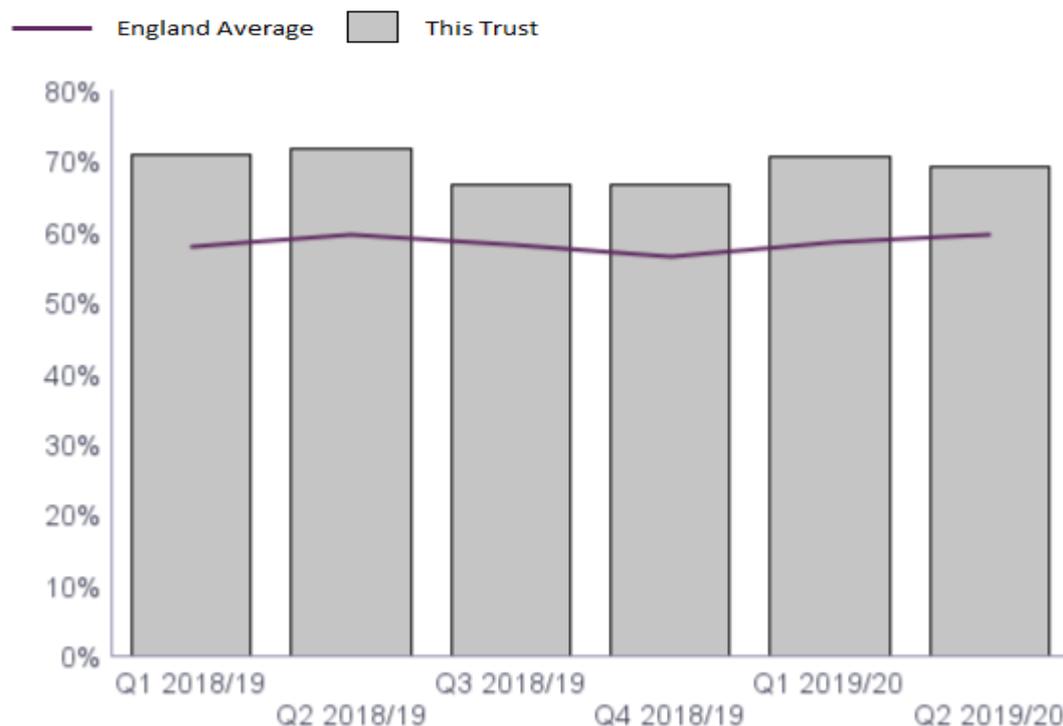
Community midwives and hospital staff supported women who experienced domestic abuse. There were discreet posters in the maternity unit. Women attending the day assessment unit were spoken to on their own prior to assessment about any domestic issues they may have experienced.

The trust offered a maternity and paediatric support service called “Birth Matters” for women and families to discuss issues related to pregnancy, birth experiences, loss of a baby, anxiety about pregnancy and childbirth and to families with a child on the special care baby unit. Also, if women displayed symptoms of post-traumatic stress, they could be referred to other services such as psychiatry for help and support. The service took referrals from other health professionals or women could refer themselves. This support service was run by midwives with qualifications in counselling and bereavement.

## **Bed Occupancy**

From April 2018 to September 2019 the bed occupancy levels for maternity were generally higher than the England average, with the trust having 69.3% occupancy in Quarter 2 2019/20 compared to the England average of 59.7%.

The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

## Meeting people's individual needs

**The service was inclusive and usually took account of women's individual needs and preferences. Staff usually made reasonable adjustments to help women access services. They coordinated care with other services and providers.**

Staff understood and applied the policy on meeting the information and communication needs including women or their partners with a disability or sensory loss. The service had information leaflets available in languages spoken by the women and local community. Managers made sure staff, women and their loved ones and carers could get help from interpreters or signers when needed. Information leaflets and website information were available to women in multiple languages and in an easy read format where required. For example, induction of labour, information for women with complicated pregnancies and induction of labour for women with diabetes or gestational diabetes. If English was not the patient's first language, the trust had an interpreter service, which could be accessed over the telephone. If necessary, the trust would hire an interpreter in person.

