University Hospitals Bristol NHS Foundation Trust
University Hospitals Bristol Main Site

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<tr>
<th>Region:</th>
<th>South West</th>
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<tr>
<td>Location address:</td>
<td>Bristol Royal Infirmary</td>
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<td>Upper Maudlin Street</td>
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<td>Bristol</td>
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<td>BS2 8HW</td>
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<tr>
<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<tr>
<td>Date of Publication:</td>
<td>August 2012</td>
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<td>Overview of the service:</td>
<td>The provider is an acute NHS foundation trust providing services across the Bristol and greater Avon area. The trust also provides specialist care to people from across the South West Region. University Hospitals Bristol Main Site provides acute services and includes, the Bristol Royal Infirmary, Bristol Royal Children's Hospital, Bristol Oncology and Haematology Centre, Bristol Heart Institute, St Michael's</td>
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Hospital, Bristol Eye Hospital and Bristol Dental Hospital.
Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

University Hospitals Bristol Main Site was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We carried out this inspection as part of our scheduled inspection programme. We visited the emergency department, medical assessment unit, ward 51 in the Bristol Heart Institute and the central delivery suite and wards 71, 74 and 76 in the maternity department of St Michael's Hospital.

We spoke with four patients on the medical assessment unit, five patients in the maternity department, five patients, one care worker supporting a patient in the emergency department and three patients on ward 51. We also observed care being delivered in the areas we visited at University Hospitals Bristol Main Site.

Overall people told us they received good care and received the information they needed about their care and treatment.

One person in the emergency department told us "I just came straight in from the ambulance and didn't have to wait". They said "on the whole, my treatment has been really good". Another person we spoke with said they had a quick transfer from the ambulance to the emergency department. They said the staff were marvellous.

All five of the people we spoke with said that staff kept them informed of what was happening, although one person said that as the department got busier they had to ask.

One relative said that care on the medical assessment unit had been superb and staff had explained things to them. Another relative of a patient on the medical assessment unit contacted us following our inspection to tell us their concerns about the care provided to their family member following our inspection and a previous inspection. The concerns raised were not observed by us during our inspection and we advised the person to
complain directly to the trust.

Patients on ward 51 told us the staff were very good on the ward. One person who had been a patient for five days said "so far I'm impressed".

Patients we spoke with in the maternity department felt that they had received good treatment and care. One woman on the transitional ward was completely satisfied with her care apart from one nurse/midwife making her feel pressurised into continuing breast feeding when she had already been supported by another midwife into undertaking a mixture of breast and formula feed as was her choice.

We found that the trust was non-compliant with outcome 13: Staffing. This was only for the regulated activity maternity and midwifery services. The trust provided evidence that they had a staffing level of one midwife to 38 births. Senior staff told us on the day of our inspection that they had a staffing level of one midwife to 39 births. The national guidance for midwifery staffing levels in a hospitals setting is one midwife to 28 births. We saw that staff were not able to take breaks in a timely manner. Staff throughout the maternity department said that although they were able to provide a safe service to all their patients they did not have time to give the extra care and support that some women might need. For example, staff having discussions about psychological issues or concerns that the woman might have in relationship to her birth, the baby or general care. One patient we spoke with said that she had not been shown how to bath her baby prior to leaving the hospital.

We observed patients in all areas we inspected, being supported in a professional manner. Patients were informed of their treatment. We saw that consent for surgical procedures was gained from patients. We were told that within the emergency department consent was sought verbally.

Staff spoken with were committed to ensuring that women in the maternity unit were involved in the decision making process about their care and were constantly aware that they needed to ensure dignity and privacy was maintained at all times.

What we found about the standards we reviewed and how well University Hospitals Bristol Main Site was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard.
People experienced care, treatment and support that met their needs and protected their rights.

**Outcome 05: Food and drink should meet people's individual dietary needs**

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

**Outcome 06: People should get safe and coordinated care when they move between different services**

The provider was meeting this standard.

People's health, safety and welfare were protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operations with others.

**Outcome 07: People should be protected from abuse and staff should respect their human rights**

The provider was meeting this standard.

