Taunton and Somerset NHS Foundation Trust

Quality Report

Musgrove Park Hospital,
Parkfield Drive,
Taunton,
Somerset
TA1 5DA
Tel: (01823) 333444
Website: http://www.musgroveparkhospital.nhs.uk/

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

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 25 and 29 January 2016. We also carried out an unannounced inspection on 9 February 2016. We carried out this comprehensive inspection at Taunton and Somerset NHS Foundation Trust as part of our comprehensive inspection programme.

This organisation has one main location:

Musgrove Park Hospital, a large acute hospital comprising all acute services. This hospital is the largest in Somerset. However some maternity and outpatients services were delivered at different sites in the county, these were not visited as part of this inspection.

The hospital opened in late 1942, having been built as an American Army Hospital. It became part of the NHS in 1952. Work to modernise the site began in 1987 with the opening of the Queen's Building, whichincludes the Emergency Department, Orthopaedics, Ophthalmology, Ear, Nose, and Throat, Oral and Maxillofacial Surgery, Endoscopy and Therapy Services. The Duchess Building, including all Medical and Care of the Elderly Wards, Outpatients, Pharmacy and Diagnostic Imaging, was opened in 1995. The new Jubilee building opened to patients on Saturday 15th March 2014. The Jubilee building has three wards, Barrington Ward on the Ground floor with 32 beds, Hestercombe Ward on the First floor with 40 beds and Montacute Ward on the top floor with 40 beds. All 112 bedrooms have en-suite bathrooms. It replaces four open plan 'Nightingale' wards in the Old Building. The wards treat mainly surgical patients for the following specialities General Surgery, Colorectal, Urology, Gynaecology, Breast, Orthopaedic, Vascular and Upper GI.

The trust provides a full range of acute clinical services. The trust has 576 Inpatient and 81 day case beds.

The trust provides specialist and acute services to approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset.

Previous inspection by the CQC in September and October 2013 found that there were breaches in three regulations around record keeping, equipment maintenance and specialised training. At this inspection we found that some actions had yet to addressed around specialist training and that it could not always be demonstrated that patients had been consulted regarding do not resuscitate decisions.

The trust had a relatively new executive team. The Chief Executive was appointed in February 2015, shortly after the Chair had been appointed. The Director of Patient Care was appointed in December 2015. However other members of the senior team had been in post for over two years, some considerably longer. The senior team was found to be cohesive and worked well together.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each section of the service receives an individual rating, which, in turn, informs an overall trust rating.

The inspection found that overall; the trust had a rating of good.

Our key findings were as follows:

- There was a strong, visible person-centred culture demonstrated by all staff. We observed staff positively interacting with patients and, patients were treated with kindness, dignity, respect and compassion while they receive care and treatment.
- Staff were overwhelmingly caring in delivering care to patients. We witnessed some outstanding examples of care being given to patients and their relatives.
- We considered the flexibility of the meals service to be outstanding. Patients had plenty of choice from two different menus or could choose what they wanted day or night
- In the emergency department arrangements were not in place to ensure suitable care and treatment was provided to children and the care environment for children was not suitable.
- There was insufficient evidence to that resuscitation trolleys were checked in line with trust policy. On some trolleys, we found out of date equipment.

Summary of findings

- Staff mostly followed good infection practices but not clinical area was clean and tidy. In some areas effective cleaning would not be possible due to aging and damaged estates and furniture.
- Medicines in a number of areas were not always securely stored
- The senior management team had engendered a culture of learning from incidents and one in which the patient was put at the centre of care provided.
- The environment at Musgrove Park Hospital was a mix of newly built units with excellent facilities and aging departments and wards. This presented challenges in delivering care in units which met current guidelines.
- Children's and neonatal staffing levels did not meet the current guidelines.
- Patients using the service were receiving effective care and treatment, which met their needs. Outcomes for patients were routinely collected and monitored, and were mostly positive.

We saw several areas of outstanding practice including:

- The trust had a Joint Emergency Therapies Team (JETT) and Older Persons Assessment and Liaison service (OPAL) which assessed all patients over the age of 75 with the view to prevent avoidable admissions.
- The hospital was named as one of the top hospitals in the 2015 CHKS awards, (CHKS is a provider of healthcare intelligence and quality improvement services), and was highly commended for patient experience. The CHKS awards commended the cancer care team, in the International Quality Improvement category, for their work.
- Investors in People awarded the gold standard to the Beacon Centre for oncology, one of only 7% of accredited organisations to win this.
- Colorectal Specialist Nurses had been trained to use clinically developed criteria and pathways to direct patients to the relevant test or clinic thus avoiding unnecessary steps or diagnostic procedures in the patient's pathway. This improved the speed of diagnosis for patients with suspected colorectal cancer.
- We saw the use of a number of initiatives to mitigate the risks identified as a direct result of previous low staffing levels and skill mix. These included; banked hours; clinical supervision; an on call system; the appointment of a Practice Educator and; the band five and six development programmes.
- Critical care participated in the Potential Donor Audit (PDA). PDA audit results for the reporting period April 2015 to September 2015 showed the trust as the best trust in the South West region for; approaching patients and, securing a good number of donors.
- A tracheostomy ward round, led by a consultant intensivist in collaboration with a nurse specialist for 'head and neck', took place daily to assess tracheostomy care and improve standards both in critical care and throughout the hospital.
- As part of the ABCDE assessment of new admissions to critical care, the team had added F (for family) to remind staff to communicate with the family about any concerns or worries they may have.
- Local safety projects were in place to highlight current incidents and areas of concern and included the 'take note project' and, 'raising standards project'.
- One of the midwives at the service had also recently won a MAFTA award for her innovative ideas. She had designed a fabric placenta as a teaching aid and designed the "smoke free buttons" located throughout the hospital, which when pressed plays a voice recording outside to remind patients and visitors of the smoke free message.
- The Marie Curie companion service is the only one currently in the country. It uses the innovative approach of using trained volunteers to help provide emotional comfort to patients. There was overwhelming praise from staff about this service and the report of the six-month review of the service showed positive feedback from family members. The service was shortlisted for the National End of Life Safer Patient Award in June 2015.
- In partnership with the complex care GPs and a neighbouring community NHS trust palliative care consultant team, the trust had made a successful bid to the Health Education South West to develop a health improvement programme between hospital

and community. The aim of the programme was to increase effective communication with regard to those who are dying. This project was ongoing at the time of inspection.