All women were encouraged to view the discharge information DVD available on Hazel ward or on social media sites.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. If the patient had a known mental health diagnosis, this would be picked up during antenatal appointments. This would be reflected in a post-natal mental health plan. If the patient was ready for discharge, staff made sure they had their correct medication and contact with their GP was pre-arranged. Staff also made the community midwives and health visitors aware of the discharge. Staff sent the summary of discharge to the

patient's GP, which detailed if the patient was either on medication or mental health support was being used.

There was a bereavement suite available for women and families to be cared for whilst grieving which met needs of bereaved women and their partners. The suite comprised of a birthing room with en-suite bathroom facilities, and a lounge with tea making facilities for parents to use. The suite had its own external entrance so that women and relatives did not have to walk through the delivery suite. All normal maternity care was provided to pregnant women from 12 weeks and over for termination for fetal abnormalities and over 14 weeks for intra-uterine death.

Staff usually made reasonable adjustments to help women access services. Women who had positive results following blood screening were referred to appropriate clinics for advice and treatment. This included infectious diseases and genetically carried conditions. Midwives contacted women with the results and offered the next available appointment if required.

As the service worked closely with NHS maternity units in Bristol and Oxford to provide more specialist care for women and babies, special referral packs were given. These included a schedule of appointments to expect when referred, contact numbers, maps of relevant units they were referred to and condition specific information leaflets.

The service did not have a particular guideline for non-obstetric emergency care for pregnant women when they attended the emergency department. If admitted, this meant women could miss routine midwifery checks.

There was a policy for admission, transfer and discharge for adult patients in the acute trust which mentioned pregnant women. The on call obstetric registrar, on call consultant or the senior midwife should be contacted by the emergency department if a pregnant woman attended and safeguarding issues were identified. However, this policy was out of date with a review scheduled for November 2013.

Staff worked to coordinate services for those women with multiple long-term conditions. Antenatal care included specialist clinics as women were increasingly presenting with pre-existing co-morbidities while pregnant. This included women who had, for example, had an organ transplant, a multiple pregnancy, known chromosomal abnormalities and diabetes including gestational diabetes. Joint medical and antenatal clinics were held. For example, the diabetic joint clinic included the diabetes specialist nurse/midwife, an endocrine consultant and an obstetrician. The diabetes specialist nurse/midwife monitored all patients individually if they were on insulin and ensured they had diabetic screening including retinopathy.

## **Access and flow**

**Women could usually access the service when they needed it and received the right care. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were not always in line with national standards.**

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. The midwifery team supported women, who were assessed as being low risk, to choose to have their babies at home or in the White Horse birthing suite. Options were discussed at the beginning and during pregnancy and when care plans were developed. These were tailored to individual women's needs and preferences. Women who were assessed as being high risk had care plans to offer safe choices of delivery.

Managers and staff worked to make sure women did not stay longer than they needed to. Women requiring specialist care, such as diabetes or with a raised BMI, were seen in joint specialist maternity clinics within the hospital. Women requiring ultra-sound scans were also seen within the clinics. Staff tried to keep waiting times to a minimum although at times the clinics were very busy. Ultra-sound scans were available Monday to Friday.

Women were discharged home from the delivery suite or admitted to Hazel ward for additional care. There was a neonatal transitional care bay on Hazel ward which provided additional specialist care for babies when the woman was well.

Managers monitored waiting times so that women could access services when needed and received treatment within agreed timeframes and national targets. Antenatal services were delivered as locally as possible to where pregnant women lived. Community midwives ran antenatal clinics from local GP surgeries and community premises.

Between August 2019 and January 2020, 77 hospital antenatal clinics were cancelled which equated to 770 appointments. The reasons for cancellation were unknown. Staff worked to ensure women's appointments were rearranged in a timely manner. However, we could not be assured that this was being monitored at a divisional level or trends for cancellation identified through divisional governance meetings.