People using the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**

The provider was meeting this standard for all regulated activities with the exception of maternity and midwifery services where we found that the provider was not meeting this standard. We judged that this had a minor impact on people using the service.

There was not sufficient qualified, skilled and experienced staff to meet people's needs.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of the
service that people receive.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the Guidance about compliance: Essential standards of quality and safety
Outcome 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People we spoke with said they had been treated with dignity and respect.

We spoke with a care worker who had escorted a person with a mental health condition into the emergency department by ambulance. They said that the nurses and doctors had tried to involve the person in their care and treatment and had adapted their communication to the needs of the individual. The care worker told us that they were kept informed of what was happening and overall they were happy with the service that they had received.

We spoke with five people receiving care in the maternity department; one person in the central delivery suite and four people on the post-natal wards.

People we spoke with during our inspection felt that they had been given excellent and supportive information especially whilst in labour. However, one person said they had difficulties regarding communication with community midwives who worked for the trust. Another person said that staff were attentive without being intrusive. They also said that staff knocked on the door of the room before coming in. People said that staff promoted the dignity of patients within the central delivery suite.
Patients we spoke with on ward 51 told us they had the information they required about their care and treatment.

Other evidence
We observed patients being supported in a professional manner. Patients were informed of their treatment. We saw that consent for surgical procedures was gained from patients. We were told that within the emergency department consent was sought verbally. The trust told us that written consent was obtained in the emergency department for procedures with more significant risks. For example, procedures involving sedation.

Staff spoken with were committed to ensuring that women in the maternity unity were involved in the decision making process about their care and were constantly aware that they needed to ensure dignity and privacy was maintained at all times.

All cubicles within the emergency department had curtains or screens around them. Notices reminding staff about privacy and dignity were displayed and these could be attached to the curtain to inform staff that treatment was taking place. We observed staff asking permission prior to entering a cubicle where the curtains were drawn.

Some patients were waiting in the corridor of the emergency department prior to being admitted to the department. We were told by the staff that they had access to facilities within the department to ensure their privacy for, example, when changing their clothing and accessing the toilet facilities.

The provider may find it useful to note that although there were systems in place to ensure the safety of patients waiting to be admitted to the emergency department from ambulances, the corridor does not ensure people's privacy or dignity. This was a corridor to other areas of the hospital including the x-ray department.

We saw that in the emergency department the observation unit had a male and female area to provide patients with separate facilities. This included toilets and showering facilities.

In the maternity department we saw that staff made efforts to ensure the privacy and dignity of the mothers was maintained. On the central delivery suite we saw all staff entering a labour room knocked before entering and on the postnatal ward, curtains were kept closed around a woman's bed space when appropriate to ensure privacy for them and their partners.

We reviewed the NHS patient surveys carried out nationally and saw that the trust monitors actions required as a result of this. In addition we saw that the trust also carried out their own surveys and engagement with patients.

We saw that the trust takes steps to engage with patients about their experience in hospital. We saw evidence of the outcomes of satisfaction surveys in the areas we visited. We also saw examples of surveys carried out by the trust by interviewing patients on the wards about their experiences at night.

In addition we saw that the trust regularly reviews concerns and complaints raised by patients who use the services. The patient experience group within the trust reviewed
this information along with other matters to improve the patient experience within the
trust. We saw that actions were identified as a result of the discussion and pertinent
issues were raised for discussion by the trust executive board.

We were also provided with evidence of the trust's engagement with patients who used
the service and had raised complaints.

We saw that there were comment cards and boxes on each ward for patients or their
relatives to make comments about their care.