- The trust had an end of life poetry project. This was led by a staff member, whose aim was to help make colleagues comfortable with having difficult conversations with patients and their families.
- The orthotic department could facilitate the provision of prosthetic boots within 15 days following an appointment. This was considered an exceptional service as this could take several months in some areas.
- The trust e-referral advice and guidance system. This enabled GPs to discuss symptoms with a specialist consultant who would advise on the preferred treatment pathway, reducing the need for hospital attendance.
- The clinical support directorate clinical lead had undergone specialist training in change management to the implementation of seven day working.
- There was priority access to imaging services for trauma and patients suspected of having suffered a stroke.
- The outpatients department worked closely with the health community setting up testing hubs in general practitioner (GP) practices. Patients could have cardiac assessments and be fitted with a 24-hour tape. Results were transferred to MPH cardiology department. This meant that only those patients who needed to attend hospital would receive appointments.

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

Importantly, the trust must:

- Ensure all emergency lifesaving equipment, is sufficient and safe for use in all clinical areas and that there is evidence it has been checked in line with the trust policy.
- Medications were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons. The trust must ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.
- Ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department, critical care and children's ward.
- Ensure trained health care professionals triage all patients attending the emergency department within 15 minutes of arrival, and have systems in place to escalate and mitigate risks where this is not achieved.
- Ensure there are robust systems in place to assess, monitor, and mitigate risks to deteriorating patients in the emergency department.
- Emergency department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
- The hospital must improve the accuracy and timeliness of patient risk assessments. Delays present serious risks to patients who are deteriorating or seriously ill and could result in a delayed treatment.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- The medical staffing levels for the provision of advanced airway management, in the absence of the consultant, did not meet the Core Standards for Intensive Care 2013.

Summary of findings

- The registered provider must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units
- The obstetric anaesthetic staffing levels for the provision of emergency work on the delivery suite, did not meet the guidelines for Obstetric Anaesthetic Services 2013.
- Trained nurse staffing did not fully meet 'British Association of Perinatal Medicine Guidelines (2011).'(BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance. (Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.
- The children's service were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.
- The registered provider must ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- Ensure an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- Develop a comprehensive framework for governance, risk management and quality measurement for end of life care.

- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- The registered provider must ensure that staff in the emergency department and children, and young peoples services staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- The Registered Provider did not have proper processes in place to enable it to make the robust assessments required by the Fit and Proper Persons Requirement.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Taunton and Somerset NHS Foundation Trust

Taunton and Somerset (T&S) NHS Foundation Trust operate from the main acute hospital site, Musgrove Park Hospital. Musgrove Park Hospital, located in Taunton, is the largest acute hospital in Somerset and provides a range of acute medical services and specialist services.

There are four additional registered locations which provide radiology and outpatient services, these are Bridgwater Community Hospital, Chard, Minehead Hospital and West Mendip Community Hospital.

These locations were mainly run by another trust and the activity levels for Taunton and Somerset NHS Foundation Trust accounted for less than 4% of the overall activity as each site.

Services are provided to approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset.

At Musgrove Park Hospital there are 576 beds, of which 527 are general and acute inpatient beds and 12 critical care beds of which 6 are intensive care level 3 beds, and 6 are high dependency unit level 2 beds and 37 maternity beds.

In addition, there are two community midwife led bed at Bridgwater Hospital, there were not inspected at this inspection.

Taunton and Somerset NHS Foundation Trust is registered to provide the following Regulated Activities:

- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.

The trust employs 3690 whole time (WTE) equivalent staff.

Taunton and Somerset NHS Foundation Trust provide specialist and acute services to approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset.

Taunton Deane ranked 193/326 in 2013 Indices of deprivation. Two Health Profile indicators are significantly worse than England including incidents of malignant melanoma and hospital stays for self-harm, but are significantly better than England for obese children (year 6).

T&S provide specialist and acute services to approximately 538,000 people in Taunton Deane, Sedgemoor, Mendip, South Somerset and West Somerset.

Taunton and Somerset NHS Foundation Trust were inspected as one of 18 CQC new wave pilot inspections in September and October 2013, the trust was not rated at this inspection.

Our inspection team

Our inspection team was led by:

Chair: Jane Barratt, Chair Thames Valley Clinical Senate.

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: including a consultant anaesthetist, obstetrician, cardiologist and nurses, a midwife, a physiotherapist and student nurse.

We were also supported by an expert by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before our inspection, we reviewed a wide range of information about Taunton and Somerset NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, Monitor, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

The announced inspection took place between the 25 and 29 January 2016. We held focus groups with a range of staff in the hospital, including nurses, junior and middle grade doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists and occupational therapists prior to the inspection. We also spoke with staff individually.

We carried out an unannounced inspection to Musgrove Park Hospital on 9 February 2016. The purpose of the unannounced visits was to look at the care provided in the emergency department, medical wards, maternity and children's services.

