University Hospitals Bristol NHS Foundation Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected University Hospitals Bristol Main Site as part of our comprehensive inspections programme of all NHS acute trusts.

The inspection was announced and took place between 22 and 24 November 2016. We also inspected the hospital on an unannounced basis on 1 December 2016.

We rated the trust as outstanding overall. The effective and well led key questions were rated as outstanding; safety and caring was rated as good; and the responsiveness of the hospital was rated as requires improvement. Surgery was rated as outstanding and all other services were rated as good.

Our key findings were as follows:

The trust had taken clear action to make improvements since our last inspection, not only in areas idenfied for improvement, but those identified as strengths. There was a strong safety culture across the trust in which staff were engaged. Patients reported that care was delivered to a consistently high level and that staff were caring and compassionate across the trust. Surgery services had consistently very positive feedback, with high response levels to the Friends and Family test and 98% of patients saying they would recommend the service. Services were well led at a service level through to trust board level.

Safe:

- We rated safety in the hospital as good, and found safety was good in all the services we inspected.
- Openness and transparency about safety was embedded in the services we inspected. Learning opportunities were identified and shared with staff within their own area and across the trust to support improved safety, and led to changes in practice.
- There was clear oversight at board level of incidents and their investigations with learning shared across the organisation.
- When things went wrong patients were provided with a timely apology and support. The majority of staff understood their responsibilities under the Duty of Candour requirement and could provide examples when they had been used.
- Innovation was encouraged, such as SHINE in the emergency department, which provided staff with a simple checklist to ensure patient-safety based actions were completed. Since its introduction there had been no incidents of a deteriorating patient not being identified and then managed.
- Wards and departments appeared visibly clean. A thorough cleaning programme was in place across the hospital and staff were observed using personal protective equipment to prevent infection. Staff were seen to use hand sanitising gel prior to providing care and treatment to patients. Clear signage was not always in place to advice patients, visitors and staff to wash their hands when entering ward areas.
- Medicines managed safely and effectively in the services we inspected. Learning was evidenced from incidents relating to medicines, and medicines administration records were fully completed. However, on two medical wards a number of creams and treatments were stored in the ward sluice, and were not secure.
- Nurse and medical staffing levels met national and local guidelines and planned to ensure safe care, and agency staff were only used when required to cover increased demand and vacancies. There were effective handovers and shift changes, to ensure staff can manage risks to patients who use services.
- Consultant cover in the emergency department did not meet the 16-hours on-site standard and was reduced significantly at weekends. However, junior doctors felt well supported and both the local management team and trust executives were aware of this concern and had actions ongoing to improve the levels of cover.
- Staff understood their safeguarding responsibilities. Staff were aware of local procedures and knew what to do if they had a concern. In surgery we found examples were staff had taken steps to prevent abuse from occurring and responding to signs of abuse by working with the safeguarding team and local authority to ensure patients were protected. There was lack of clarity around the correct processes to safeguard children between the ages of 16 and 18 years in the surgical trauma assessment unit. There were concerns in this unit around the levels of safeguarding training provided to staff working overnight.

Summary of findings

- Staff carried out comprehensive risk assessments for patients and developed management plans to ensure risks to patients' safety were monitored and maintained. The World Health Organisation surgical safety checklist was utilised effectively to keep patients safe. However, the environment for patients on the oncology ward presented a potential risk to the safety of patients who may be confused or could not maintain their own safety.
- Systems to ensure patients' information was kept safe were not always implemented. Records were found to not be stored securely which could cause a potential breach of patients' confidentiality in the emergency department, outpatients departments and on medical wards.
- Mandatory training compliance for nursing and medical staff across the services we inspected were below the hospitals target, including fire, resuscitation and safeguarding training for medical staff. Receptionists in the emergency department had not received any training or guidance to help them identify potentially seriously unwell patients.
- Chemicals were not always stored securely within the emergency department or on some wards.

Effective:

- We rated the effectiveness of services within the hospital as outstanding. Urgent and emergency services were rated as outstanding, and medical care and surgery were rated as good. We do not currently rate the effectiveness of outpatients and diagnostic imaging.
- There was a truly holistic approach to planning people's discharge or transfer to other services, and this was done at the earliest stage. The safe use of innovative approaches to care and how care was delivered was actively encouraged. Patients had comprehensive assessments of their needs, which include consideration of clinical needs, including both mental and physical health and wellbeing, nutrition and hydration needs.
- We found there was a high level of multidisciplinary working and people received care from a range of different staff, teams or services, in a coordinated way. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Patients' care and treatment was planned in line with current evidence based guidance. Clinical care pathways were developed in accordance with national guidelines. Trust policies included reference to NICE guidance and other national strategies. However, the diagnostic imaging service did not always ensure it met best practice clinical guidance for report turnaround time for medical staff requesting diagnostic imaging to be carried out.
- Patients received care from different teams who worked together to coordinate care. We observed board rounds taking place on wards, which demonstrated effective multi-disciplinary working. For some wards complex discharges were daily occurrences. A multidisciplinary audit programme was in place and actively used by staff to encourage and monitor improved outcomes. There were links with GPs and community providers to ensure safe patient discharge.
- Staff were actively engaged in activities to monitor and improve quality and outcomes, including benchmarking and peer review. The hospital achieved good patient outcomes and delivered effective care in the emergency department and medical wards. Mortality rates were better than the England average in all audits we reviewed. A programme of local and national audits was used to monitor care and treatment. Some areas showed improvements, including the national stroke audit and national emergency laparotomy audit. In outpatient departments clinics were benchmarked against each other and actions put in place to improve outcomes. Outcomes for people who used the surgical services were mixed. The trust performed well in the bowel cancer audit and the oesophago-gastric cancer national audit. However, results were not always in line with the national scores. For example, in some aspects of the hip fracture audit, although the numbers of were relatively lower than other centres.
- Innovative approaches were used to deliver care. This included simple solutions such as a touchscreen guideline system in the emergency department resuscitation area, and the close working relationships with external partners to deliver alternative care pathways and admission avoidance programmes. The SHINE patient safety assessment tool had driven significant improvements and clearly demonstrated improved outcomes.

Summary of findings

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- Not all staff had received an appraisal in the last year, with particular low compliance in the ancillary staff group. Without an appraisal, learning needs may not be identified and a plan put in place to support staff to develop their practice.

Caring:

- Overall, caring within the hospital was rated as good. Surgery was rated as outstanding for caring and all other services we inspected were rated as good. We spoke with in excess of 200 patients and their relatives during our inspection and collected a large number of comment cards from 90 wards and clinics across the trust.
- Patients and their families praised the staff for their kindness and compassion. Patients told us they had been treated with dignity and respect at all times by staff who were respectful and caring. Within surgery services, feedback from patients and those close to them were continually very positive about the way staff treated people with no negative comments. We were given multiple examples where staff had gone the extra mile and where care received exceeded patients' expectations.
- Staff often went out of their way to meet the emotional and physical needs of patients. It was clear they had taken the time to get to know and understand their patients. Staff took the time to ensure patients were comfortable, responding compassionately to patients in pain or distress and giving reassurance and support.
- We observed doctors and nurses introducing themselves when they met patients and their families for the first time. Patients in the emergency department were addressed by their preferred name.
- Patients and those close to them were treated as partners in their care and supported to make informed decisions about their care and treatment. We saw examples where relatives and carers were included as part of the care provided for both physical and emotional wellbeing. In outpatient departments staff talked about patients compassionately with knowledge of their circumstances and those of their families. Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible.
- We saw staff from all groups assisting patients and others who were confused or lost in the emergency department in a helpful and supportive manner. One doctor was seen helping a patient to the toilet.
- Staff in the emergency department had received lots of positive feedback about the compassionate care provided in the form of cards and letters, and these were displayed in the staff room.
- Patients' privacy and dignity was respected and staff sought permission before carrying out care and treatment in all the services we inspected. In the emergency department staff used curtains around the bed spaces to provide privacy when assessing and treating patients, and ensured patients' dignity was maintained when curtains were opened. Patients in the corridor, however, did not have the same provision to ensure their privacy. Staff did their best to ensure confidentiality and privacy in the corridor by keeping conversations as quiet as possible, but because of the close proximity of other patients and relatives conversations could still be overheard.

Responsive:

- Overall, improvements were required to ensure that services within the hospital were responsive to patients' needs. We rated the responsiveness of services within the hospital as requires improvement. Urgent and emergency services was rated as requires improvement. However, surgery, medical care and outpatients and diagnostic imaging were rated as good.
- Access and flow was an issue within the hospital. The hospital was consistently failing to meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of their arrival at the emergency department. The emergency department suffered from regular crowding, and this was cited as the department's greatest risk. Patients spent longer in the emergency department compared to the England average.
- However, there was significant engagement across the trust, and at all levels, with commissioners and partners to address system-wide flow issues and introduce innovative methods to improve patient flow.

Summary of findings

- Escalation procedures were well embedded and worked effectively with minimal impact on patient care.
- Waiting times, delays and cancellations were minimal and managed.
- Referral to treatment times for different specialties within the medicine division were not all within the England targets. Within surgery referral to treatment standards were being met 92% of the time. Where there had been a slip in performance there were clear actions to address these which had been proven to be effective. In the outpatients department referral to treatment standard were worse than the national average.
- Processes to ensure patients who were medically fit to leave the hospital were not always effective. However, in the majority of cases, reasons for discharge delays were not attributable to the hospital.
- We found that medical and surgical services were planned and delivered in a way that met the needs of local patients. The hospital offered choice and flexibility to patients and provided continuity of care. New clinics, services and virtual facilities were implemented, to ensure services met patients' needs. However, sometimes incurred delays due to issues elsewhere.
- The medical wards were creative to ensure patient flow through the hospital was maintained and was responsive to the ever-changing demand. There was a constant oversight by senior staff, of how different departments were managing flow, to ensure staff across all areas of the hospital prioritised patient safety, whilst maintaining the flow of patients through the hospital.
- The flow of patients through the medical division was monitored and actions taken to minimise the numbers of patients being cared for on wards other than those related to their medical condition/specialty. These patients were known as medical outliers. The hospital ensured outlying patients received the care and input from nursing and medical staff, relevant to their medical condition/specialty.
- The radiology department was slightly below the national standard of 90% of patients referred by the cancer referral process to be seen within two weeks. However; the diagnostic and imaging department was above the national average for the percentage of patients seen within six weeks.
- Patients were not always able to locate the outpatients and diagnostic imaging departments because they were not clearly signposted. A wide selection of information leaflets were available to patients; however, they were not available in other languages.
- The parking facilities did not always meet the demand leaving patients unable to find a space in a timely manner.
- There was good support for patients living with dementia or learning difficulties, and translation services were available for patients whose first language was not English. Reasonable adjustments were made for people living with dementia or with learning difficulties including use of the 'this is me' document and access to activities for stimulation. There were access to dedicated teams for dementia, learning disabilities and psychology which were always available.
- In response to the last inspection and feedback from patients, each outpatient department had introduced waiting time boards which displayed the waiting times for each clinic for that day.