Access and flow of women on the delivery suite was delayed. The delivery suite cared for women waiting for routine caesarean section, women in labour, women post caesarean section and women who were too unwell to be moved to the ward. There were no high dependency beds on delivery suite. However, women requiring level 2 care were moved to the intensive care unit.

For women requiring planned induction of labour, this did not appear well organised at inspection. Women admitted for induction were usually admitted onto the delivery suite to wait for induction. If the delivery suite was busy, this could be delayed. The cause was increased capacity of workload on Hazel ward and the delivery suite. Management was aware of this access and flow issue and induction of labour rates were discussed at regular monitoring meetings which all staff were encouraged to attend and, was on the divisional risk register. A data request was made regarding the number of delays to induction of labour (% of delays compared with all inductions), but this was not provided. The service had an induction of labour monitoring group to oversee the quality improvement project being introduced and a new induction of labour pathway being initiated.

## **Learning from complaints and concerns**

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

Women, relatives and carers did not always know how to complain formally but did raise concerns. Women and families, we spoke with were uncertain of the formal procedure to report complaints but told us they would feel comfortable raising concerns directly with staff. They felt confident their concerns would be taken seriously. There were leaflets and posters throughout the service informing women on the patient advice and liaison service (PALS).

Managers investigated complaints and identified themes. We reviewed three recent complaints, their investigation and response. They were clear, informative and invited the complainant to have a face to face meeting if they wanted to discuss their concerns further.

The service's divisional directors had oversight of all formal complaints and these were cascaded to the most relevant member of staff to investigate. We were told of an example of a formal complaint by a woman who felt she had received excellent care by the service but was unhappy with an inaccurate death certificate. The head of midwifery met with the woman as part of the investigation and changed their processes for issuing death certificates.

Formal complaints were centrally managed by the trust's complaints team, who acknowledged concerns in writing and allocated them to the relevant service line managers. Complainants were fully engaged in and supported through the complaints process. We were told of examples where the complainants were contacted by telephone by the investigating manager. This allowed them to introduce themselves, explain the process and timescales and to 'triage' the complaint. This ensured concerns and expectations of the complainant were fully understood.

The report in 2016 highlighted some maternity complaints about care and delivery not received according to personalised birth plans. Senior midwives told us as a result they were planning to introduce a birth matters service. This would be facilitated by a midwife and provide women and their partners the opportunity to discuss, review and understand their personal experiences in more detail. During this inspection we were told of the success of the birth matters service. This was offered to all women, including those who had miscarried. Women were given a card with the contact details of the birth matters team.

Managers shared feedback from complaints with staff and learning was used to improve the service. This was widely discussed in meetings and publicised in newsletters and email.

### Summary of complaints

From November 2018 to October 2019 the trust received 25 complaints in relation to maternity at Great Western Hospital. The trust took an average of 21.4 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be closed within 25 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical Treatment	13	52.0%
Communications	4	16.0%
Other	4	16.0%
Staff	2	8.0%
Access to treatment or drugs	1	4.0%
Privacy, dignity and wellbeing	1	4.0%
<b>Total</b>	<b>25</b>	<b>100.0%</b>

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

### Number of compliments made to the trust

From November 2018 to October 2019 there were 29 formal compliments at Great Western Hospital about maternity.

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

## Is the service well-led?

## **Leadership**

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

Managers were highly respected and well liked. Maternity was led by the divisional director for women and children's services division, supported by the deputy divisional director, clinical director, head of midwifery and two matrons. The head of midwifery provided strategic leadership for the service. We were told all levels of management were frequently visible, at least daily, to staff and women in all parts of the service. Staff told us all managers were approachable and supportive. The head of midwifery reported to the trust's divisional director of nursing and midwifery, had direct access to the board and presented bi-annual reports to them.

The head of midwifery was supported by two matrons, who provided operational day-to-day leadership. One matron was responsible for inpatient services and the other for community services. The matrons were frequently visible in all parts of the service and undertook walkabouts Monday to Friday to ensure they were accessible to staff and women. They participated in the on-call rota for senior midwifery advice and support out of hours.