We held an event for the public in Taunton on 21 January 2016 where members of the public shared their views and experiences of the trust. We also held focus groups with members of the public. Some people also shared their experiences of the trust with us by email and telephone.

What people who use the trust's services say

We received information from people prior to the inspection through our website.

This CQC Inpatient survey looked at the experiences of over 59,000 people who were admitted to an NHS hospital in 2014. Between September 2014 and January 2015, a questionnaire was sent to 850 recent inpatients at each trust. Responses were received from 451 patients at Taunton and Somerset NHS Foundation Trust. The survey placed the trust "about the same" as other trusts in all of the areas of questioning.

In the NHS Friends and Family Test, the trust were scoring consistently above the national average for patients who would recommend the hospital.

In the National Cancer Patient Experience Survey 2014, the trust scored in the top 20% of trusts in England for 12 of the 34 questions and in the bottom 20% for one area.

The patient-led assessments of the care environment (PLACE) programme are self-assessments undertaken by teams of NHS and private/independent healthcare providers, and include at least 50% members of the public (who are known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services, such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The PLACE results for 2013 -15 showed performance for all areas was either better than or about the same as the England average.

We held a listening event in Taunton, Somerset on 22 January 2016 where members of the public were able to share their views and experience of the trust with us. People mostly reported that care was excellent, but some feedback we received was often conflicting, depending on individual experience.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated the trust overall as requiring improvement to ensure that patients are protected from avoidable harm. We found that: • In the emergency department arrangements were not in place to ensure suitable care and treatment was provided to children and the care environment for children was not suitable. • Patients were not always triaged by clinical staff within 15 minutes in the emergency department, so was not in line with best practice. This applied to adults and children, delays in triage may affect timely delivery of treatment. • Medicines were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons. However, patients received their medicines when they were needed and there was an effective system in place to ensure medicines were available on discharge. • Staff mostly followed good infection control practices but not all clinical areas were clean and tidy. In some areas effective cleaning would not be possible due to aging and damaged estates and furniture. • There was insufficient evidence to demonstrate that resuscitation trolleys were checked in line with trust policy. On some trolleys, we found out of date equipment. • The environment at Musgrove Park Hospital was a mix of newly built units and aging departments and wards. This presented challenges in delivering care in units which met current guidelines. • Staff understood their responsibility to report incidents and there was mostly systems in place to ensure there was learning implemented. • Policies outlined the processes for safeguarding vulnerable adults and children. Staff followed specific guidelines and care pathways where concerns around safeguarding children and young people were identified.	**Requires improvement** 

- Staffing shortfalls for nurses had been addressed through the recruitment of over 100 overseas nurses. Processes were in place to ensure these nurses were inducted and supported in their role.

Duty of Candour

- The Duty of Candour regulation came into force in November 2014. It intends to ensure providers are open and transparent with patients and sets out specific requirements that providers must follow when things go wrong with care and treatment. These include informing people about the incident, providing reasonable support, providing truthful information and an apology.
- 'Duty of Candour' was integrated into the incident reporting and complaints processes. During the incident reporting process should an incident score greater than three (this is an amber rating) then the duty of candour box appeared on the incident form so that duty of candour could be applied to this incident.
- Whilst not all staff were familiar with the term 'Duty of Candour' there understood and recognised their responsibilities to be open with patients when things went wrong.
- New employees were given awareness of 'Duty of Candour' at the corporate essential learning element of their induction program.
- Candour, openness, honesty, transparency, and challenges to poor practice were evident.
- There was a policy and procedure available for staff to follow.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children.
- The trust had safeguarding leads for adults and children and staff knew where to contact them for guidance and advice.
- The trust target for staff completion of safeguarding adult and children's training was 90%.This was not always achieved, and the trust reported difficulties accessing level three children's safeguarding training. This had identified this as a risk on the women's and children's risk register.
- The annual adult safeguarding report for 2014/5 reported that safeguarding adults was a mandatory subject for induction and ongoing updates. For 2014/5 the mandatory training rate for safeguarding adults was 87%.
- Staff knew who to contact for safeguarding advice and we were given many examples of where staff had raised concerns.

Summary of findings

- The trust had recognised that access to face to face children's safeguarding level three training had been challenging. An eLearning programme had been in put in place to mitigate against staff having sufficient knowledge. The 2014 / 2015 annual child safeguarding report confirmed that 100% of staff who required this level of training had completed this training during 2014/2015.
- In April 2015, the Care Quality Commission carried out a review of health services for children looked after and safeguarding.
- The annual adult safeguarding report for 2014/15 identified key priorities for the coming year, this included reviewing policies, strengthening multi-agency working and learning from safeguarding investigations.
- The safeguarding committee met on a three monthly basis to monitor safeguarding activity, development work and monitor progress in relation to the Safeguarding and Learning Disability Action Plans.

Incidents

- The trust used an accessible electronic reporting system to report incident and near misses. Staff understood their responsibility to report incidents but in maternity services it was acknowledged that some commonly occurring incidents were not always reported.
- We saw many examples of learning from incidents. However, there had been two never events in surgery where it was found on both occasions that the five steps to safer surgery checklist had not been fully completed. Therefore, opportunities to check and stop the procedure before mistakes were made were potentially lost.

Staffing

- Over the past year the trust has recruited in excess of 100 nurses from overseas to fill gaps in nurse vacancies. A tailored induction, training and preceptorship programme had been put in place to support these staff. The recruitment of these staff had impacted positively on the amount of bank and agency staff use.
- There were systems in place to escalate any shortfalls in staffing levels. Most areas maintained staffing levels in accordance to staffing guidance part from children's' services which were below guidance levels, although the trust regarded the level of staffing as safe.

Summary of findings

Are services at this trust effective?