**Our judgement**
The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and
experiences were taken into account in the way the service was provided and delivered
in relation to their care.
Outcome 04: Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
  * Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

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<td>The provider is compliant with Outcome 04: Care and welfare of people who use services</td>
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<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>We spoke with five patients in the emergency department. One person told us &quot;I just came straight in from the ambulance and didn't have to wait&quot;. They said &quot;on the whole, my treatment has been really good&quot;.</td>
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<td>Another person we spoke with said they had a quick transfer from the ambulance to the emergency department. They said the staff were marvellous. They said they were taken for an x-ray quickly but had to wait to return to the emergency department. We asked this person how they would sum up their experience of the emergency department and they said &quot;short and sweet, very good but very quick. I wish I could stay a bit longer!&quot;</td>
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<td>All five of the people we spoke with said that staff kept them informed of what was happening, although one person said that as the department got busier they had to ask.</td>
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<td>One relative said that care on the medical assessment unit had been superb and staff had explained things to them. Another relative of a patient on the medical assessment unit contacted us following our inspection to tell us their concerns about the care provided to their family member following our inspection and a previous inspection. The concerns raised were not observed by us during out inspection and we advised the person to complain directly to the trust. We raised these concerns with the trust directly and they implemented an immediate investigation into the concerns raised. We will be following up with the trust about these concerns.</td>
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Patients we spoke with in the maternity department felt that they had received good treatment and care. One woman on the transitional ward was completely satisfied with her care apart from one member of staff making her feel pressurised into continuing breast feeding when she had already been supported by another member of staff in undertaking a mixture of breast and formula feed as was her choice.

Patients on ward 51 told us the staff were very good on the ward. One person who had been a patient for five days said "so far I'm impressed".

**Other evidence**

We saw evidence that people's treatment and care were provided with best practice in mind. We saw that the trust had suitable guidelines for treatment and care in place to ensure that care was provided safely and in accordance with national guidance and best practice. We reviewed the guidelines in place for maternity services, the medical assessment unit and the emergency department.

We reviewed the care records for people in all of the areas we visited in the hospital. We saw that there were plans for patients' treatment and care in place. We saw that assessment and screening of patients needs had occurred and risk assessments were in place. These included for the risk of pressure ulcers, nutrition, falls, manual handling and also a nursing screening tool. We saw that care plans were in place to manage patients' needs.

We saw that observations were taken to monitor each patient's condition and were documented within an early warning scoring chart. This was so that where a patient's condition deteriorated staff were alerted and action could be taken to rectify this.

We saw that where patients needed additional support, for example with nutrition, this was marked on a chart behind their bedside to ensure that staff had accessible information. We also saw that this was done in way that maintained the patient's dignity. Staff we spoke with were knowledgeable about the patients they were caring for.

We had received information that the trust had increased levels of pressure ulcers occurring in patients. We saw that pressure ulcers were discussed at the quality and outcomes committee of the trust executive board and actions had been put in place in order to reduce the level of pressure ulcers within the trust. These actions included the implementation of the "Being the Best" programme. The trust was reviewing and updating the guidance on the risk, assessment, prevention and management of pressure ulcers at the time of our inspection. The trust had engaged with the safeguarding team at Bristol City Council with respect to pressure ulcers.

During our inspection we saw patients queuing in the corridor of the emergency department with ambulance staff whilst waiting to be admitted. The patients remained in the care of the paramedics until there was a bay available where the hospital staff could treat them. During our visit we saw that there were five patients waiting. One paramedic told us they had been waiting two hours already with their patient. We were told that hourly observations were carried out for patients within the emergency department unless a doctor had advised otherwise. We were told and shown documentation to demonstrate that the patients in the corridor were continually being monitored and where care needs had changed significantly then they were prioritised for admission.
We discussed this situation with the trust who told us that the number of people waiting was unusual although waits do sometimes occur. We were told that this had happened because the emergency department was unable to discharge patients to other wards in the hospital due to a lack of available beds.

We saw evidence that processes had been put in place to ensure that it was clear to both emergency department staff and ambulance staff who was responsible for monitoring and caring for the patients during the waiting time. We saw there were effective systems in place for the handover of patients from ambulance staff to emergency department staff to ensure that the risks to people waiting were managed.

We saw that the trust monitored the waiting times for patients to be admitted to the emergency department on a daily basis. We also saw that when long waits (those outside of the trust target times) occurred this was escalated within the trust.

We revisited the emergency department on the day after our planned inspection visit to the trust and saw that there were no patients waiting to be admitted to the emergency department from ambulances. This was at a similar time of day as the queue of five patients the day before.