Midwives were supported professionally by a team of professional midwifery advocates, who were experienced practising midwives providing clinical supervision and pastoral support. There were also team leaders and specialist midwives who led in different areas, such as staff education, safeguarding lead midwife, bereavement support and the service had just recruited a research midwife.

Medical staff had service line leadership. There was a clear line of management for obstetrics within the division. Consultants had protected time for managerial responsibilities and provided strategic leadership for the medical workforce. They were supported by a governance lead consultant for obstetrics responsible for governance. All junior doctors had a clinical supervisor and an educational supervisor.

The management team told us of the challenges the service faced and describe their priorities for ensuring a sustainable, compassionate and inclusive and effective leadership. Although the management team had only worked together for a short time, they spoke confidently about workstreams and improvement plans which had been developed and were ongoing to improve performance. They acknowledged challenges already encountered and those for the coming year. The service understood the priorities of the service. We were told by all staff of the complexity of current and future patient needs and the route to meeting these complexities. Staff morale and implementation of saving babies lives care bundle and better births were high on the service's agenda.

## **Vision and strategy**

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

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

The service was an active member of the county-wide Local Maternity System, which had developed a local vision and delivery plan. The trusts' vision and plans were focused on the national project of "Continuity of Carer" (where every woman should have a small team of midwives to follow them throughout pregnancy and birth), as part of the 'Better Births' programme. This was planned to be provided for 50% of women by 2021. There was acknowledgement from all staff that this would be a challenging period of change for management and staff.

The trusts' maternity strategy was combined into the "Nursing and Midwifery Strategy 2019-2024" It had a vision for the service based on four pillars of outstanding care, staff and volunteers feeling valued, joining up community and acute services in Swindon and using funding wisely to improve patient care. The strategy was aligned with the NHS Long Term Plan, the trust strategy and the quality improvement strategy. It was also formulated with allied health professionals in the trust. The strategy has three themes for focus; quality of care, workforce transformation and a professional agenda. Each theme has ambitions to achieve. It provided direction, focus and commitment for staff to understand the nursing and midwifery priorities over the next five years.

## **Culture**

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

Managers and staff described the service as a happy place to work. We spoke to student midwives who had completed placements in the service returned to work there after qualification. They told us they felt welcomed and supported.

Staff at all levels told us they were valued and respected; there was mutual respect and cooperative and appreciative relationships between job roles and disciplines. The service participated in the trust-wide '#HiddenHero' nomination system and regularly nominated colleagues for doing something excellent or 'going the extra mile'. Staff spoke with passion and pride about their service and there was a high level of job satisfaction and a desire to provide the best possible care to women and their families.

Staff felt confident and safe to raise concerns. Some told us they would approach their line manager, others said the professional midwifery advocates were a good source of support. All staff were familiar with the trust's freedom to speak up guardians and told us they would feel confident to approach a guardian.

There was a strong emphasis on staff safety and well-being. Professional midwifery advocates were available to facilitate reflective practice when staff experienced difficult or distressing clinical situations. There had been a number of staff on maternity leave in the last 12 months and they had been supported on their return to work in a way that allowed them to balance their work and child care responsibilities.

## **Governance**

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

There were monthly maternity governance and divisional governance meetings, chaired by the head of midwifery and divisional director. There was a standing agenda, which included a review of the performance dashboard, risk register, incidents, complaints and other feedback from women, guidelines for ratification and audits. Minutes were circulated to the divisional directors and staff via email and key messages were captured in the maternity SMART newsletter and via a closed social media group. There was a rolling action log to ensure actions were progressed in a timely way.

Reviews of deaths and unexpected outcomes were discussed at regular mortality and morbidity meetings, which were consultant led. Learning points were discussed and there was a prompt to consider inclusion on the risk register. The service had a newsletter called SMART to disseminate learning as well as safety huddles and handovers.