Good

We rated the trust overall as good in providing patients with effective care.

We found that:

- The trust had effective multidisciplinary working in place.
- Care and treatment was mostly provided in line with national guidance, where there were shortfalls in meeting recognised guidance the trust was aware of this and had plans in place to address this.
- The trust took part in local and national audits to assess patient outcomes and the quality of care. Results from these audits were mostly positive.
- There was effective multidisciplinary working evident throughout the trust between different departments and with partner agencies.
- Mental Capacity Act training rates were low although staff showed some awareness of the mental capacity act.This was being addressed but uptake for the eLearning training remained low.

Evidence based care and treatment

- Care and treatment was mostly provided in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Outcomes for patients were routinely collected and monitored, and were mostly positive.
- We found examples where the trust was not complying with recognised guidance, in these circumstances the trust was aware of the shortfalls and had plans in place to work towards compliance.
- The trust participated in a range of national and local audits.
- There was evidence of some seven day working particularly from diagnostic imaging and reporting.

Patient outcomes

- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The data showed that there was no evidence of elevated risk at this trust compared to other trusts.

Summary of findings

- A sepsis care pathway was put in place so staff could identify when to provide treatments in line with best practice guidelines. However, during our inspection this was not always used.
- The trust took part in local and national audits to assess patient outcomes and the quality of care. Results from these audits were mostly positive.
- Information about patients care and treatment and their outcomes were routinely collected and monitored. This information was used to improve patient care.

Multidisciplinary working

- The trust had effective multidisciplinary working in place. We saw effective discussions taking place to plan care that met patient's needs.
- Working groups to improve services contained multidisciplinary personnel so that all aspects could be considered.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- While staff mostly showed an awareness of the Mental Capacity Act 2005 training rates for staff were low. There was a plan to develop training programmes for the mental capacity act to improve the training rate. An eLearning package had been developed in November 2015 but the reported uptake was low.
- We observed positive interactions when staff obtained consent.
- The annual safeguarding adult report 2014/5 identified the priority to increase the training of senior staff in the use of the Mental Capacity Act 2005.
- The trust recognised that patients must be involved in DNACPR decisions and that it is best practice to involve families as well. However there was not always evidence of discussions taking place with patients, or reasons why it had not been discussed, with patients.
- Where patients lacked the capacity to make decisions for themselves we found that staff had not always assessed the capacity of patients before decisions were made in their best interests.

Are services at this trust caring?

Outstanding ☆

We rated the trust overall as Outstanding in providing care that provided respect and dignity to all patients in a compassionate manner.

We found that:

- We saw outstanding compassionate care particularly within the critical care and medicine wards.
- We saw a trust in which every member of staff cared for the patient and those close to them as individuals.
- We saw that care was provided in a compassionate way and that patients were involved in their treatment and care.
- National surveys supported that care was better than the national average.

Compassionate care

- The trust had good results in the Cancer Patient Experience Survey 2013/14 scoring in the top 20% of all trusts for 12 out of 34 selected questions, and bottom 20% for one out of 34 questions.
- The Friends and Family Test scores for the period July 2014 – July 2015, were consistently better than England average.
- The results for the CQC inpatient survey 2014 showed that the trust scored as a better performing trust in four out of 12 questions scored. The remaining eight questions were scored about the same as other trusts.
- Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff involved patients in their care and treatment and patients said staff ensured they understood what was happening to them.

Understanding and involvement of patients and those close to them

- The latest carers survey in December 2015 showed that patients and those close to them felt involved and supported by hospital staff. This survey also demonstrated that patients and their loved ones were involved prior to admission so that they felt that the hospital fully understood their own situation.
- Relatives or carers of patients were encouraged to continue the support and care they provided to patients in their own home.
- Open visiting had been introduced to allow patients to receive visitors at times which suited those close to them.

Emotional support

- The Marie Curie companion service is the only one currently in the country. It uses the innovative approach of using trained volunteers to help provide emotional comfort to patients. There was overwhelming praise from staff about this service and the report of the six-month review of the service showed positive feedback from family members. The service was shortlisted for the National End of Life Safer Patient Award in June 2015.

Summary of findings

- Staff were observed providing compassionate and supportive care to patients.

Are services at this trust responsive?

Good

We rated the trust overall as Good in being responsive to the needs of patients.

We found that:

- Patients were at the centre of the care provided. Specialist nursing staff were available to meet patients who required complex care.
- The trust had invested in specific areas of care to meet the needs of the growing elderly population.
- Services were planned in collaboration with Somerset Clinical Commissioning Group and the public.
- The service was tailored to the individual receiving care for instance we heard about a patient with a learning disability who needed surgery had specialised staff to follow them through the procedure to ensure that they felt safe and calm at all times.
- All staff were aware of their responsibility for providing care to patients living with dementia.
- The trust had an active chaplaincy service, to support patients' and relatives' individual spiritual and emotional needs.
- There were suitable systems in place to handle, and learn from complaints.

Service planning and delivery to meet the needs of local people

- The children and young people's areas department was not fully compliant with standards for 'Children and Young People in Emergency Care Settings 2012'.
- Bed management meetings were comprehensive and there was a dedicated patient flow team managing and responding to bed capacity.
- The acute medicine directorate had introduced new acute admissions services to meet the needs of local people and deal with increasing demand. This included the development of a unit consisting of ambulatory emergency care centre, a nurse-led medical day unit, an acute medical admissions unit and an Older Persons Assessment and Liaison (OPAL) unit.
- Services were planned in collaboration with Somerset Clinical Commissioning Group and the public.