In the maternity department we were told that unannounced 'live skills drills' were carried out. This was where the emergency bells were activated and staff responded to an emergency scenario and practice the skills required in such situations. These live skills drills were assessed and feedback given to staff to promote learning.

Our judgement
The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.
Outcome 05: Meeting nutritional needs

What the outcome says
This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement
The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We spoke with patients about their experiences with food within the hospital. One person in the central delivery suite told us that they had arrived at the hospital without having eaten as they were expecting to have a surgical procedure. This had been changed, as a result of their choice, on arrival at the hospital. They told us that staff had immediately arranged for them to have some food and a drink.

Patients in the emergency department told us that they were not allowed to drink or eat for a period of time on admission (nil by mouth). One person told us "Once the doctor had said that I could drink, I was given a coffee and some toast".

Other evidence
At out last inspection in December 2011 we issued an improvement action relating to this outcome.

We reviewed the nutritional screening monitoring report for the trust from April 2011 to June 2012. This demonstrated improved completion of documentation relating to nutrition. However, the provider may find it useful to note that the compliance with the trust's standard for documentation of the review of nutritional assessments after 72 hours was at 48% in June 2012 having increased from 29% in April 2012. This means over half of the patients have not had a documented review of their nutritional needs 72 hours after the initial assessment.

We reviewed the mealtime monitoring report for the trust (April 2011 to June 2012). This demonstrated that people were receiving the support they needed at mealtimes,
people were receiving a choice of food and most of the time people were receiving the food that they had ordered. This report also reviewed whether protected mealtimes were observed for all patients on the ward. The report stated that this happened most of the time.

We saw there were signs displayed to indicate that people required support at mealtimes. We also saw people were given a choice of menu the day before and that there were signs up on ward 51 stating that snacks were available all of the time.

In the central delivery suite and maternity unit we were told that snacks were available all of the time and that hot meals were available out of hours for patients. We were told that food for each area was served in the dining room. We were told that the main cause for complaint in the maternity department was the types of food available. For example, they would prefer more Mediterranean meals rather than the traditional meals available. We were told that there was work ongoing with the catering team to improve this and include the views of people using the service. We were also told that there was limited availability of food within St Michael's Hospital for fathers or birth partners (although refreshments would be provided) out of hours.

We observed the mealtime on ward 51 and in the medical assessment unit. We saw that a knife and fork sign was used above beds to demonstrate to staff who needed support. We were told by staff on ward 51 that there had been a problem in supporting a patient to eat their meal on one day in the week prior to our inspection. This patient required a special pureed diet. This was because the meal had been put out prior to staff being ready to support the patient in eating and had to be destroyed. Staff had to find other suitable food for this patient to eat. The food staff were able to find for this patient was some weetabix and milk which they crushed up to meet the special dietary needs. This meant that the patient did not get a hot meal which met his nutritional requirements. However, on the day of our inspection we observed people being supported to eat their meals with no problems. Following our inspection the trust told us that this person had also been given dietary supplements. We saw examples of staff helping people move position. We also saw that people were not disturbed during the mealtime and found the mealtimes to be a relaxed. Staff on the medical assessment unit reported that sometimes mealtimes could be difficult because of the high turnover of patients, but where possible they would let individuals finish their meal before being taken to another ward.

We saw that nutritional assessments were carried out and options for diets (for example, vegetarian) and special dietary needs were documented in the patient’s care records.

Our judgement
The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.
Outcome 06: Cooperating with other providers

What the outcome says
This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement
The provider is compliant with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
We did not speak with people using the service about this outcome area.

Other evidence
On the day of our inspection we observed that ambulance staff were queuing with patients waiting to be admitted to the emergency department. We were told that this happens often and that as a result a procedure had been put into place to clarify who provided care for the patients during this time. This was clear and had been posted on the wall in the area where ambulance staff wait with patients. This was to ensure the safety of patients whilst waiting to be admitted to the emergency department.