Well led:

- We rated the well led domain as outstanding. Urgent and emergency services and surgery were rated as outstanding and medical care and outpatients and diagnostic imaging were rated as good. Services were well led at an individual service level through the organisation to a trust board level.
- The leadership, governance and culture promoted the delivery of high-quality person centred care. There was a clear statement of vision and values within the trust which was driven by quality and safety. We found clear statements of vision and values for medical care, surgery, and outpatients and diagnostic imaging, which were driven by safety and quality. The strategies and supporting objectives were stretching, challenging and innovative whilst remaining achievable. However, an emergency department strategy had not yet been drafted and agreed, although there were programmes of work underway which showed progress towards achieving the department's vision.
- Alongside the overarching trust strategy a clinical strategy had been developed, which was patient centred. This was ambitious and had clear standards for a high level of patient care.

Summary of findings

- Staff understood the vision and strategy and their role in in delivering it. They were proud to work for the hospital and patient focused. Staff demonstrated a kind culture, both to patients and relatives, and to each other.
- Given the size of the organisation governance structures were complex. However, the board and other levels of governance within the hospital functioned effectively and interacted well. There was excellent oversight of risks and issues at board level and challenge was effective and supportive. Governance processes had been reviewed and there was a focus on continual improvement and development to ensure that processes were robust.
- Staff told us their responsibilities were clear and quality, performance and risks were understood and managed. Risks were escalated when needed and the information communicated to the hospital board flowed well. Processes were in place to monitor, address and manage current and future risk. Performance issues and concerns were escalated to the relevant committees and board. There was a continued focus and drive to improve safety and quality through excellent governance and leadership.
- Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture and to motivate staff to succeed. Leadership and culture were intrinsically linked within the trust. Leaders understood the challenges to good quality care within and outside the organisation, and there were collaborative relationships with stakeholders.
- Staff felt leadership was good and divisional lead staff were accessible. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement. Leaders and staff demonstrated the participation and involvement of patients who used the service was important to them.
- Staff were proud of the organisation as a place to work and spoke highly of the culture. There were high levels of constructive engagement with staff. Where there had been a poor culture identified innovative and effective actions were put into place to resolve them.
- Innovative approaches were encouraged and supported, and these had a clear focus on patient safety, quality and performance, from staff led forums to improve the efficiency of work streams to research in pioneering research techniques. Changes were monitored effectively to evidence the improvements to patient care the changes had.
- Leaders demonstrated a drive for continuous learning and improvement through the ongoing evaluation and monitoring of the service and by delivering projects and innovative developments aligned to this.
- The management and governance of current performance of staff mandatory training did not ensure all staff were fully training. For medical staff, this included fire, safeguarding and resuscitation training.
- The medical division had recognised a risk in the acute oncology service at night, concerning both staffing levels and a lack of suitably skilled triage staff. However, sufficient action was required to minimise the risk to patients in both the service provision and staffing provision.

We saw several areas of outstanding practice including:

- In times of crowding the emergency department was able to call upon pre-identified nursing staff from the wards to work in the department. This enabled nurses to be released to safely manage patients queueing in the corridor.
- The audit programme in the emergency department was comprehensive, all-inclusive and had a clear patient safety and quality focus.
- New starters in the emergency department received a comprehensive, structured induction and orientation programme, overseen by a clinical nurse educator and practice development nurse. This provided new staff with an exceptionally good understanding of their role in the department and ensured they were able to perform their role safely and effectively.
- In the emergency department the commitment from all staff to cleaning equipment was commendable.
- The comprehensive register of equipment in the emergency department and associated competencies were exceptional.
- Staff in the teenagers and young adult cancer service continually developed the service, and sought funding and support from charities and organisations, in order to make demonstrable improvements to the quality of the service and to the lives of patients diagnosed with cancer. They had worked collaboratively on a number of initiatives. One such project spanned a five year

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period ending May 2015 for which some of the initiatives were ongoing. The project involved input from patients, their families and social networks, and healthcare professionals involved in their care. It focused on key areas which included: psychological support, physical wellbeing, work/employment, and the needs of those in a patients' network.

- The use of technology and engagement techniques to have a positive influence on the culture of an area within the hospital. There were clear defined improvements in the last 12 months in Hey Groves Theatres.
- The governance processes across the trust to ensure risks and performance were managed.
- The challenging objectives and patient focused strategy used to proactively develop the quality and the safety of the trust.
- The use of real time feedback from staff via the 'happy app' to improve and take action swiftly in areas where staff morale is lower.
- The focus on the leadership development at all levels in order to support the culture and development of the trust.
- The use of innovation and research to improve patient outcomes and reduce length of stay. The use of a discrete flagging system to highlight those patients who had additional needs. In particular those patients who were diabetic or required transport to ensure they were offered food and drink.
- The introduction of IMAS modelling in radiology to assess and meet future demand and capacity.
- The use of in-house staff to maintain and repair radiology equipment to reduce equipment down time and expenses.
- The introduction of a drop in chest pain clinic to improve patient attendance.

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

- Ensure all medicines are stored correctly in medical wards, particularly those which were observed in dirty utility rooms.
- Ensure records in the medical wards and in outpatient departments are stored securely to prevent unauthorised access and to protect patient confidentiality.
- Ensure all staff are up to date with mandatory training.
- Ensure non-ionising radiation premises in particular Magnetic Resonance Imaging (MRI) scanners restrict access.

In addition the trust should:

- Ensure chemicals are stored securely at all times in the emergency department and on medical wards.
- Ensure checks of the equipment in the emergency department's resuscitation area are recorded consistently.
- Ensure patients in the emergency department have access to call bells at all times.
- Ensure reception staff are able to recognise patients who attend the emergency department with serious conditions need urgent referral to the triage nurse and provide a formalised process for summoning help.
- Continue working towards providing 16-hours on-site consultant cover in the emergency department, and increase consultant cover at the weekend.
- Ensure the emergency department is accessible to wheelchair users and the layout of the reception desk allows staff to interact with wheelchair users whilst sat at the desk.
- Ensure the emergency department develops and formalises its vision and strategy.
- Ensure staff in the emergency department are up-to-date with their mandatory training, including safeguarding adults and children.
- Work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.
- Ensure all staff working in the emergency department and medical staff receive an annual appraisal.
- Ensure clear signage and equipment is in place for staff, patients and visitors to wash their hands when entering a medical ward area.
- Ensure the environment in the oncology department and ward keeps patients safe and comfortable, especially for patients who may be confused or cannot maintain their own safety.
- Ensure access to the staff room on the medical assessment does not allow access to unauthorised people.
- Take remedial maintenance action to ensure the heating system on ward D703 maintains a suitable and safe temperature for staff and patients.

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- Ensure staff have a greater understanding and awareness of the intercom system on the Hepatology ward, to ensure safe and prompt access to the ward and confidentiality of patient information.
- Ensure medical doctors' inductions are undertaken in scheduled blocks and planned so doctors do not start work on the wards without an induction.
- Ensure clear signage and equipment is in place on medical wards to advice staff, patients and visitors to wash their hands when entering a ward area.
- Ensure delays in take home medicines does not delay patients.
- Ensure medical records are legibly and fully completed. This includes patient risk assessments.
- Audit records in the cardiac catheter laboratory to ensure they are fully complaint with the World Health Organisation surgical safety checklist for all surgical procedures.
- Address the risk in the acute oncology service where patients may be placed at risk by reduced staffing levels at night due to admissions of emergency oncology patients. There should be suitably skilled staff in place at night to ensure safe triage advice is given to patients accessing the emergency oncology service. Whilst the trust recognised these risks, sufficient action should be taken to minimise the risk to patients in both the service provision and staffing provision.
- Ensure pain audits are established to monitor if pain was managed effectively for patients with an ability to express their pain.
- Continue to monitor staff's use of the Abbey Pain Scale to ensure patients with cognitive impairment in the specialised services division have an effective tool to assess their pain needs.
- Continue to ensure all efforts be made to maintain flow through the hospital and patients be nursed on the correct wards to meet their needs.
- Reduce the risk on the hepatology ward in relation to lone working practices, when accompanying patients off the ward at night to smoke.
- Improve the level of safeguarding training for staff working overnight in the surgical trauma assessment unit.
- Improve compliance for mandatory training in surgical areas.
- Improve patient outcomes to bring them in line with the national average for the hip fracture audit and improve the National Emergency Laparotomy Audit.
- Ensure patients within all of the diagnostic imaging waiting rooms can be monitored by staff.
- Monitor the World Health Organisation (WHO) Surgical Safety Checklist is always used in the appropriate area as a checklist when carrying out non-surgical interventional radiology.
- Provide leaflets within outpatient departments are available in different languages
- Check local and national diagnostic reference levels (DRLs) are on display as stated in Regulation 4(3)(c) of IR(ME)R 2000 and IR(ME) amendment regulations 2006 and 2011.
- Make improvements on the follow up backlog waiting list to meet people's needs and minimise risk and harm caused to patients through excessive waits on follow up of outpatient appointments andthe reporting of images.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to University Hospitals Bristol NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust comprises eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008.

The trust had 899 beds and employed 7,745 full time equivalent staff. In the financial year 2015/16, the trust had an income of £599.2 million and costs of £596.7 million, meaning it had a surplus of £3.5million for the financial year. This was the 13th successive year of reported surplus for the trust. The trust predicted it would have a surplus of £16million in 2016/17.

The trust provided services to three distinct populations. Acute and emergency services were provided to the local population of around 450,000 in south and central Bristol. Specialist regional services were provided across the region from Cornwall to Gloucestershire. Specialist services were also provided across the whole of the South West, South Wales and beyond.

The 2015 Indices of Deprivation showed that Bristol was the 77th most deprived local authority out of 326 local authorities. Life expectancy for men, at 78.4 years, was slightly lower than the England average of 79.5 years. Life expectancy for women, at 82.9 years, was very slightly lower than the England average of 83.2 years. Bristol was significantly worse than the England average for the proportion of children living in poverty, levels of violent crime, and educational attainment. However, Bristol was better than the national average for England for the proportion of children living in households with long-term unemployment. There were significant variations in levels of deprivation within the city of Bristol and there were areas of prosperity within the city and the immediate surrounding area. Census information showed that 16% of Bristol's population was non-white, with 6% declaring their ethnic origin as Black, 5.5% as Asian and 3.6% as mixed race.