Meeting people's individual needs

- There was a named part time nurse for patients with a learning disability. The nurse provided training, practical support advice for staff as well as getting involved in supporting patients with a learning disability. The type of support provided to patients included discharge planning, support to access services at the hospital and multi-agency care planning.
- There was a telephone translation service available which staff could readily access. Face to face interpreters could also be booked if required. For patients living with dementia or a learning disability communications passport were used to improve patient participation and involvement.
- The electronic patient record system had an alert flag to inform staff if a patient had a learning disability.
- Some dental clinics ran special session to provide care to patients with a learning disability.
- The trust had an active chaplaincy service, to support patients' and relatives' individual spiritual and emotional needs. The service had strong links and access to local faith leaders for patients of different religious beliefs, including Christians, Muslims, Sikhs and Buddhists, as well as providing support to non-religious patients.

Dementia

- The trust has a dementia strategy which has been agreed at board level. All staff were aware of their responsibility for providing care to patients living with dementia.
- The trust has a team of specialists who advise on the care of patients living with dementia. They ensure that staff have the right skills and work within positive culture to maintain the safety and dignity of patients living with dementia.
- The trust had changed the design of one ward to ensure that the risks to patients living with dementia were reduced.
- The team were trying to increase working with health and social care providers in the community to improve identification of patients living with dementia.
- The trust used a forget me not symbol to identify patients living with dementia.
- The trust monitored the delivery of dementia care services though a monthly metrix system which assessed a range of aspects relating to care delivery.
- There was a tiered system of dementia awareness training for staff dependent on their role. This allowed all staff to deliver care which met people's needs.
- There were a team of volunteers who worked with patients living with dementia.

Access and flow

Summary of findings

- Bed occupancy rates at the trust were consistently lower than the England average. The two winter periods 2014/15 saw the highest bed occupancy (82% and 85%); these figures were still lower than England average. However on discussion with the trust these figures did not present an accurate picture as the tally was taken at midnight each day and the figure included patient areas that were not utilised 24 hours each day. At inspection we found the trust reported capacity issues as demand had grown.
- There was a significant delay in discharges evident with data showing that 59% of all delayed transfers were a result of waiting for non – NHS acute care.
- The trust had a Joint Emergency Therapies Team (JETT) and Older Persons Assessment and Liaison service (OPAL) which assessed all patients over the age of 75 with the view to prevent avoidable admissions.
- The trust had worked with other stakeholders to ensure that they had beds available when an emergency accident occurred on the M5. This demonstrated that in times of need the trust and stakeholders worked together for the benefit of all patients.

Learning from complaints and concerns

- The trust had suitable arrangements for handling complaints. Staff understood the importance of listening to patients and their representatives and tried to resolve any concerns at the earliest opportunity.
- There were policies and procedures in place to guide staff on how to handle complaints.
- For the period 2014/15 there were 354 complaints received by the trust. This was an increase in number form the period 2013/14 but there was an overall trend of reducing complaints since 2011/12.
- Clinical staff were involved in investigating complaints and learning was cascaded within relevant directorates.

Are services at this trust well-led?

Good

We rated the trust leadership as good. We found that:

- The leadership, governance and culture are used to drive and improve the delivery of high quality person-centred care.
- The senior management team encouraged a culture which ensured that staff felt able to highlight improvements to services, either through lessons learnt from incidents or through staff feedback in an honest, open and supportive environment.
- The senior team were visible to staff at all levels.

Summary of findings

- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- The senior management team had an inspiring shared purpose in which patients were at the heart of the service.

Vision and strategy

- The trust had a clear set of values which were "To put our patients first by working as one team; leading and listening; and striving for the best. Together, we make the difference". These values were known to all staff and there was overall commitment by staff to these values.
- We saw that staff engrained these values into their everyday practice through sharing learning and driving improvement to provide outstanding patient care.
- The trust had a strategy in place in which they were working closer with the community to ensure a seamless transfer of care. This strategy was 2020 Joining up the dots. Significant steps had been taken by the trust to ensure that working relationships with the community were strong and that patients care were delivered in a one health care economy.
- The trust had recently considered the acquisition of Weston Area Health NHS Trust. However whilst this would have met the needs of people living across Somerset this would not ensure long term financial sustainability. Therefore the Trust Development Agency had concluded that this course of action was not in the best interests of either party.

Governance, risk management and quality measurement

- The trust had a clear governance and risk management structure and accountabilities for assurance were well defined. The trust board used various methods to gain ward to board assurance.
- During our inspection we attended part of the trust board meeting and reviewed the papers and agenda. We saw appropriate information was received by the board and that challenge was provided on significant issues. Discussions were held which were open and non-confrontational. The public part of the board meeting began with a patient's story which highlighted how the hospital staff worked with the local community to meet the needs of a patient with learning difficulties. The patients' story highlighted areas where the hospital staff had done well and areas for further development. Non-executive directors challenged the trust on steps to be taken in the future to improve access to hospital services.