There was programme of clinical audit and regular audits took place to monitor safety performance. These included audits of infection control, multiple pregnancy, epidural administration, cardiotocography, caesarean section and NIPE. There were investigations and actions when data identified inconsistent or concerning performance. For example, recent audits on surgical site infections demonstrated a spike in infections. Actions resulting from the audits included advice to staff and additional teaching and working methods. Learning from audits was disseminated to staff through safety briefings and hot briefs, designed to look at current areas of concern. Audit findings were taken to the maternity governance meetings by the governance team. Thereafter, the triumvirate (divisional director, divisional director of nursing and divisional medical director) would present the findings at board meetings. Trust-wide, there were plans to increase the WHO checklist audit to 20 per week, week commencing 2 March 2020.

Following our last inspection, the service had increased governance capacity to ensure better oversight and review of policies of clinical guidelines. The trust told us that intrapartum guidelines was one document but in the process of being separated into individual guidelines. They were, at present, under review and out for comment with the clinical teams but remained in use. Many of these guidelines were past their review date of 2018. We also reviewed a selection of antenatal and new-born screening policies and guidelines that had already been separated and they were in date. However, the prevention and management of baby/child abduction policy was out of date and should have been reviewed in December 2019.

## **Management of risk, issues and performance**

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

During our last inspection in 2016, processes did not ensure the trust had a complete overview of all serious incidents. At this inspection, oversight of all incidents was much improved. There was a maternity governance midwife, a clinical audit midwife and a medical consultant lead for governance. They had oversight of all incidents in maternity. They identified immediate learning and communicated to staff through various channels. There had been recent recruitment of a lead midwife for governance. The head of midwifery and maternity governance lead presented to the board twice a year

There were effective systems to ensure all incidents, including complaints, were investigated and lessons learned were shared with staff. There was a weekly risk management meeting which was open for all staff to attend. This was regularly attended by obstetricians, paediatricians and midwives. Additionally, urgent incident review meetings were held, when needed, and the trust-wide teams were invited to these meetings.

During our inspection we found an issue with the lack of reception staff on delivery suite, especially overnight. This was important as there were opportunities for unwell women to attend the delivery suite and not be seen immediately. This was not raised as a risk on the divisional risk register. The trust assured us that no incidents had been reported and they were actively recruiting for more reception staff and a new triage process was due to be introduced on the delivery suite on

31 March 2020. Staff have attended training at another trust in order to use the Birmingham Symptom Specific Obstetric Triage System planned as the new triage system.

There were monthly maternity governance, divisional governance and patient safety and quality meetings where incident themes were discussed. The service maintained a risk register, which was also discussed each month and managed by the governance team. The risks recorded here mostly aligned with what senior staff told us they were concerned about and included continuity of carer, electronic maternity recording system and lack of space within the community to hold clinics.

The service was part of the South West clinical network to share learning from incidents. They took part in safety forums every three months. We were told of an example of the service presenting on neonatal resuscitation to improve outcomes for premature babies. Those involved in the safety forum included paramedics, obstetricians, neonatologists, and governance midwives.

Patient safety alerts were managed through the governance team and the divisional medical director. The governance team recorded patient alerts and reported these into the patient and safety quality teams to be actioned.

## **Information management**

**The service collected reliable data and analysed it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated but were secure. Data or notifications were submitted to external organisations as required.**

At our last inspection in 2015 we told the trust to improve the maternity and trust IT systems to remove duplication and increase accessibility. At this inspection, the position had not much

improved as the electronic maternity records system still did not interact with other hospital systems. We found test results could not be viewed on the maternity electronic system from the main hospital electronic system. This meant abnormal antenatal blood results would not be identified in a timely way and further investigations or treatment could be delayed. Patient information could be potentially missed by clinicians as patient care episodes were electronic and paper records. This was being monitored through the risk register while the new electronic system was being rolled out.

Every contact with a pregnant woman for the whole of her pregnancy must be recorded. The trust was in the process of implementing the National Maternity Record Standard and needed to be compliant by September 2020.