This inspection was a follow up to our inspection in September 2014, when the trust was rated as requires improvement overall. We focused this inspection on services rated as requires improvement: surgery; medical care; and outpatients and diagnostics. We also inspected urgent and emergency care, although it was rated as good in the inspection in 2014, because national problems in accident and emergency departments and frequent ambulance queues at the Bristol Royal Infirmary were a cause for concern. We inspected the following hospitals as part of this inspection:

- Bristol Royal Infirmary
- Bristol Heart Institute
- Bristol Oncology and Haematology Centre
- Bristol Eye Hospital
- The University of Bristol School of Oral & Dental Sciences

Our inspection was carried out in two parts: the announced visit, which took place on 22, 23, and 24 November 2016; and the unannounced visit, which took place on 1 December 2016.

Our inspection team

Our inspection team was led by:

Chair: Andrew Welch, Medical Director, Newcastle Upon Tyne Hospitals NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists including: accident and emergency nurse; accident and emergency doctor; medical nurse team leader; medical doctor; theatre nurse specialist, surgical doctor; surgery nurse team leader; medicine nurse; outpatients nurse team leader; radiographer; two experts by experience and a board level director.

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How we carried out this inspection

We carried out the announced part of our inspection between 22 and 24 November 2016 and returned to visit some wards and departments unannounced on 1 December 2016.

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

Prior to the inspection we obtained feedback and overviews of the trust performance from local Clinical Commissioning Groups and NHS Improvement.

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

What people who use the trust's services say

We spoke with over 200 patients and relatives during our inspection. All were overwhelmingly positive about the care and treatment they had received. Patients told us they had received compassionate and sensitive treatment and care by staff.

Patients on wards we spoke with were consistently positive about how staff interacted with them. Patients we spoke with said they made sure people's privacy and dignity were always respected, including during physical or intimate care.

When patients experienced physical pain, discomfort or emotional distress, we saw staff responded with kindness and compassion in a timely way. Patients said their needs were responded to in time and with good care.

Patients told us they felt involved in the decisions about their care, and relatives told us they were kept informed and updated with any changes to their relatives care.

We spoke with a patient and family who told us how the staff had tried to ensure they were treated by the same medical team as their admission several years earlier, in order to provide consistency of care.

Facts and data about this trust

University Hospitals Bristol NHS Foundation Trust comprises eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008.

The trust had 899 beds and employed 7,745 full time equivalent staff. In the financial year 2015/16, the trust had an income of £599.2 million and costs of £596.7 million, meaning it had a surplus of £3.5million for the financial year. This was the 13th successive year of reported surplus for the trust. The trust predicted it would have a surplus of £16million in 2016/17.

The trust provided services to three distinct populations. Acute and emergency services were provided to the local population of around 450,000 in south and central Bristol. Specialist regional services were provided across the region from Cornwall to Gloucestershire, into South Wales and beyond.

Between August 2015 and August 2016 there were 129,694 attendances at the emergency department.

Between September 2015 and August 2016 there were 139,486 inpatient admissions, and between July 2015 and June 2016 there were 712,591 outpatient appointments.

The trust had a stable board, with the most recent executive appointments being the director of strategy and transformation in 2016. The chief executive had been in post since 2010. The eight non-executive directors had also been appointed with most having been in post for at

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least three years. At the time of our inspection the chief executive was leading the work for the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan.

Inspection History:

This is the twelfth inspection of the trust since it was registered with the commission in 2010. In September 2014 we carried out an announced comprehensive review of the trust and all locations, and closed down all outstanding compliance actions. We rated the trust as requires improvement overall. Urgent and emergency care, critical car, maternity and family planning, services for children and young people, and end of life care were all rated as good. Medical care, surgery, and outpatients and diagnostics were rated as requires improvement.

Previous inspections include:

- January 2014: Dementia themed inspection
- November 2013: Responsive inspection at the Bristol Royal Hospital for Children
- April 2013: Follow up inspection
- September 2012: Responsive inspection
- May 2012: Responsive inspection
- March 2012: Special review of termination of pregnancy procedures at the Central Health Clinic.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Good

We rated safe as good because:

- There was a good reporting and safety culture throughout the trust. Incident reporting was good and trends indicated that reporting was increasing.
- Investigations were thorough and learning was identified and disseminated.
- When something went wrong patients received a sincere apology and were told about actions taken to improve processes. Openness and transparency about safety was encouraged.
- All areas of the trust appeared visibly clean and staff used personal protective equipment available to protect patients from infection.
- Performance showed a good track record with steady improvements.
- There were clearly defined and embedded systems, processes and standards operating procedures in place to keep people safe. These included NatSIPPS and LocSIPPs in theatres, use of the World Health Organisation surgical safety checklist and national early warning score system. There were also systems in place to ensure that patients were safeguarded from abuse. These were used effectively by staff within the trust.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. Any staffing shortages were swiftly responded to.
- Staff throughout the trust recognised and responded to patient risk and deterioration swiftly.

However:

- Patient records were not always stored safely.
- Some medicines were not always stored safely.
- Mandatory training levels did not meet the trust compliance level of 90% in all areas. Compliance by medical staff was at a lower level than that for nursing staff.

Incidents

- Throughout the trust there was a positive reporting and safety culture. All staff were aware of their responsibilities to report incidents. Staff said they were encouraged, empowered and supported by their managers to report incidents.

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- Policies were in place for reporting incidents and serious incidents. These had been recently reviewed (in July 2016) and took account of the NHS England Serious Incident Framework (March 2015). They were easily accessible, with signposting on the cover of who needs to read the policy and what sections were relevant to which role. The policies were supported by clear standard operating procedures, of no more than two pages, which included one on the identification of incidents or serious incidents from complaints.
- Incidents were investigated within the divisions with oversight and support from a central patient safety team.We reviewed the investigations of a large number of incidents and six serious incidents across the trust. We found that these were investigated well although there was complex technical language used in some reports which may not be easy for a patient or their family member to understand. There were actions taken as a result of incidents to prevent reoccurrence.
- Learning and improvement as a result of incidents were identified through thorough investigation. Staff told us they received feedback as about incidents that had occurred and there was evidence throughout the hospital of sharing of incidents reported in different areas. For example, safety focus posters on the back of toilet door.
- Performance showed a good track record and steady improvements in safety. There was a good reporting culture within the trust with upward reporting trends. Between October 2015 and April 2016 there were 35 serious incidents reported. One never event was reported between October 2015 and September 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systematic protective barriers are available at a national level, and should be implemented. The investigation into this never event was ongoing at the time of our inspection.
- Incidents were visible throughout the organisation and there was oversight at the clinical quality group meeting chaired by the chief nurse. This committee provided further scrutiny and ensured proper closure of incident actions and learning. There was also visibility at board via the quality and outcomes committee. This committee provided the board with assurance that governance systems and processed for the management of incidents and serious incidents were robust and in line with national and local policies. Challenge was provided by non-executives (one of whom chaired the committee) and executives and meetings were seen to be well attended. There were examples of programmes to improve patient safety and

the quality of care as a result of incidents seen through this committee. The first was falls group work, another was work undertaken surrounding the deteriorating patient and the third was the patient letter programme which was part of the transforming care project.

Duty of Candour

- When things went wrong patients were provide with a timely apology and support. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- All staff we spoke with had a good understanding of the duty of candour and some were able to give examples of when they had fulfilled the requirements of the Regulation.
- Records of incident reports showed that where patients had suffered moderate or serious harm and found evidence that duty of candour had been followed. We saw support had been given to patients and their families, explanations and apologies were provided and recorded, and investigation findings were shared once completed.

Cleanliness, infection control and hygiene

- All areas of the hospital visited appeared visibly clean and cleaning staff were seen throughout the hospital managing the cleaning rotas.
- All staff were observed to be following the bare below the elbows and regularly used hand sanitising gel to reduce the risk of cross infection. In some areas, for example, the emergency department staff were seen to use hand sanitising gel before or after patient contacts, but, were not often seen to use soap and water to clean their hands.
- Personal protective equipment, including gloves and aprons were available in all areas of the hospital and staff were seen to use them and change them between attending to different patients.
- There had been no cases of methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia in the departments and divisions we inspected. There were on average three cases of Clostridium difficile per month in the 13 months to November 2016 on medical wards with a reducing trend and only four cases on surgical wards between April 2016 and August 2016.

- There were processes in place to decontaminate patients and staff pre- and post-operatively to reduce the risks of surgical suite infection. The trust submitted data to Public Health England for the surveillance of surgical site infections. Between April 2015 and March 2016 of the 33 hip replacement operations and 90 reduction of long bone fracture operations done of them had surgical site infections. Of the 199 repair of neck of femur operations done only two had a surgical site infection (one percent) which was comparable to the England average.
- The trust managed and decontaminated reusable medical devices in line with national guidance which resulted in the sterile services department gaining International Organization for Standardization accreditation. There were clear processes in place to ensure there was separation and tracking of sterile and non-sterile equipment.
- In most places equipment was clean and clean and dirty equipment was stored separately. Equipment appeared visibly clean. However, within the Queen's day unit and endoscopy suite, there was a shared dirty utility where clean equipment was stored.

Medicines

- Medicines were managed effectively within the trust.In most areas medicines were all stored securely, although on a few wards, creams, gels, enemas and suppositories were stored in an unlocked sluice.
- Controlled drugs were stored and managed in line with legislation. Access was only by authorised staff.
- Medicines records were seen to be well completed and recorded patients allergies. Medicines which were needed 'as required' were recorded clearly with instructions for staff about doses and ranges of administration.
- There was clear evidence of the auditing and monitoring of medicines errors. Themes were visible at board level. Lessons were identified and shared widely.
- There was a medicines safety group and medicines safety officer in the trust. A sub-group of this focused on medication errors. There was divisional representation at the medicines safety committee, and themes within the incidents reported relating to medicines were reviewed. Actions were reported back through the medicines governance group and then through quality and safety and patient safety groups to the trust board. There was evidence of improvements monitored through the medicines safety group. This included a focus on

reducing the number of omitted doses of medication within the trust. In September 2016 this had reduced to zero. There was also a medicine advisory group which focused on strategic issues.

Records

- Patient records viewed were well completed. Most were found to be legible, complete, signed, timed and dated.Risk assessments and management plans were mostly completed and provided direction to staff as to what treatment and care to provide. In some records, medical staff writing was not clear.
- In most areas records were stored securely. However, on four out of 16 medical wards, notes trolleys were in place but not locked when unobserved. In places there were unsecured medical records left on desks, waiting for collection.These were accessible to the public or patients on the wards.

Safeguarding

- Staff understood their responsibilities to report safeguarding concerns and also knew how to recognise, raise and report concerns. However, mandatory training levels were not being met. Medical staff generally had lower compliance levels with mandatory safeguarding training than nursing staff for example in the emergency department 56% of nursing staff had completed safeguarding children training whereas only 43% of medical staff. Training data for safeguarding adults was 96% for nursing staff and 74% for medical staff. The compliance target was 90%.
- The trust safeguarding policies described the definition of abuse and who might be at risk. These policies were easily accessible on the trusts intranet pages along with information provided by the trusts safeguarding team (including contact details and phone numbers). Despite the levels of safeguarding training people understood their responsibilities and adhered to safeguarding policies and procedures.
- Staff received training in female genital mutilation to ensure actions were taken to support those patients. Literature was available in staff rooms to support patients and staff.
- There were reliable systems in place to monitor safeguarding processes within the trust. The trust safeguarding activity and arrangements were monitored by the safeguarding steering group, chaired by the chief nurse, with divisional representation. This reported through to the clinical quality group and quality and outcomes committee to the trust board.