Summary of findings

- The board received reports from the Governance Committee, Treasury and Investment committee and the council of Governors. We found that throughout the organisation staff were aware of the governance structure of the trust and could articulate the part they played in this.
- All of the senior team were able to articulate the top risks for the organisation and these were reflected on the corporate risk register. The corporate risk register identified that the top risk was financial followed by being unable to replace older estate, capacity, provision of some specialist services and the number of nursing vacancies. We also identified these as concerns as did the staff we spoke with.
- The director of patient care told us that the trust was working hard to recruit nursing staff. However there had been some issues with the overseas nurses recruited. The trust had been later than many trusts to go overseas and had sought the experiences of other trusts in establishing overseas nurses into the workforce. These lessons included language support and cultural support. Three practice development nurses were assigned to overseas nurses to ensure that they provided care in line with Taunton and Somerset's ethos and policies. She also informed us that the trust was currently reviewing the structure within nursing and so that managers were given more time to lead and develop staff.
- The trust was an early supporter of "Sign up to Safety." This is a national patient safety campaign which aims to make the NHS the safest health care system in the world. There were five areas of focus for the trust Sepsis, The care of the deteriorating patient, maternity quality improvement, learning for improvement and falls prevention. We saw evidence of different initiatives relating to these three areas during our inspection. For example, the trust had carried out improvement work relating to reducing falls. On Wordsworth Ward the ward manager had introduced a number of initiatives to reduce the risk of falls, including serving decaffeinated drinks after 4pm. We saw that the initiatives had reduced falls over time. Staff from other wards were now beginning to implement these initiatives to reduce falls in their area.
- We met with the medical governance lead who was able to demonstrate the commitment to improving services through audit and sharing lessons learnt. Activities undertaken by the trust to improve patient care included a hospital wide medical records audit, readmission audit, review of mortality meetings and incident investigation. The outcomes of these audits were shared with both local and trust wide teams so that improvements to patient care occurred. The medical director

sent out a Lesson of the Week document via email to all medical staff which covered the learning from audits and incidents. Because of the no blame culture engendered at the trust medical staff felt able to raise issues and to discuss incidents in order to improve care for patients. Re-audits were used to demonstrate improvements to care for example the re-audit of medical records showed improvement to the completeness of medical records.

- The trust were working closely with providers in the community and the chief executive worked closely with local GP's to undertake research and redefine pathways of care. The senior management team also worked closely with local authorities and had participated in the recruitment of the Director of Adult Social Services. This close working relationship was tested when a tanker overturned on the motorway and the hospital declared an internal incident since staff were severely delayed getting to work, even though there were no injuries involved. They worked closely with the council and other providers on this.

Leadership of the trust

- Although in part, a relatively new leadership team, all leaders displayed the skills, knowledge and experience to lead. This was demonstrated through the cohesive support from staff at all levels to fulfil the trusts values.
- The leadership team were cognisant of the challenges the organisation faces but were able to articulate actions to mitigate these.
- The leadership team were known to staff and were visible within the hospital. The senior management had recently moved from the outskirts of the hospital site to an older building nearer to the hospitals main buildings. This was to increase visibility and access. We saw and heard that this move had encouraged staff to drop into the management offices.

Culture within the trust

- From ward to board the values of the organisation were known and embedded. This led to the patients being the centre of the care they received. Examples of this can be seen within the caring and responsive domain where staff went the extra mile to meet the needs of individual patients.
- All staff were able to identify where improvements to care had been made. A significant proportion of staff were involved in some development and improvement activity. Initiatives led by senior members of staff were inclusive of junior members of staff.

- There was an open and learning culture within the organisation from ward to board. Staff were not afraid to raise issues or incidents so that others could share the learning from these. There was a tangible learning culture within the trust.
- Staff felt respected and valued for both the care that they offered to patients and through sharing their ideas for improvement. The chief executive had an open door policy which included an email address called 'Ask Sam'. Whilst initially staff used this email address to contact the chief executive contact in this manner had begun to reduce. Instead staff felt able to directly email the chief executive with ideas, issues and suggested service developments. Themes from this email were feedback to staff through newsletters and team briefs.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a new regulation that intends to make sure senior directors are of good character and have the right qualifications and experience.
- We found that processes had not all been followed to ensure fit and proper persons were in directors roles.
- We looked at the file of six directors. Directors had not all completed self declarations and some checks were not in place or had not been made in respect of changing roles. This included disclosure and barring service (DBS) checks.

Public engagement

- The hospital actively sought out the views of their patients and prospective patients. A recent survey went out to 10,000 members regarding improving the discharge process. The suggestions and comments from members were fed into the re design of the discharge process.
- The hospital had a significant number of volunteers who worked around the hospital. Many of these were patients who had or were receiving services. However a number were not. The hospital utilised these volunteers in a number of ways, directing patients and relatives around the hospital, assisting at meal times, working with patients living with dementia.
- The hospital also utilised Marie Curie companions to sit with and talk to patients at the end of their life. Patients and their relatives commented on the difference this had made to their care.
- The senior staff had requested feedback from a local school specialising in teaching people with learning disabilities. The feedback was generally positive in that their needs were met.

Summary of findings

Negative feedback included waiting times and directions around the hospital. The trust had plans to address this and had recently introduced a hospital map to assist people in finding their way around the buildings.

Staff engagement

- The senior team communicated to staff in a number of ways. They had introduced staff bulletins through which they informed staff of recent activities and future plans for the trust. They also communicated lessons learnt from incidents through this media.
- The trust has an improvement portal which staff can access to identify learning or development needs.
- Staff at all levels were involved in improvement projects.
- The trust undertook a quarterly staff pulse check which asked a number of questions of staff. The latest quarter's results Q2 2015/16 show that 75% of staff felt inspired by their leaders to do a good job. 64% of staff felt that the trust senior leaders acting in line with the trust values. Figures of 75 and 77% were recorded in respect of feeling valued and learning and improvement.
- There were seven negative findings for the trust on the NHS Staff Survey 2014 and one positive finding. The remaining 23 findings were within expectations. Negative findings included staff feeling secure when raising concerns about unsafe clinical practice, and suffering work related stress in the last 12 months.

Innovation, improvement and sustainability

- Whilst the trust currently had a reported surplus of £0.1 million for 2014/5, projections for the coming financial indicated that there was likely to be significant budget deficit. Staffs at all levels within the trust were aware of the budgetary projection and were concerned of what this meant for the trust. Monitor had appointed a 'turnaround director' to support the trust to improve the financial position.