We also saw that there was onsite management support from the ambulance trust and managers within the emergency department. These two organisations were working together to manage the issues preventing the patients from being admitted to the department.

When we spoke with the manager from the ambulance trust and the matron of the emergency department they told us monthly meetings were held to review the situation. We were told that there had been issues around the electronic handover screen used by ambulance staff to check people into the emergency department. We were told that the screen had been moved to its current position after discussions around the best place to situate it.

We saw that other work between the two trusts had been carried out to look at the
reasons for delays in admission to the emergency department. This included the
development and implementation of a new handover procedure. Staff from the
ambulance trust and the emergency department had also undertaken joint training
about this procedure.

Our judgement
The provider was meeting this standard.

People's health, safety and welfare were protected when more than one provider was
involved in their care and treatment, or when they moved between different services.
This was because the provider worked in co-operations with others.
Outcome 07: Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement
The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us they felt safe in the hospital.

Other evidence
We reviewed the safeguarding and whistle blowing procedures for the trust. The safeguarding adults from abuse policy covered all areas of safeguarding adults including the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The whistle blowing policy "speaking out" provided information to staff about raising concerns. The trust also had a whistle blowing telephone number where concerns could be raised anonymously.

We saw there was guidance for staff on reporting incidents to the police, dealing with domestic abuse and caring for babies and children when their parent is admitted to hospital. We also saw that there were information leaflets for parents about safeguarding procedures.

We spoke with three of the safeguarding professionals working within the trust. They told us that the training for child safeguarding was based on the "safeguarding children and young people: roles and competences for health care staff" intercollegiate document 2010.

We were told that the trust had widened the group of staff who required level 2 safeguarding children training in January 2012 and they were now training more staff to achieve the target compliance levels. We were told there was a plan in place to ensure
that all the staff that now required level 2 safeguarding children training completed this. Staff in the emergency department received both safeguarding children and adults training.

We saw evidence that the level of training required in both adult and child safeguarding had been identified for staff roles within the trust. We saw that the levels for staff training in adult and child safeguarding were between 62% and 89%. We saw that this was monitored on a monthly basis. We saw that there was a recovery plan in place to ensure that all staff had received the appropriate safeguarding training by the end of 2012.

Staff we spoke with were knowledgeable about what constituted abuse and the reporting mechanisms that were in place. One member of staff on the medical assessment unit told us about a specific example of when they had raised a safeguarding alert because they were concerned about the medication that had been given to a person by their relative.

However, within the maternity department three of the eight staff we spoke with told us they had not received training regarding the safeguarding of adults. All of the staff we spoke with in maternity had received training in safeguarding children. We were told sessions had been arranged to deliver adult safeguarding training to staff requiring this but that it had been cancelled due to an emergency within the trust. We were told that 20 staff in the emergency department required training and that this had been arranged by the training coordinator.

The trust have reported two child safeguarding issues directly to us since August 2011. We saw that appropriate action was taken with regards to the engagement of the local authority safeguarding team and the police. The trust provided us with documentation to demonstrate that actions had been taken as a result of these issues.

We saw that there were systems in place to monitor action taken as the result of recommendations from child death serious case reviews. We also saw there were audit systems in place to monitor adult and child safeguarding alerts.

We saw that audits had recently been undertaken of the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards within the trust. Areas of good practice had been noted within this audit along with recommendations for improvement. We saw that these were all reviewed by the safeguarding steering group in the trust.

**Our judgement**
The provider was meeting this standard.

People using the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.
Outcome 13:  
Staffing

What the outcome says  
This is what people who use services should expect.