Mandatory training

- Mandatory training levels within the trust did not meet the trust compliance target of 90%. Compliance rates were lower for medical staff than for nursing staff. In the emergency department, no topic met the compliance level and compliance ranged from 37% in information governance, to 78% in conflict resolution training and equality and diversity training.
- On medical wards, medical staff mandatory training compliance ranged from 39% in information governance to 84% for fire safety and nursing staff compliance ranged from 75% for information governance to 99% for conflict resolution.
- Within surgical services, 92.6% of nursing staff had completed all mandatory training, compared with 65% of medical staff.
- In outpatients 89% nursing staff had completed mandatory training but only 42% of medical staff had.
- Training was monitored centrally through the trust training centre and monthly updates were sent to managers and clinical educators to identify those needing training. On some wards and departments there were lists of people who needed to complete training on notice boards in staff rooms.

Assessing and responding to patient risk

- Patients were kept safe across the hospital through the use of observation tools. Staff carried out comprehensive risk assessments for patients and developed management plans to ensure risks to patients' safety were monitored and maintained. These were in line with guidance from the National Institute for Health and Care Excellence (NICE).
- The trust used the national early warning scoring system (NEWS) to alert staff to the deteriorating patient. This had been implemented in 2015. Staff recognised and responded to changing risks to patients on wards. Records reviewed showed that staff consistently responded to scores, and identified those who were deteriorating and responded appropriately.
- National early warning scores scoring was audited on a monthly basis and identified 90% compliance in recording and escalating of the deteriorating patient between April and October 2016 which was the same as results from a previous year. Data from April to October 2016 showed an increasing trajectory in compliance.
- Within the emergency department, patients were kept safe through the use of observation tools. Having recognised the impact of crowding in the department on patient safety, and particularly the increased risk for patients waiting in the corridor, a research project was undertaken which resulted in the introduction of a new patient safety checklist. The SHINE project was introduced by the department in November 2014

and provided staff with a simple checklist to ensure patient-safety based actions were completed. Since its introduction there had been no incidents of a deteriorating patient not being identified and then managed.

- In every record we looked at in majors, minors, resuscitation and the observation unit we found the patients had all had observations completed and documented on an hourly basis. An early warning score system was being used, and since the introduction of SHINE the recording of an early warning score had increased from 51% to 82%.
- In outpatients risks to people who used the service were assessed and their safety was monitored and maintained.
- Staff we spoke with were able to describe the processes involved when managing a deteriorating patient. There were clear pathways and processes for the assessment and management of deteriorating patients within outpatients who were clinically unwell and required hospital admission. In most clinics nurses had acute experience and were able to recognise and manage patients who became unwell and transferred them.
- Due to an increase in the number of unwell patients seen in outpatients, an emergency blue box had been devised in a number of clinics within the hospital. A413 and A410 and A407 to streamline care. The box contained specific equipment to be able to take blood tests or administer intravenous medication swiftly. This enabled nurses to spend more time with the patient and focus on their treatment and care rather than gathering the equipment.
- The diagnostic imaging service ensured the 'requesting' of an X-ray, MRI, nuclear medicine or other radiation diagnostic test, was only made by staff or approved persons in accordance with IR(ME)R.
- In all operations we observed, the National Patient Safety Agency five steps to safer surgery were being followed as part of the World Health Organisation (WHO) surgical safety checklist. This included a surgical briefing, signing in, time out, signing out and debriefing. The briefing was an opportunity for the operating or interventional team to share information about patients and discuss potential and actual safety issues before the theatre list takes place. Staff present included theatre nurses, operational departmental practitioners, anaesthetists, surgeons, specialist registrars and scrub nurses.
- The trust was committed to ensuring all surgical procedures completed the surgical safety checklist. The hospital monitored audit data over the 12 months prior to our inspection, which showed the theatre department were 99.6% compliant with the

WHO surgical safety checklist. One member of staff we spoke with said there had been “a massive culture change” around the checklist and they felt they had “the freedom to speak up without repercussions”.

- The trust had a National Safety Standards for Invasive Procedures (NatSSIPs) workgroup in order to streamline practice across the hospital. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs), which were embedded.

Staffing

- Nurse staffing levels and skill mix were planned and reviewed so people reviewed safe care and treatment at all times, in line with trust policy. Acuity and dependency were reviewed on a daily basis and staffing was adjusted to meet the demands on the wards. Bed meetings were held at 8:30am and 2:30pm on a daily basis to assess bed flow and staffing in the hospital.
- Staffing levels were set across the hospital by the chief nurse and reviewed annually at a divisional level. Senior nurses used the safer care tool to record acuity and dependency. Scoring was recorded daily. The results were matched against the funded establishments and the staffing tool used from the Department of Health report, to ensure staffing was appropriate. Senior nursing staff met regularly to discuss staffing and skill mix.
- As a minimum, wards were staffed at a ratio of one nurse to every six patients during the day and one to eight at night. However, these ratios differed across the different wards within the hospital, based on standards specific to the patient group.
- Staffing levels were good and actual staffing figures matched those planned. On each ward we visited staffing levels met the dependency of patients and the acuity tool used. Where risks were greater staffing levels were increased to match this need. For example, on an orthopaedic ward we found additional staff were made available to care for patients living with dementia.
- In the emergency department a scoring system for acuity and dependency was used and aligned to staffing numbers. The tool was used daily to review staffing levels based on the needs of the patients in the department. Advanced staffing levels were planned using historical data, including attendance numbers, acuity and dependency. Staffing levels met national guidance and kept patients safe, although staffing in minors was highlighted by staff as a concern because of timeliness of assessments and the impact on patient experience.

Summary of findings

- In July 2016 the trust reported a vacancy rate of 6% for all staff types across the trust. The rate for nursing and midwifery staff was 6.1%, allied healthcare professionals was 7.2% and for medical staff was 3.6%.
- Duty matrons worked between 8am and 6pm and reviewed staffing and acuity. During the evening, the site team were responsible for this role. An escalation process was established for when extra staff were required.
- For all staff working on the bank, agency or in a locum role, an orientation checklist was used to enable staff to familiarise themselves with the allocated work area. Staff were required to sign and date the form when completed to provide an audit trail of checks completed.
- Use of bank staff and agency staff were low, with bank staffing levels remaining consistently below 5% and agency staffing levels remaining consistently below 2% between September 2015 and August 2016. Overtime of staff was constantly below 1% of staffing expenditure during the same period of time.
- Sickness rates between April 2016 and August 2016 were 3.8%. However, the trust identified turnover was a risk with the average turnover between April 2016 and September 2016 being 13.3%. This was lower than the England average.
- Arrangements for medical staffing kept patients safe. In June 2016, the proportion of consultant grade staff at the trust was higher than the England average. The proportion of junior (foundation year 1-2) staff working at the hospital was lower than the England average.
- Medical and surgical cover generally kept patients safe, but consultant cover in the emergency department was recorded as a risk in the department, particularly at weekends. The emergency department had completed a benchmarking exercise and identified they had fewer consultants when compared with other departments locally. It was recognised they were unable to meet 16-hours of planned consultant presence, and the weekend was highlighted as a particular risk.
- Between September 2015 and August 2016 the bank and locum usage rate was 3.3% in the emergency department.
- There were consultants trained in general medicine available at all times. On the medical assessment unit there were three consultants. The acute medical consultant had responsibility for 20 patients, the gastroenterology consultant for six patients and the respiratory consultant for six respiratory patients, plus their ward specialty areas. There was a ‘take’ consultant who admitted patients referred from the emergency department and GPs.

Summary of findings

- We observed a medical handover and found it to be comprehensive. We observed excellent communication between the whole medical team at the handover, with each doctor taking the time to handover their patient in detail with others clearly listening. Patient safety considerations were highlighted and the opportunity to have a quick learning discussion was maximised. In the same way as the nursing handover, the medical team finally completed the 'ABC of handover in the ED'. The handover was also attended by the nurse in charge, psychiatric liaison and representatives from a partner organisation providing the REACT service.
- Medical staff told us there were no problems accessing senior staff and consultants. Junior medical staff confirmed there was good middle grade doctor support and felt there were good opportunities for doctors including performing local audits, and care of the elderly education. They told us there were good relationships with other medical teams; an example given was of a particularly good relationship with the psychiatric and care of the elderly teams.
- Staff we spoke with said there was adequate consultant presence at the weekends within surgical services. We spoke with consultants and anaesthetists who commented that work had been done to improve the fractured neck of femur pathway to ensure lists were running seven days a week with very few gaps in the rotas.
- Surgical staff were not undertaking twice daily ward rounds. However, risks involved were being proactively mitigated to ensure safety to patients. Consultant ward rounds were done every Tuesday, Thursday, Friday, Saturday and Sunday. Patients had a consultant review each day in the afternoon. Registrar ward rounds were held on a daily basis with input from consultants if necessary.
- Anaesthetists reported frustrations when predicted staff vacancies were not recruited into in a timely manner. Staff reported to us when they identified future staffing shortfalls such as retirement, they were not able to start the recruitment process early enough to mitigate the staff shortage.

Are services at this trust effective?

Outstanding ☆

We rated effective as outstanding because:

- There was a truly holistic approach to planning and delivering care and treatment to patients which was in line with recognised national guidance.

- Innovative and pioneering approaches to care and its delivery were actively encouraged. The SHINE patient safety assessment tool within the emergency department was one example.
- Care pathways and standard operating procedures were in place to ensure patient safety. These included national safety standards for invasive procedures.
- The outcomes of patients' care were routinely collected and monitored to measure the effectiveness of care and treatment. The trust took part in national audit programmes and also established local audits. Results tended towards being better than the England average and actions were put in place to drive improvement.
- Emergency readmission rates were low.
- Patient reported outcomes showed more patients health improving.
- There was excellent multidisciplinary working within the trust and with partners. There was a partnership approach to holistic discharge planning for patients.
- Consent practices were actively monitored and reviewed to improve how patients were involved in making decisions about their care. They were well embedded and monitored with the trust, as was the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

However:

- Improvement was required in the monitoring of compliance with the WHO surgical safety checklist within the cardiac catheter laboratory.