Overview of ratings

Our ratings for Musgrove Park Hospital

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

Our ratings for Taunton and Somerset NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Outstanding	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had a Joint Emergency Therapies Team (JETT) and Older Persons Assessment and Liaison service (OPAL) which assessed all patients over the age of 75 with the view to prevent avoidable admissions.
- General Practitioners (GPS) worked in the emergency department. GPs supported management of patients in the ambulatory stream with primary care problems.
- The hospital was named as one of the top hospitals in the 2015 CHKS awards, (CHKS is a provider of healthcare intelligence and quality improvement services), and was highly commended for patient experience. The CHKS awards commended the cancer care team, in the International Quality Improvement category, for their work.
- Investors in People awarded the gold standard to the Beacon Centre for oncology, one of only 7% of accredited organisations to win this.
- Colorectal Specialist Nurses had been trained to use clinically developed criteria and pathways to direct patients to the relevant test or clinic thus avoiding unnecessary steps or diagnostic procedures in the patient's pathway. This improved the speed of diagnosis for patients with suspected colorectal cancer.
- We saw the use of a number of initiatives to mitigate the risks identified as a direct result of previous low staffing levels and skill mix. These included; banked Hours; clinical supervision; an on call system; the appointment of a Practice Educator and; the band five and six development programmes.
- Critical care participated in the Potential Donor Audit (PDA). PDA audit results for the reporting period April 2015 to September 2015 showed the trust as the best trust in the South West region for; approaching patients and, securing a good number of donors.
- A tracheostomy ward round, led by a consultant intensivist in collaboration with a nurse specialist for 'head and neck', took place daily to assess tracheostomy care and improve standards both in critical care and throughout the hospital.
- As part of the ABCDE assessment of new admissions to critical care, the team had added F (for family) to remind staff to communicate with the family about any concerns or worries they may have.
- Local safety projects were in place to highlight current incidents and areas of concern and included the 'take note project' and, 'raising standards project'.
- One of the midwives at the service had also recently won a MAFTA award for her innovative ideas. She had designed a fabric placenta as a teaching aid and designed the "smoke free buttons" located throughout the hospital, which when pressed plays a voice recording outside to remind patients and visitors of the smoke free message.
- Two paediatric consultants developed an App, whose aims was to develop a single care pathway from home through to community healthcare and into hospital. The app 'HANDI Taunton' was launched in March 2015 and provided parents with 'clear and concise advice' about the six common childhood illnesses. The conditions covered included, diarrhoea, chesty baby, chesty child, high temperature, abdominal pain and common new-born problems.
- The Marie Curie companion service is the only one currently in the country. It uses the innovative approach of using trained volunteers to help provide emotional comfort to patients. There was overwhelming praise from staff about this service and the report of the six-month review of the service showed positive feedback from family members. The service was shortlisted for the National End of Life Safer Patient Award in June 2015.
- In partnership with the complex care GPs and a neighbouring community NHS trust palliative care consultant team, the trust had made a successful bid to the Health Education South West to develop a health improvement programme between hospital and community. The aim of the programme was to increase effective communication with regard to those who are dying. This project was ongoing at the time of inspection.
- The trust had an end of life poetry project. This was led by a staff member, whose aim was to help make colleagues comfortable with having difficult conversations with patients and their families.

Outstanding practice and areas for improvement

- The orthotic department could facilitate the provision of prosthetic boots within 15 days following an appointment. This was considered an exceptional service as this could take several months in some areas.
- The trust e-referral advice and guidance system. This enabled GPs to discuss symptoms with a specialist consultant who would advise on the preferred treatment pathway, reducing the need for hospital attendance.
- The clinical support directorate clinical lead had undergone specialist training in change management to the implementation of seven day working.
- There was priority access to imaging services for trauma and patients suspected of having suffered a stroke.
- The outpatients department worked closely with the health community setting up testing hubs in general practitioner (GP) practices. Patients could have cardiac assessments and be fitted with a 24-hour tape. Results were transferred to MPH cardiology department. This meant that only those patients who needed to attend hospital would receive appointments.

Areas for improvement

Action the trust MUST take to improve

- Ensure all emergency lifesaving equipment, is sufficient and safe for use in all clinical areas and that there is evidence it has been checked in line with the trust policy.
- Medications were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons. The trust must ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.
- Ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department, critical care and children's ward.
- Ensure trained health care professionals triage all patients attending the emergency department within 15 minutes of arrival, and have systems in place to escalate and mitigate risks where this is not achieved.
- Ensure there are robust systems in place to assess, monitor, and mitigate risks to deteriorating patients in the emergency department.
- Emergency department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
- The hospital must improve the accuracy and timeliness of patient risk assessments. Delays present serious risks to patients who are deteriorating or seriously ill and could result in a delayed treatment.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- The medical staffing levels for the provision of advanced airway management, in the absence of the consultant, did not meet the Core Standards for Intensive Care 2013.
- The registered provider must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units
- The obstetric anaesthetic staffing levels for the provision of emergency work on the delivery suite, did not meet the guidelines for Obstetric Anaesthetic Services 2013.

Outstanding practice and areas for improvement

- Trained nurse staffing did not fully meet 'British Association of Perinatal Medicine Guidelines (2011).'(BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance. (Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.
- The children's service were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.
- The registered provider must ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- Ensure an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- Develop a comprehensive framework for governance, risk management and quality measurement for end of life care.
- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- The registered provider must ensure that staff in the emergency department and children, and young peoples services staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- Ensure all emergency lifesaving equipment, is sufficient and safe for use in all clinical areas and that there is evidence it has been checked in line with the trust policy.
- Medications were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons. The trust must ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.
- Ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department, critical care and children's ward.