People who use services:  
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

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| The provider is non-compliant with Outcome 13: Staffing. We have judged that this has a minor impact on people who use the service.  
Except in respect of Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures, Family planning, Management of supply of blood and blood derived products, Surgical procedures, Transport services, triage and medical advice provided remotely and Treatment of disease, disorder or injury, where the provider is compliant. |

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<tr>
<td>We did not speak with people using the service about this outcome area.</td>
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<tr>
<td>We reviewed the staffing in all of the areas of the trust we inspected. We found that there were sufficient staff to meet the needs of the patients on the day of our visit. However, there were some areas of concern.</td>
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Prior to our visit we were aware that the staffing level in the maternity department was at one midwife to 38 births (1:38). The trust provided evidence that they had a staffing level of one midwife to 38 births. Senior staff told us on the day of our inspection that they had a staffing level of one midwife to 39 births. The recommended guidance from the Royal College of Obstetricians and Gynaecologists Safer Childbirth guidance and the Royal College of Midwifery is a staffing level of one midwife to 28 births (1:28) in a hospital setting and 1 midwife to 35 births in a home setting. We saw evidence that the consultant presence on the labour ward was less than that recommended by the Department of Health. We saw that this had been added to the trust risk register and was being monitored by the trust executive board. |
An action plan had been put in place by the maternity management team to mitigate the risks associated with the staffing levels. This included the use of specialist nurses on wards and in the obstetric theatre department. We saw that staffing levels were monitored and evaluated on a daily basis against this action plan.

The trust provided us with workforce benchmarking data for the whole organisation. This included combined data for nursing and midwifery. This was calculated in relation to beds not in relation to the birth rate so we were not able to determine whether the midwifery staffing levels were in line with other trusts. The trust also provided us evidence which identified that their ratio of midwife to birth rate was the lowest of any teaching hospital in the country outside of London.

We were told by our specialist maternity advisor, that the staffing levels were not unusual compared to other maternity units, who find that meeting the required standard of safe staffing a challenge especially with the increasing national birth rate and other demands, such as, increasing medical and obstetric challenges that patients can present with.

Although we did not see practice which was unsafe within the maternity department on the day of our inspection due to the staffing levels, we did observe that staff working on a 12 hour shift did not take their breaks in a timely manner. For example, on one ward we visited we saw that staff were eating their lunch at 4pm. One member of staff said that was usual and that they had taken a quick break at about 12 noon to have "breakfast". Staff not being able to take breaks from work in a timely manner means that there is a risk that they are not able to deliver care safely and effectively.

Staff throughout the maternity department said that although they were able to provide a safe service to all their patients they did not have time to give the extra care and support that some women might need. For example, staff having discussions about psychological issues or concerns that the woman might have in relationship to her birth, the baby or general care. One patient we spoke with said that she had not been shown how to bath her baby prior to leaving the hospital. She said that this was not a particular problem for her but could be for other women who were not able to articulate their needs for any reason.

In addition we saw evidence that the central delivery suite at the trust had to close on 53 occasions in the year 2011-2012 as it had reached capacity. We also saw that on 50% of these occasions the other trusts that patients would be diverted to were also unable to take labouring mothers. As a result the unit did not close even though it had reached capacity, and continued to admit labouring mothers. This resulted in an increase in clinical risk within the maternity department at St Michael's Hospital and the wider population.

The trust told us they had plans in place to develop a new midwifery led birthing unit with additional staff from December 2012. This would increase the number of midwives to one midwife to 34 births (1:34). The trust also provided us with evidence of the actions they were taking to increase the number of staff which supported this. We asked the trust if there were documented plans in place to achieve the one midwife to 28 births staffing level. The trust told us that they were planning to work with other NHS trusts in order to develop plans to work towards the one midwife to 28 births staffing level.
The provider may find it useful to note that we did not see any plans in place to achieve the 1:28 level and CQC will continue to monitor the trust's actions in respect of this.

The information provided to us by the trust demonstrated that the birth rate within Bristol had risen over a number of years. It also demonstrated that the trust had assessed its bed capacity in relation to managing the increasing birth rate and the plans had been developed with this in mind. The trust told us it monitors staffing levels in the maternity department on an annual basis in line with NHS Litigation Authority (NHSLA) requirements.

The trust told us that maternity staffing was calculated using the recommendation in the Royal College of Obstetrics and Gynaecology Safer Childbirth guidance. Previously to this, the "Birth-rate plus" national benchmark which is recognised best practice. This calculation included all midwives midwifery assistants and matrons but not the specialist midwives who would routinely work outside the core services, or nurses who compliment the workforce. The trust also told us that they also audit the staffing levels and business planning around staffing against the Clinical Negligence Scheme for Trusts (CNST) maternity standards which are based on the Royal College of Obstetrics and Gynaecology Safer Childbirth guidance.