Evidence based care and treatment

- Across the trust there was a holistic approach to planning and delivering care and treatment to patients who used services. Care and treatment was planned with national guidance in mind. This included National Institute for Health and Care Excellence guidance and that of the Royal Colleges. For example, the hospital policy for transfer of patients both internally and externally to other locations, referenced the NICE guidance Acutely Ill Patients in Hospital, July 2007, and the south-west dementia partnership hospital standards in dementia care. This outlined clear roles, responsibilities and processes to ensure patients were safely and effectively moved between teams, both within and outside of the hospital.
- Innovative and pioneering approaches to care and its delivery were actively encouraged. This included the implementation of the SHINE patient safety assessment tool within the emergency department. As a result of this compliance with the sepsis

pathway had increased from 93% to 95%, with the stroke pathway rose from 86% to 97% and the pathway completion for patients with a fractured neck of femur, increased from 92% to 97%.

- The trust identified falls prevention as a priority area in 2016 and had instigated a programme in response, called 'Eyes on Legs'. The concept was devised by a ward sister and matron following a serious patient fall. The aim was to ensure all staff, regardless of their role, understood the message that falls prevention was everyone's responsibility.
- Stroke pathways were in place to support patients to access the right services and effective treatment at the earliest point of admission, in line with NICE guidelines for the management of stroke and transient ischaemic attack. This meant specialist nurses and nursing staff were available at all times to undertake thrombolisation (the breakdown of a blood clot) and bring the patient from the emergency department to the ward.
- Enhanced supervision teams were established in the hospital to support wards and staff with patients with extra needs during the day. Their role included taking patients to the dementia café, activity clubs and supporting activities on the ward. They were allocated where a need was identified and were not counted as part of the ward staffing level. Usually three of these staff worked each day, this included night shifts. They carried a bleep to ensure they were used where needed.
- In order to streamline practice across the trust, National Safety Standards for Invasive Procedures (NatSSIPs) for specimen checking was in the process of being implemented and posters were printed and ready to be displayed. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures.
- The pre-op assessment area made good use of technology to improve its effectiveness. Video recording of assessments had also been introduced for high risk patients to allow them to use this information alongside data collected in the clinic

Patient outcomes

- The outcomes of patients' care were routinely collected and monitored to measure the effectiveness of care and treatment. The trust took part in national audit programmes and also established local audits. These included the quarterly Sentinel Stroke National Audit programme (SSNAP), National heart failure audit, National Diabetes Inpatient Audit, Myocardial Ischaemia National Audit Project (MINAP), Hip Fracture Audit, Bowel Cancer Audit, Oesophago-Gastric Cancer National Audit

(OGCNCA) National Emergency Laparotomy Audit (NELA). Results were mixed but tended towards being better than the England average. In all, areas for improvement were identified and action taken to improve outcomes for patients.

- Mortality rates were better than the England average in all audits we reviewed.
- The emergency department had taken part in a number of national audits since 2014, including the Royal College of Emergency Medicine severe sepsis and septic shock audit, paracetamol overdose audit, venous thromboembolism in lower limb immobilisation audit, procedural sedation in adults audit and mental health audit. Performance varied, but overall the department performed better than the national average. Clear action plans were put in place to increase performance where needed, and re-audits had either taken place or were planned. Where re-audits had taken place there was a demonstrable improvement in performance.
- Within outpatients rates of patients who "did not attend" clinics and cancellation rates were monitored in each outpatients department as well as centrally by the appointment booking centre. Clinics were then benchmarked against each other and actions put in place to improve outcomes.
- Additional local audits included asthma management and seizures. Again, where standards were not being met there were clear recommendations and action plans produced to improve performance in those areas, including re-audits in the future and these were showing improvements were being made.
- Falls management was audited regularly and actions produced as a result. The data showed whilst the number of falls per month varied and was seen to have increased in October 2016, the number of falls resulting in harm had fallen from March 2016 to October 2016.
- Within the dermatology department outcome data for each case of skin cancer excision was collected and then benchmarked. The most recent data showed reduced re-operation rates.
- Audit meetings were held to discuss the progress of audits and present audit results and recommendations once completed. These meetings were recorded and minutes were circulated to staff.
- There had been an improvement in the number of patients receiving antibiotics within one hour of arrival, for patients undergoing chemotherapy who presented with potential neutropenic sepsis.

- Unplanned re-attendance rates between October 2015 and September 2016 were about 8%. This was higher (worse) than the national standard of 5%, but similar to the England average of 7.5%.
- The department was about to start a project with pre-hospital partners, including the ambulance service and GPs, to help further improve patient outcomes. The pre-hospital partners had agreed to trial an early warning score system so differences pre-hospital, on arrival and during assessment, observation and treatment could be compared and considered.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, the two indicators relating to groin hernia showed more patients' health improving and fewer patients' health worsening than the England averages.
- Emergency re-admission rates were low with the only 1.75% of patients returning to hospital between April 2016 and August 2016. This is improved from 2.82% of patients returning to hospital between April 2015 and March 2016.
- The cardiac catheter laboratory used a World Health Organisation surgical safety checklist for all surgical procedures. We were unable to see any procedures but staff told us the records were not audited to ensure they were all fully completed. However, this did not provide assurance that safety checks were well implemented.
- The diagnostic imaging department was preparing to submit documentation in preparation for an inspection by the Imaging Services Accreditation Scheme (ISAS). Previously the diagnostic imaging service used ISO9001 as their set of quality standards for the diagnostic imaging department. The department had set a target to achieve accreditation by September 2017.

Multidisciplinary working

- Staff and teams across the trust were committed to multidisciplinary working. Staff across all grades in all areas of the trust were observed to work exceptionally well together. On wards board rounds were seen to be engaging and focused around the patient, risks and ongoing treatment plan. Discussions were seen to be meaningful and inclusive, identifying clear actions for ongoing care.
- There were multidisciplinary board rounds three times a day on medical wards which engaged partners from outside the trust in the ongoing care for each patient to implement arrangements which supported discharge at the earliest opportunity from the trust. Discharge from the trust to was carried out at an appropriate time of day and the number of out of hours discharges were monitored by the trust.

- Within the emergency department there was inclusive and productive multidisciplinary working with a positive culture where all staff could provide supportive challenge to ensure the best patient care. Examples, included, a nurse challenging a doctor about the prescription of medicines for a patient and achieving an agreed treatment plan together. Ambulance staff were an active part of the multidisciplinary team and good working relationships existed.
- The trust had engaged with a third party organisation to set up a virtual ward to provide medical and nursing care within a patient's home wherever possible. Staff worked closely with colleagues to ensure the patients received care in the right place at the right time. This also included engagement with local authority colleagues to set up packages of social care.
- Timely access to mental health provision remained difficult within the emergency department, but action had been taken to increase numbers of psychiatric liaison nurses.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff throughout the trust had an excellent understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent. They could clearly articulate their responsibilities.
- Records showed that consent had been obtained and recorded clearly. Where consent was refused this was also clearly documented within the notes. Patients said they had been asked for consent prior to surgical procedures, told the risks and benefits of the procedure and had the opportunity to ask questions.
- Consent practices and records were actively monitored and reviewed to improve how people were involved in making decisions about their care and treatment. Audits were undertaken within the medical division areas for improvement identified and action taken.
- Staff had a clear understanding of the Mental Capacity Act 2015 and associated Deprivation of Liberty Safeguards. A dedicated section of the trust intranet was available to provide access to policies, guidance and the necessary paperwork.
- Records of do not attempt cardiopulmonary resuscitation were clear and documented in line with guidance. Rationales were recorded, as were discussions with the patient and their family and no junior doctors had signed the forms.

Are services at this trust caring?
We rated caring as good because:

Good

- Feedback from patients and their relatives was consistently positive about the ways staff treated patients.
- We observed patients being treated with dignity, respect and kindness throughout the trust.
- Patients were involved and encouraged to be partners in their care and in making decisions about their care. Staff took time to ensure patients understood their care, treatment and diagnosis.
- Friends and family tests were well responded to and results showed a large majority of patients would recommend services to their friends and families.
- Feedback about and observations of care demonstrated that staff were caring and compassionate to all patients.

However:

- Privacy and confidentiality could not be maintained in the emergency department corridor when the department was crowded.

Compassionate care

- Feedback from patients and their relatives was consistently positive about the ways staff treated patients.
- Patients and their families praised the staff at the trust for their kindness and compassion. Patients said they had been treated with kindness and dignity at all times.
- We observed staff taking time to interact with patients and their families, addressing patients by their preferred name and always introducing themselves by their first name.
- Staff were skilled in talking to and caring for their patients. We observed staff bending down to speak with patients on their level, making eye contact and referring to the patient in their preferred name. Throughout staff made references to patients which indicated that they had taken time to know and understand their patients' needs.
- Friends and family tests were responded to well with results showing that a large majority for patients would recommend services to their friends and families. In the majority of the trust more than 90% of patients would recommend services to their friends and family, with 97.5% of patients in surgical services recommending the service. In the emergency department the percentage of patients who said they would recommend the service was lower than the England average. However, there was an increasing trend between March and August 2016 from 71% to 80% of patients saying they would recommend the service. Response rates across the trust were better than the England average.

- Throughout the trust we saw patients being treated with privacy, dignity and respect. On wards and in departments we saw staff ensure doors were closed and curtains were pulled when patients received care and treatment. Staff knocked or sought permission from patients before entering. However, during times of increased pressure when the emergency department was overcrowded, staff were not always able to maintain the confidentiality and privacy of patients waiting in the corridor.
- We observed staff responding to call-bells quickly on all wards regardless of how busy they were.

Understanding and involvement of patients and those close to them

- Patients were involved and encouraged to be partners in their care and in making decisions about their care. We observed staff explaining things to patients in a way that they could understand and providing time for patients and their relatives to ask questions about their care.
- Patients were kept informed of their care and treatment, and relatives were included as necessary.
- Staff ensured patients and their relatives understood diagnoses and treatment and were given the opportunity to ask questions.

Emotional support

- There was emotional support provided to patients and their families throughout the trust. We observed staff providing emotional support to family members in the resuscitation area of the emergency department and being provided with private space in the relative's room. Staff took time to talk with them and provide them with the support they needed. Regular updates on the patient's condition was provided.
- Staff understood the impact person centred care had on patients and those close to them, both emotionally and socially. We were given multiple examples of how care had been given in ways to alleviate anxieties and concerns. We observed on multiple occasions on wards where care had been delivered in a way which supported positive wellbeing both in hospital and for their onward journey out of hospital. For example, discussions about discharge were given in a supportive and reassuring way, and where there had been delays in discharge patients were given time with nurses to discuss concerns and worries.
- Clinical nurse specialists provided specialist support to patients regarding their condition, this included emotional support.

Summary of findings

- There was a chaplaincy service within the trust and chaplains regularly visited wards to provide emotional support to patients and their relatives.

Are services at this trust responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were challenges to the access and flow of patients through the trust. The trust was failing to consistently meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of arrival at the emergency department. Patients spent longer in the emergency department than the England average.
- Referral to treatment times within the outpatients department and some medical specialties were worse than the national average.
- The needs of patients who used a wheelchair and mental health patients were not always met within the emergency department.