Outstanding practice and areas for improvement

- Ensure trained health care professionals triage all patients attending the emergency department within 15 minutes of arrival, and have systems in place to escalate and mitigate risks where this is not achieved.
- Ensure there are robust systems in place to assess, monitor, and mitigate risks to deteriorating patients in the emergency department.
- Emergency department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
- The hospital must improve the accuracy and timeliness of patient risk assessments. Delays present serious risks to patients who are deteriorating or seriously ill and could result in a delayed treatment.
- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed anddocumented for every patient undergoing a surgical procedure.
- The medical staffing levels for the provision of advanced airway management, in the absence of the consultant, did not meet the Core Standards for Intensive Care 2013.
- The registered provider must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units
- The obstetric anaesthetic staffing levels for the provision of emergency work on the delivery suite, did not meet the guidelines for Obstetric Anaesthetic Services 2013.
- Trained nurse staffing did not fully meet 'British Association of Perinatal Medicine Guidelines (2011).'(BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- Staffing within the children's service, although currently considered as being safe by the senior management, and reflecting both occupancy rates and the fluctuating number of children as inpatients, were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they had two less staff per shift than recommended by national guidance. (Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.
- The children's service were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.
- The registered provider must ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- Ensure an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- Develop a comprehensive framework for governance, risk management and quality measurement for end of life care.

- The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3).
- The registered provider must ensure that staff in the emergency department and children, and young peoples services staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.

Outstanding practice and areas for improvement

- The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure.
- When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.
- The Registered Provider did not have proper processes in place to enable it to make the robust assessments required by the Fit and Proper Persons Requirement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2)(a)** Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment. **How the regulation was not being met:** • Ensure trained health care professionals triage all patients attending the emergency department within 15 minutes of arrival, and have systems in place to escalate and mitigate risks where this is not achieved. • There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients, this must be addressed. • The trust must take action to ensure that the WHO five steps to safer surgery checklist are completed and documented for every patient undergoing a surgical procedure. • The trust should ensure DNACPR decisions are recorded in line with trust policy. **Regulation 12(2)(c)** Care and treatment must be provided in a safe way for service users by ensuring the persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. **How the regulation was not being met:** • The trust must ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department, critical care and children's ward.

This section is primarily information for the provider

Requirement notices

- Ensure staffing meets national guidance in in the children's service, neonatal service and obstetric service.

Regulation 12(2)(e)

The registered person must ensure care and treatment is provided in a safe way.

How the regulation was not being met:

- The registered provider must ensure the resuscitation trolleys, neonatal transport systems, and emergency and lifesaving equipment are checked, properly maintained and fit for purpose in all clinical areas.

Regulation 12(2)(g)

Care and treatment must be provided in a safe way for service users by the proper and safe management of medicines.

How the regulation was not being met:

- Medications were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons. The trust must ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
- Fridge temperatures were monitored and recorded, but these were not completed consistently which could impact on the optimum storage conditions of medicines.

Regulation 12(2)(h)

Assessing the risk to the health and safety of service users of receiving the care or treatment.

How the regulation was not being met:

- Staff did not always assess and document patient risk in a timely manner, this could result in a delay to treatment.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(b)** System or processes must be established and operated effectively to assess, monitor and mitigate the risk relating to health, safety and welfare of service users **How the regulation was not being met:** Emergency department leaders were not aware of all of the current risks affecting the department and the delivery of safe care. Risks identified during the inspection such as no paediatric nurses working in the department and the environment had not been assessed or placed on the department risk register.
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1)** Sufficient numbers of suitably qualified, competent and skilled persons must be deployed. **How the regulation was not being met:** • The medical staffing levels for the provision of advanced airway management, in the absence of the consultant, did not meet the Core Standards for Intensive Care 2013. • The obstetric anaesthetic staffing levels for the provision of emergency work on the delivery suite, did not meet the guidelines for Obstetric Anaesthetic Services 2013. • The trust must ensure that staffing within the children's service meets Royal College of Nursing (RCN) (2013) guidance. • Staffing within the children's service, although currently considered as being safe by the senior

Requirement notices

management were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance because they said they had two less staff per shift than recommended by national guidance.

- Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.
- Trained nurse staffing did not fully meet 'British Association of Perinatal Medicine Guidelines (2011).'(BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- The service were not compliant against the 'Facing the Future' standards because of a lack of permanent consultant cover between 5pm – 10pm. The trust identified that in accordance with 'Facing the Future 2015' funding had been secured to provide additional senior paediatric consultant cover until later evenings (5pm until 10pm) to match periods of highest activity.
- Full funding for the paediatric high dependency unit (HDU) was not available which had affected the numbers of staff employed to provide this part of the service.

Regulation 18(2)(a)

Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise.

How the regulation was not being met:

- The registered provider must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.

This section is primarily information for the provider

Requirement notices

- The registered provider must ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13(2)(3)** The registered person must ensure service users are protected from abuse and improper treatment. **How the regulation was not being met:** • The registered provider must ensure that clinical staff who have direct contact with children and young people have completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3). • The registered provider must ensure that staff in the emergency department and children, and young peoples services staff are suitably trained to have the skills and knowledge to identify and report suspected abuse.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(c)** The registered person must ensure effective governance, including assurance and auditing systems or processes.

This section is primarily information for the provider

Requirement notices

The registered person must ensure that an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1)** • When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. • Ensure that appropriate systems are in place to ensure that DNACPR decisions for patients who lacked capacity were made in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 (1)** - Be of good character - Have the qualifications, competence, skills and experience which are necessary for the work to be performed, and; - Be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic for the work they are employed. **How the regulation was not being met:** The Registered Provider did not have proper processes in place to enable it to make the robust assessments required by the Fit and Proper Persons Requirement.