The service had access to information which provided managers with an overview of performance. A maternity performance dashboard was maintained and reported each month. Managers told us data was readily available and reliable.

During our inspection staff were alert to their responsibility to protect personal data and took steps to ensure the safe storage and movement of records. Staff checked women's hospital records corresponded with their hospital notes.

## **Engagement**

**Leaders and staff usually engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.**

### **Public engagement**

The service was committed to improving services by engaging with women and their families and capturing their feedback. The service worked with the "Maternity Voices" partnership, which was a collaborative of providers of maternity service, parents, parents-to-be and other stakeholders, reviewing local maternity care and supporting service users to share their experiences.

Matrons and ward managers routinely met and spoke with women and their families to capture their feedback. The service also used the friend and family test questionnaire to monitor feedback and this was reviewed at clinical effectiveness committee meetings.

The head of midwifery told us about plans to provide a counselling / bereavement room for the day assessment unit. This was a result of patient feedback.

Following patient feedback, the visiting times on Hazel ward had changed to be more family friendly and waiting areas had been upgraded and improved.

Midwives offered a service called "Birth matters". This service discussed aspects of maternity care and provided a forum for women to discuss any issues they had experienced, for example, a traumatic birth.

### **Staff engagement**

Recent trust staff survey results (November 2019) had been mixed, with staff highlighting they did not feel engaged to influence decision, were not able to meet all the conflicting demands at work, there were not enough staff to do their job properly and senior managers did not act on staff feedback. The service was awaiting this information to fully understand any areas of concern. However, the division scored highly on staff knowing what their work responsibilities were, they felt trusted to do their job and felt supported by their work colleagues. Also, 100% of staff had not experienced physical violence from a patient or relative at work or had not experienced any form of discrimination from patients, relatives or managers.

The Women's and Children's division had developed the IDEAs Programme to enhance staff engagement and build upon a continuous improvement culture. Ideas from staff were put into a dashboard with delivery phases to track progress. Types of ideas generated from staff included quick-wins, quality improvement projects, cost and time savings as well as transformational opportunities. A number of themed ideas weeks had been held within the division, including a staff health and wellbeing week in December 2019, which included aromatherapy, massage sessions, drinks rounds and dog therapy. Following the success of the programme, it was being rolled-out to other areas within the trust and a full-time Ideas Lead had been seconded to lead this.

Maternity staff felt informed and involved. Communication was good and key messages were communicated at staff handovers, by the "SMART" newsletter and through email. Maternity staff felt their views mattered and they were encouraged to contribute feedback and ideas to improve performance and the experience for women.

The service had recently introduced an 'engage to change' forum for staff to engage with leaders to problem solve as a team. Key questions asked; what does it look like? what is stopping us? and what are the priorities? From the first meeting, communication was the topic of discussion. The first meeting was thought to be a success and further monthly meetings were planned.

The service had signed up to the 'Caring for You' charter with the aim of improving the health, safety and wellbeing of the staff.

## **Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The service was focused on learning and quality improvement projects to improve patient outcome and staff wellbeing. The commitment for continuous quality improvement was discussed throughout our inspection and all staff told us they felt engaged in the process. The service had recently received funding for a twelve-month secondment for a research midwife.

The service had developed an 'Ideas Dashboard', which included quick wins, staff engagement, technology and transformation, time and cost savings, review processes and key pathways for efficiencies, and quality improvement. The 'Ideas' programme identified and captured a range of improvement opportunities generated by staff on a continual basis, and the 'Ideas Dashboard' was visible on the service's computer screens across the service.

We were told of the Preterm quality improvement project, launched in January 2017, which has been nominated for national awards. Due to the success of the project it will be implemented across the South West of England, known as PeriPREM.

Other quality improvement projects included: neonatal transitional care, improving the care of babies at risk of neonatal hypoglycaemia, induction of labour, improving the care of women with diabetes, delayed cord clamping and delivery cuddles.