However:

- Staff across the trust worked well with commissioners and partners to address system-wide flow issues. Innovative methods to improve patient flow were being used.
- There was clear visibility and senior leadership input into the issues surrounding flow. Cross division projects to improve flow were coordinated by a central transformation team.
- There was good support for patients living with dementia or learning difficulties.
- Escalation procedures were seen to be effective, with support at differing levels within the trust to maintain flow in times of increased pressure. Good support was provided to the emergency department at times of increased pressure, without an impact on patient care on other areas of the trust.
- Waiting times, delays and cancellations were minimal and managed.
- Patient flow was proactively monitored and actioned throughout the trust.
- Patient transfers between wards were avoided out of hours.
- It was easy for patients to complain or raise a concern. Patients were mostly treated with compassion when they made a complaint. New processes and approaches were being embedded within practice in the trust at the time of our inspection.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered in a way that met the needs of the local population. There was significant engagement with partners and stakeholders in the planning and delivery of care at all levels throughout the trust.
- There was consideration to choice and continuity of care in planning and delivery. The trust contracted with a third party provider to provide a virtual ward to deliver care and treatment in patients home. This included treatment such as intravenous antibiotics, and was available to patients attending the emergency department and also being discharged from medical wards. At the time of our inspection 19 patients were receiving care from this service, but there were plans to increase this over time to 30 patients.
- There were clear escalation plans in place across the trust, for providing additional nursing support to the emergency department in times of intense pressure, and also for the opening of areas to provide additional beds to support the flow of patients through the hospital.

Meeting people's individual needs

- The needs of different people were taken into account in the planning and delivery of services.
- The clinical alert system was used for patients with a learning disability, Parkinson's disease and known carers. This meant teams and services were alerted when these patients were admitted to, or attended the hospital. This ensured the hospital provided timely access to additional specialist support, review and services. A hospital passport system was in place and use for patients with a learning disability.
- Individual care needs and adjustments were put in place. When individuals with learning disabilities were referred to the learning disabilities team by carers or external providers (local authority), the learning disability team was able to support pre-planned admissions and make reasonable adjustments according to identified needs.
- For patients who were visually impaired individual care needs and adjustments were put in place which included adjusted cutlery, non-slip plates, assistance with meal times and assistance with menu selection.
- It was common for patients who were hard of hearing to be put in a side room upon request, so they could have their radio/TV on at a raised volume without upsetting the other patients.
- There was disabled access throughout the trust. However, within the emergency department access to patients using a wheelchair from the drop off point was not easy. The door was heavy and not automatic. In addition, although there were

lowered sections of the reception desk to accommodate patients who use wheelchairs, large computer monitors blocked access and staff had to stand up to talk with patients in a wheelchair, whilst inputting information.

- There was good access to translation facilities throughout the trust. Information leaflets were readily available in English, braille and large print, but there were limited leaflets in other languages.
- There needs of patients with mental health conditions were not always met within the emergency department. This had been identified on the trust risk register since April 2012.This was due to long waits for assessment by the mental health liaison team provided by a third party provider. The trust was making efforts to rectify the issues, but this remained an issue at the time of our inspection and we saw patients waiting in excess of nine hours for an assessment.
- Within outpatients, patients' needs were well met. There were processes in place to identify patients who had diabetes, and staff were able to offer food and drink to patients who were waiting for longer periods of time.

Dementia

- There was a dementia strategy implementation group who formulated an action plan to develop the dementia provision. The trust had a named consultant geriatrician who was the lead for dementia and delirium. There was a lead dementia practitioner in post together with a dementia nurse practitioner and support worker. The team was notified of admissions via the clinical alert system. Referrals were made by agencies: for example, the dementia well-being service, safeguarding team and the later life mental health team.
- The monthly audit for caring for patients with a cognitive impairment care plan was introduced in 2014. The medicine division was consistently compliant: the numbers of patients with this care plan were significantly higher than the other divisions, which demonstrated the medicine division understood the importance of delivering care for these patients.
- Patients with dementia were highlighted on the majors' whiteboard with a forget-me-not sticker. A booklet called 'All about me' was available and patients or someone close to them were asked to complete information about them to help staff meet their individual needs. This occurred throughout the trust.

Access and flow

Summary of findings

- Access and flow remained a challenge within the trust. However, there were proactive arrangements and processes in place within the trust to minimise the impact of this.
- The trust was failing to consistently meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of arrival at the emergency department. Patients spent longer in the emergency department than the England average.
- The percentage of patients waiting between four and 12 hours to be admitted to the hospital from the emergency department had fluctuated since December 2015 with peaks of 27% and 25% in January 2016 and October 2016 respectively. Between August 2015 and July 2016 16 patients waited for longer than 12 hours to be admitted to the hospital.
- Demand was causing issues with higher numbers of patients in the emergency department, which at times was being exacerbated by the surgical and medical take.
- There were; however, processes in place within the emergency department to manage the flow. Patient flow coordinators were in place within the majors area 24 hours a day seven days a week to provide oversight and movement of patients out of the department.
- Within the medical division the service was flexible and creative to ensure flow was maintained. Managers had focused on improving patient flow and discharge by working more closely with community based care to access beds.
- Escalation procedures were in place with the objective of keeping the trust at a green status with no obstructions to flow. Clear actions were in place to return the status to green. Meetings occurred throughout the day within the trust to monitor and manage bed capacity and flow. These were seen to be effective across the trust in times of increased pressure, and there was significant senior input.
- There was a focus on planning and supporting patients to be discharged from the hospital swiftly, although processes were not always effective. In the majority of cases reasons for delays to discharge were not attributed to the trust. Some patient were delayed in their discharge because they were waiting for services or packages of care to be put into place in their home. These were outside of the trust's control. Reasons for delayed transfers of care were audited by the trust between August 2015 and August 2016. Out of 388 delayed transfers of care, only seven were attributed to the trust's processes.

Summary of findings

- The trust continually monitored patient discharge data to highlight any ways that discharge and transfer could be made more efficient. Work to reduce delayed discharges continued as part of the emergency access community wide resilience plan.
- Transferring patents out of hours was avoided. Transfers, whenever possible, took place between 8am and 8pm to avoid disruption to patients and maintain safe staffing levels. Although the trust did not advocate the transfer of patients between wards out of hours, there were occasions when this was unavoidable, and patient transfers and discharges at night did take place. If an out of hours transfer was required, a set of criteria must have been met. Staff had a duty to report out of hours transfers of patients with a learning disability or dementia.
- Where medical patients were cared for on non-medical wards, there were systems in place to ensure that they received regular review by their consultant and nursing staff knew who to contact for additional support. There were very few surgical patients on non-surgical wards.
- The trust monitored the number of times a patient moved ward and actions were implemented to try to reduce the number of moves made.
- Care and treatment was cancelled or delayed only when absolutely necessary. Between July 2014 and June 2016 cancelled operations for elective admissions remained slightly higher than the national average, but remained consistently between 0.8-1.3% of patients.
- Waiting times, delays and cancellations were minimal and managed.
- Most people had timely access to initial assessment, diagnosis and urgent treatment. Referral to treatment times was monitored on a weekly basis and reported to the trust board monthly. Specialities were held to account by referral to treatment time leads and action plans were in place for services which were not meeting the national standard. Within surgical services, dental services and the cleft palate service were not meeting referral to treatment times. Other services were. The endoscopy service was not meeting the two week cancer wait standards. However, the cancer waiting list was well managed in the surgical head and neck division. For outpatients, referral to treatment time was not met for gastroenterology, oral surgery, neurology, cardiology and trauma and orthopaedics. There were some services which were above the national average. These included: rheumatology, ophthalmology, and ear, nose and throat. Overall the trust was achieving 90% of patients being seen within 18 weeks against a 92% standard.

Clear agreed actions were in place to move the trust performance back above the standard. Consultants were held to account for performance and there were systems in place to review and assess patients waiting longer times.

Learning from complaints and concerns

- The trust had taken action to improve the complaints process and their response to complaints. These improvements were on-going at the time of our inspection. The complaints policy was reviewed and updated in August 2016. This was in line the Parliamentary and Health Service Ombudsman principles of good complaints handling. There were clear procedures for: the escalation of complaints to the executive lead and for identifying incidents from complaints.
- There was work on-going to enable staff to resolve complaints and concerns locally and good support was provided to staff and complainants by the complaints team. They were highly professional, polite, courteous and patient with all they spoke with. Additionally a case worker was assigned within the team to each complainant to support them through the process.
- The responsibility for investigating complaints remained within each division. This included the decisions on the processes for conducting the investigations so as to enable greater ownership of individual complaints.
- There were processes for a meeting to occur with a complainant when an informal complaint occurred but it was not clear if this was the case when a formal complaint was made.
- Our review of five complaint files showed that complaints were responded to in a timely manner. Responses to complainants all included an apology, response to the complainants concerns and were signed by an executive director. However, the degree of empathy, compassion and personal sincerity in the responses were variable and there was limited information about learning within the files demonstrating further work to embed new processes was required.
- The trust has begun (in September 2016) to contact complainants six weeks following the final response letter was sent to gain feedback.
- The governance systems were clear and in place and complaints system had been reviewed shortly prior to our inspection. There was a clear audit trail for monitoring and progress of complaints.

Are services at this trust well-led?
We rated well-led as outstanding because

Outstanding ☆

Summary of findings

- Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. There was a very strong executive leadership team within the trust. The board were cohesive and provided strong and supportive challenge within the governance of the organisation.
- Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. Leadership and culture were intrinsically linked.
- The leadership of the trust drove continuous improvement. This was the approach to delivering the improvements seen since our last inspection, through engaging and enabling staff to be accountable for delivering change.
- There was a transparent, open and learning approach within the trust. The open culture was cited by many staff as one the best reasons for working within their department and the trust. Staff throughout felt able to raise concerns and believed they would be listened to and supported.
- The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. There was a clear vision and values for the service which put patient care and quality of care at the forefront of the service.
- There was a systematic approach to working with other organisation to improve care outcomes, tackle inequalities and obtain best value for money.
- Governance and performance management arrangements are proactively reviewed and reflect best practice. Although there were strong governance frameworks in place within the trust the looked to review and develop these further.
- There was evidence that action was taken throughout the organisation to improve the quality and safety of services with the use of dashboards within divisions and action plans regularly reviewed to ensure continued improvement.
- The board were clearly sighted on risks within the organisation. A good risk management culture exists within the organisation with proactive use of the corporate risk register and board assurance framework by the board.
- The provider had a policy in place to meet the Fit and Proper Person's requirements which linked with the recruitment policy for executives. There was action in place to strengthen this at the time of our inspection and it was confirmed afterwards that this had been completed.
- The trust implemented a step change approach in patient involvement as part of their "year of engagement" in 2015/16. A consistent focus on improving patient experience alongside safety and patient outcomes was at the heart of this. The programme focused on both staff and public engagement.

Summary of findings

- There were high levels of staff satisfaction across the trust. Staff were proud to work for the organisation and spoke highly of the culture.
- A 'Happy App' had been developed and rolled out in areas across the trust. This was designed as a method of gauging staff morale and created a rapid feedback loop for local managers to respond.
- There was a clear and proactive approach to seeking out and embedding new and more sustainable models of care. The trust had made many improvements and innovations since our last inspection, corporately and within divisions within the trust. In all the trust cited in excess of 80 innovations and improvements which had either been implemented or were on-going at the time of our inspection.

However:

- Although there was visibility at board level of equality and diversity and were sighted on the BME agenda, there was still evidence of discrimination for BME staff especially those in lower grade roles. The trust was working through a programme of lead ship development for managers across the organisation, of which part, would provide support to focus on this area.

Leadership and culture of the trust

- Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. There was a very strong executive leadership team within the trust. The board were cohesive and provided strong and supportive challenge within the governance of the organisation. Accountabilities and responsibilities were clear within the organisation. Clinical divisions reported directly to the chief executive, but there were also reporting lines for key clinicians to the medical director and chief nurse. There was a positive learning and development culture led from the chief executive and chair to enable all throughout the organisation to be supported within their role and develop further.
- The non-executive directors were impressive, with a clear awareness of issues within the trust. They were clear on the responsibilities and accountabilities and were highly engaged. Governance arrangements were in place and there was clear evidence of holding executives to account.
- The council of governors were active within the trust and had representation from staff and younger people within the population. Governors spoke of how the influence of the council had developed over a number of years. They were engaged and provided challenge to the trust.

Summary of findings

- Leaders within clinical divisions were held accountable for delivery through the governance framework and at board. Non-executive directors had clarity and visibility of issues within divisions via reporting to board and associated committees and talked of further steps in the governance for them to gain a great exposure to divisional leaders.
- Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. Leadership and culture were intrinsically linked. Alongside the organisational strategy, the trust had developed a quality strategy, which was ambitious and yet identified "how we do things around here". Patients, quality and safety were at the heart of this, and there was clear staff engagement in moving this forward. The significant work undertaken to move staff engagement forward and to ensure that staff were engaged within and helping to lead the quality strategy, innovation and delivery was notable.
- There was significant integrity throughout the trust led by the executive team. The approach to learning from where things went wrong and on ensuring a transparent approach was clear throughout but was also central to the quality strategy. This clearly acknowledged the independent review of children's cardiac services and the questions about transparency and communication with patients and their families as well as changes which had occurred since the period of scrutiny. It links this to the trust's on-going learning.
- There was strong collaboration and support across all functions and a common focus on improving the quality of care and patient experience. The quality strategy was at the centre of this and was clearly articulated and evident in the actions of leaders and staff throughout the organisation.
- The leadership of the trust drove continuous improvement. This was the approach to delivering the improvements seen since our last inspection, through engaging and enabling staff to be accountable for delivering change. They were not complacent. Executives were clearly aware of what had been achieved, what needed to be further developed and even where excellence delivered, there was a desire to further learn and improve.
- There was a strong patient and patient safety culture led by executives and key senior leaders within the trust. There was a quality strategy in place within the trust, which set out the trust priorities, the first of which was quality. The patient centred principle of "nothing about me without me" was one of the key foundations. The strategy outlined quality and patient safety aspirations, as well as expected standards of care, based on

and aligned with the trust values, vision and overarching strategy. This patient and safety focus was palpable throughout the trust, in all conversations we had with staff and observations of care provided.

- There was clear evidence of ward to board to ward feedback loops and escalation with a strong basis in the governance systems in place within the trust. Staff felt respected and valued within the trust.
- Staff reported excellent support from and visibility of the executive team. The nursing team without exception commented on the support from the chief nurse and the chief executive and medical director were also noted to be visible and supportive.
- There was a transparent, open and learning approach within the trust. The open culture was cited by many staff as one the best reasons for working within their department and the trust. Staff throughout felt able to raise concerns and believed they would be listened to and supported. Staff within theatres talked about the positive culture change that had occurred and said that they were being listened to. We saw evidence of staff being open to challenge and actively challenging others where quality was not as expected. Staff also cited examples of where they had challenged more senior members of staff on issues and said that they felt empowered to do so.
- Duty of candour was well embedded within the trust and staff were open, honest and offered a sincere and frank apology to patients when things went wrong. Lessons were learnt not just within clinical areas but at divisional leadership, executive and board level. There was a clear desire to ensure that mistakes made did not happen again.

Vision and strategy

- The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. There was a clear vision and values for the service which put patient care and quality of care at the forefront of the service. The trust had a clear five year strategic plan (2014-2019) which was focused on patient quality and safety as well as sustainability of services, operationally, clinically, financially and from a workforce point of view. This had been developed with the clinical divisions and have been widely promoted with staff. It was understood and supported by staff.
- Although published prior to the NHS Five Year Forward View, it has similar themes and focuses on the future challenge of maintaining and developing the quality of services with fewer resources.

- There was a systematic approach to working with other organisation to improve care outcomes, tackle inequalities and obtain best value for money. There were good working relationships with partner organisations and commissioners. The trust chief executive was the chief officer and lead for the Sustainability and Transformation Plan (STP) within the local health economy.
- Strategies within services and divisions were aligned to the trust strategy. For example, within outpatient services we saw a detailed strategy to achieve the vision for the outpatient department where services worked together to improve whilst maintaining effective working relationships within their divisions.
- There was a realistic strategy for achieving priorities and delivering good quality care across the trust. For example, within surgical services, divisional operating plans for 2016/17 and 2017/18 highlighted the trust strategic objectives broken down into ten divisional objectives, actions required to complete the objectives, and how the division planned to complete them.
- The mission "to improve the health of the people we service by delivering exceptional care, teaching and research, every day" and vision "for Bristol, and our hospitals, to be among the best and safest places in the country to receive care" were clearly articulated.
- Staff across the trust had an understanding of the trust vision and strategy and could articulate this within their working environment.
- Trust values were patient focused and were clearly embedded. Staff throughout the trust had a good understanding of the core trust values of: respecting everyone, embracing change, recognising success and working together; and were committed to providing patient-centred care. The values of the organisation were displayed on the walls of the outpatient departments.

Governance, risk management and quality measurement

- Governance and performance management arrangements were proactively reviewed and reflected best practice. Although there were strong governance frameworks in place within the trust, they looked to review and develop these further. An external review of governance within the trust was undertaken in June 2015 which identified areas to further strengthen the governance and leadership within the organisation. Actions were taken and included review of the board assurance framework to ensure clarity, on-going review of strategy and

risks to delivery of with the five year forward view and further strengthening and embedding of risk management within divisions. This was seen as a continual improvement programme as part of business as usual work. The arrival of a new trust secretary in May 2016 has seen further strengthening of governance processes and frameworks.

- The trust had a devolved system of governance to divisions, but with tight control at a corporate level. There was strong expertise in the corporate team with good oversight of and support for divisions and a culture of improvement to support the trust ambition to provide safe quality care. Alongside this there was a clear and embedded leadership focus on the identification and management of clinical risk.
- There was an effective ward to board assurance process in place. The trust quality and outcomes committee provided the assurances to the board that governance systems and processes were robust and in line with national guidance. Scrutiny and challenge was provided by strong non-executive directors both at the quality and outcomes committee and at board. A notable example was in the review of the board assurance framework which following review provides clear alignment between strategic priorities and risks within the organisation. There was a supportive culture of challenge within board, sub-board committees and divisional leadership. Frameworks differed slightly within different divisions but there was evidence of key risks and issues being escalated clearly from ward staff through to the trust board.
- There was evidence that action was taken throughout the organisation to improve the quality and safety of services with the use of dashboards within divisions and action plans regularly reviewed to ensure continued improvement. These included performance regarding patient falls, flow and discharges as well as incidents and complaints. The flow of information was followed through to board.
- The board were clearly sighted on risks within the organisation. A good risk management culture exists within the organisation with proactive use of the corporate risk register and board assurance framework by the board. The trust wide risk register was comprehensive and had high level risks which were a combination of patient safety, health and safety, quality, statutory and financial risks. There were identified owners of risks and a summary of mitigation for each with actions identified for staff throughout the organisation. Each risk was provided with an action required or accepted risk status. There was evidence of escalation of risk from ward to board.

- Similarly there was clear board oversight of incidents and serious incidents. Scrutiny of incident and serious incidents was via the clinical quality group, chaired by the director of nursing. Approval, sign off and monitoring of actions following incidents and serious incidents by this committee was minuted and showed good practice. The patient safety group pulled together learning form serious incidents for wider sharing across the organisation. Other specialised committees and groups, including the medicines safety committed and the falls and tissue viability groups.
- There was visibility of complaints at board, via the quality and outcomes committee and also through patient stories at the beginning of each board meeting.
- Both executive and non-executive directors understood and could clearly articulate the issues within the organisation, along with the actions in place.

Equalities and Diversity – including Workforce Race Equality Standard

- There was visibility at board level of equality and diversity and the trust produced the required data for reporting under their legal and regulatory obligations in line with the Equalities Act 2010 and the Workforce Race Equality Standard. The information and data produced and reported was to a high standard and in an easily readable form.
- The board understood its responsibilities and had recently undertaken equality and diversity training. They were sighted on the equality and diversity and BME agenda. Members of the board articulated that this was not reflected at a middle management level within the trust and that there were plans to implement focussed training for the 800 middle managers in the trust on equality and diversity awareness and management as part of the leadership and management training programme in 2017.
- The composition of the trust board does not reflect the staff mix or local community mix and there is not an even spread of BME staff across the staff bands within the trust. The majority of BME staff within the trust were employed in band one and two positions with few at a senior management level.
- There was a BME staff group, however, this was not functioning and had only met once in the 18 months prior to our inspection. There was limited attendance with the chair and only one member of staff attending. Feedback from staff mirrored the data presented to the board and identified discrimination for BME staff especially those in lower grade roles. Staff survey results (published 2016) also identify this.

Actions were in place and clearly articulated by the board. There was evidence that the board recognises this as an issue and were clear in their desire to address the problem. Plans that were in place alongside the strong leadership from the board will move the agenda forward considerably.

Fit and Proper Persons

- The provider had a policy in place to meet the Fit and Proper Person's requirements which linked with the recruitment policy for executives. The new trust secretary had undertaken a review of the policy and recommendations were made and accepted at the trust remuneration committee in September 2016 to strengthen the policy and systems in place. This policy was to increase the number of checks undertaken by the trust when recruiting executives and include credit, insolvency and bankruptcy checks with a reputable agency. The policy was ratified in December 2016.
- Annual declarations were made by executives of their probity and we saw that these were in place in the records we reviewed.
- At the time of our inspection no executives had been employed by the trust since the Fit and Proper Person requirements had come into force. The trust was ensuring retrospective check of all executives was undertaken in line with the new policy. We received written confirmation that these would be completed by the end of January 2017.
- A new electronic recording system had been implemented alongside the new policy for ease of update and review.

Public engagement

- The trust implemented a step change approach in patient involvement as part of their "year of engagement" in 2015/16. A consistent focus on improving patient experience alongside safety and patient outcomes was at the heart of this, and has included: live patient stories at board; wide and visible display of feedback from comments cards and the NHS Friends and Family Test; and engagement of patients in changes to patient letters.
- The trust also made efforts to reach out to families under the care of the children's heart service. A pilot approach to engaging patients, relatives and carers was implemented through a 'Conversation Week' at Bristol Royal Hospital for Children. There was a clear approach to engaging children and young people in the improving care and adherence with treatment.

- The trust was using innovative approaches to gather feedback from patients using the service and the public. It had also implemented an involvement network which offered the opportunity to have conversations with people across the communities of Bristol. The focus was to gather information about the care received and what really matters to the people in communities, and then to use to improve and develop services.
- Examples of changes made as a result of patient feedback were given throughout the trust. These included: altering the way waiting times were displayed in the cardiology outpatient department; the introduction of air-conditioning on a surgical ward; changes to the multidisciplinary team processes so as to improve communication with patients; and in the emergency department patients were involved in the development of the SHINE patient safety assessment tool project.
- Throughout the hospital there were opportunities for collecting patient feedback, through the use of touchscreen surveys, text messaging, comments cards and postcards.

Staff engagement

- There were high levels of staff satisfaction across the trust. Staff were proud to work for the organisation and spoke highly of the culture. There had been a clear focus on staff engagement since our last inspection. In 2015 and 2016 a "year of engagement" was planned and implemented. This involved senior clinicians and management teams. The focus was on improving staff engagement and experience through improved communication channels, listening, acting on concerns and providing feedback. Staff experience was also identified as a key priority in the transforming care programme for 2015/16. This shifted the agenda from a business as usual response to the annual staff survey to a more creative and agile approach. Staff were consulted through a series of executive supported focus groups in July and August 2015 which had significant interest and generated wide-ranging feedback to the senior leadership team. This helped to shape the next phase of leadership development. The approach has been to create the correct conditions to strengthen the connection between staff and the organisation in order to implement the improvement methodology within the trust.
- This focus had continued into the 2016/17 year with action plans in place to work on communication and staff engagement in all divisions.
- In the NHS staff survey (published 2016) the trust scored similar to other trusts in 31 questions and worse than other trusts in

three questions. These were effective team working; the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month; and the percentage of staff satisfied with the opportunities for flexible working patterns.

- There was evidence that the trust valued and encouraged staff to raise concerns. There were formalised staff engagement programmes, which included staff drop-in sessions. Staff throughout the trust reported that they could give open and honest feedback to managers at all times and said that ideas and concerns were listened to and taken forward where possible. They also felt managers actively engaged with them and notably within outpatients staff felt they had been involved in the planning and delivering the service as well as the development of the culture.
- A 'Happy App' had been developed and rolled out in areas across the trust. This was designed as a method of gauging staff morale and created a rapid feedback loop for local managers to respond. It was an electronic device for staff to flag how they were feeling and to record any issues or comments. The trust had received an award in the staff engagement category in the Health Service Journal awards in the week of our inspection.
- There was a strong focus on promoting staff wellbeing and safety. This was particularly evident within the theatre department where a week-long programme to support staff had been implemented which culminated in sessions for staff to provide feedback to managers and identifying further discussion points. These fed into work with the transformation project steering group.
- Staff innovation was celebrated. There were staff success and recognition awards within the trust, at trust and divisional level, which were published within the staff "Voices" newsletter.
- We had significant staff engagement in focus groups, with additional sessions added for senior nursing leaders. Staff throughout the organisation noted how things had improved over the year prior to our inspection.
- New visual messaging to staff had been implemented which included: values posters; recognising success posters; chief executive video briefings; safety bulletins and the 'We are proud to care' film focused on the quality of patient experience.

Innovation, improvement and sustainability

- There was a clear and proactive approach to seeking out and embedding new and more sustainable models of care. The trust had made many improvements and innovations since our last inspection, corporately and within divisions within the trust. Corporately and at a trust-wide level, the trust conducted

a baseline-assessment of the safety culture across the organisation, with feedback to board. The trust were in the process of putting additional systems to support and strengthen the safety culture within clinical teams as a result of this.

- A programme promoting and rewarding innovation which improved patient care had been implemented across the trust. This was for all staff to put forward innovative solutions to day-to-day challenges.
- The trust undertook a project to transform patient letters, following complaints from patients about the shortcomings of their letters. This resulted in a set of 'letter quality standards' which were being applied to all appointment letters and existing letter templates within the trust patient administration system.
- Others include: The 'Happy-App', providing real time feedback on staff morale, which had received an HSJ award in November 2016. The InfoWeb portal, providing information and performance reports in one place for managers and staff to access easily; the updated board assurance framework and risk management system, ensuring that this is fully embedded from ward to board; and the implementation of the new involvement network for the trust patient and public involvement programme.
- A vast number of improvements and innovations have been undertaken within divisions across the trust.
- These included those focused on improving access to and flow within the hospital: The development of a virtual ward with a third party provider to provide the care that patients, admitted via the emergency department and medical wards, would receive in hospital in their own home to avoid lengthy stays in hospital. The planned care programme within surgery, focused on streamlining elective and emergency patient flow to develop separate elective an emergency surgery bed bases to reduce the number of cancelled operations. An electronic patient flow tracker, providing real-time central visibility of the bed state within the trust, including any obstacles to patient flow, for example, deep cleaning of cubicles, and where specific flow issues occur, notifications to the smart phones of escalation teams. Rapid access clinics for older people, providing a one-stop multidisciplinary rapid assessment and treatment service for frail elderly patients in the community.
- Innovations and improvements surrounding patient care and safety were also significant and included: The 'point of care team' training providing human factors training as close to the patient as possible, working directly with staff on wards to

develop team work. The emergency department has implemented a World Health Organisation style checklist in response to a NatSSIPs alert. They are the only centre in the UK to be using this and it has been adopted by the Royal College of Emergency Medicine. The emergency department SHINE project incorporating an emergency department safety checklist, focused on a time-based framework of tasks that is completed for every majors patient had been implemented and adopted by other trusts within the region. This has improved the monitoring of vital signs, calculation of early warning scores, pain scoring and administration of medication with the department and no clinical incidents related to failure or delay in recognising a deteriorating patient had been reported.

- There were also state of the art innovations and research provided by the trust. These included: Icon gamma knife radiotherapy treatment implementation in July 2015. This was the second such installation in the world. The assessment of preterm labour risk by the complementary use of fetal fibronectin and ultra-sound cervical length measurement. The use of 'smart bandages' in children with burns to detect infections.
- In all the trust cited in excess of 80 innovations and improvements which had either been implemented or were on-going at the time of our inspection.
- The trust had also received or been nominated for a number of awards, including: The HSJ Value and Efficiency Award 2015; HSJ Environmental and Social Sustainability Award 2015; CHKS Top Hospitals winner 2016; and the Bristol Royal Infirmary redevelopment was shortlisted in the community benefit category of the Royal Institute for Chartered Surveyors Awards 2016. Members of staff had also been recognised in awards such as the Bristol Evening Post Health and Care Awards, Health Education England Star Awards and by professional bodies.

Overview of ratings

Our ratings for University Hosptials Bristol Main Site are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	☆ Outstanding	Good	Requires improvement	☆ Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	☆ Outstanding	Good	Requires improvement	☆ Outstanding	☆ Outstanding

Our ratings for University Hospitals Bristol NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- In times of crowding the emergency department was able to call upon pre-identified nursing staff from the wards to work in the department. This enabled nurses to be released to safely manage patients queuing in the corridor.
- The audit programme in the emergency department was comprehensive, all-inclusive and had a clear patient safety and quality focus.
- New starters in the emergency department received a comprehensive, structured induction and orientation programme, overseen by a clinical nurse educator and practice development nurse. This provided new staff with an exceptionally good understanding of their role in the department and ensured they were able to perform their role safely and effectively.
- In the emergency department the commitment from all staff to cleaning equipment was commendable.
- The comprehensive register of equipment in the emergency department and associated competencies were exceptional.
- Staff in the teenagers and young adult cancer service continually developed the service, and sought funding and support from charities and organisations, in order to make demonstrable improvements to the quality of the service and to the lives of patients diagnosed with cancer. They had worked collaboratively on a number of initiatives. One such project spanned a five year period ending May 2015 for which some of the initiatives were on-going. The project involved input from patients, their families and social networks, and healthcare professionals involved in their care. It focused on key areas which included: psychological support, physical wellbeing, work/employment, and the needs of those in a patients' network.
- The use of technology and engagement techniques to have a positive influence on the culture of an area within the hospital. There were clear defined improvements in the last 12 months in Hey Groves Theatres.
- The governance processes across the trust to ensure risks and performance were managed.
- The challenging objectives and patient focused strategy used to proactively develop the quality and the safety of the trust.
- The use of real time feedback from staff via the 'happy app' to improve and take action swiftly in areas where staff morale is lower.
- The focus on the leadership development at all levels in order to support the culture and development of the trust.
- The use of innovation and research to improve patient outcomes and reduce length of stay. The use of a discrete flagging system to highlight those patients who had additional needs. In particular those patients who were diabetic or required transport to ensure they were offered food and drink.
- The introduction of IMAS modelling in radiology to assess and meet future demand and capacity.
- The use of in-house staff to maintain and repair radiology equipment to reduce equipment down time and expenses.
- The introduction of a drop in chest pain clinic to improve patient attendance.

Areas for improvement

Action the trust MUST take to improve

- Ensure all medicines are stored correctly in medical wards, particularly those which were observed in dirty utility rooms.
- Ensure records in the medical wards and in outpatient departments are stored securely to prevent unauthorised access and to protect patient confidentiality.
- Ensure all staff are up to date with mandatory training.

Outstanding practice and areas for improvement

- Ensure non-ionising radiation premises in particular Magnetic Resonance Imaging (MRI) scanners restrict access.

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 17 HSCA (RA) Regulations 2014 Good governance The provider must maintain securely at all times records in respect of each service user. These should only be accessed and amended by authorised people. Records within cardiology, dermatology and outpatient departments were not always kept in locked containers.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure premises used by the service provider are safe to use. Patients within the radiology department could access unlocked Magnetic Resonance Imaging (MRI) rooms

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g) the proper and safe management of medicines. There was not always proper and safe management of medicines with sluices being used to store some creams and treatments. The sluice rooms were not an appropriate area for storage.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The provider had failed to have suitable arrangements in place to ensure all medical staff were supported to receive fire training, resuscitation training and safeguarding training to enable them to be prepared should an event occur.