We saw that the trust monitored the workforce and clinical indicators in the maternity department. These were monitored in line with guidance and best practice. We saw that despite the low workforce levels against national guidance, the clinical indicators for the maternity department were on the whole positive.

Staff on ward 51 told us the ward had recently undergone a restructure which had resulted in reduced levels of staffing. We were told that the new structure on this ward had only been in place for a month at the time of our inspection. We were also told approval for recruitment for the vacant posts on the ward had been given on the week prior to our inspection and that the recruitment process was underway.

Staff in the emergency department and medical assessment units reported that they had sufficient staff numbers to meet the needs of the patients safely although it was always busy. Staff in the emergency department told us that each area was staffed with the appropriate skill mix and that clear staffing arrangements were in place for each area of the department. We were told that a review of the staffing in this department was taking place.

Staff in the medical assessment unit told us staffing levels were generous compared to other similar settings. They said they were generally well 'protected' from staff being taken to work elsewhere. However, on occasions staff were asked to work in the emergency department if the demand was high there.

We reviewed staffing rotas in the areas we visited and saw that staff on the wards were in line with the planned numbers. We also saw that there were systems in place to release staff to support on other wards where necessary. We saw that there was a bank of staff to provide cover for shifts rather than using agency staff.

We saw that the workforce staffing levels were monitored across the trust both at divisional board level and at trust executive board level. We saw that this was on a head count and financial level against expected numbers and budgets.
Our judgement
The provider was meeting this standard for all regulated activities with the exception of maternity and midwifery services where we found that the provider was not meeting this standard. We judged that this had a minor impact on people using the service.

There was not sufficient qualified, skilled and experienced staff to meet people's needs.
Outcome 14:
Supporting workers

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement
The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
People we spoke with told us the felt staff were knowledgeable about the treatment and care they were providing.

Other evidence
We reviewed the record of essential training carried out in the trust as of June 2012. This identified the areas of mandatory, statutory and regulatory training required by staff within the trust. The trust has stated a compliance level of 80% for most areas of essential training and is aspiring to 95% compliance for those required by the NHS Litigation Authority (NHSLA). For trust induction, health and safety, infection control, violence and aggression, food safety, resuscitation, nutrition, level 1 and level 3 adults safeguarding training and level 1 child safeguarding training the trust had achieved their compliance levels.

We saw that there were some areas of essential training where the trust was lower than their compliance level. The trust had developed and implemented recovery action plans to address the areas of non compliance on the training identified. Some of these areas of lower compliance were because the trust had increased the numbers of staff who required these areas of training. We will continue to monitor the trust's recovery action plans.

We saw that there was a system for reporting non-attendance at essential training sessions. The procedure ensured feedback to line managers and human resources, where non-attendance occurred. This was monitored by the trust.
We saw that there were systems in place for new nurses, midwives and healthcare professionals to gain access to preceptorship (a system to support newly qualified staff) within the trust. This was in line with the NHS knowledge and skills framework. This framework was used by the preceptor and line managers to ensure the development of new professionals and evidence was monitored by the trust.

We also saw that there were development opportunities for nursing and midwifery assistants to gain clinical vocational awards and diplomas at level 2 and level 3. There were development opportunities for staff to undertake management courses and "skills for life" courses. One member of staff in the maternity department told us they had previously worked as a maternity assistant and the trust had sponsored their training to become a midwife.

Staff we spoke with said they had received the training they needed to meet the needs of the patients they cared for. Three out of the eight members of staff we spoke with in the maternity unit said they had not received training in adult safeguarding. This was corroborated by the evidence regarding essential training in the women's and children's division supplied by the trust. However, this was being addressed.

Staff we spoke with told us they had received an annual appraisal. We were told that although staff do receive an annual appraisal in maternity, often it is reliant upon staff on the maternity wards to carry this out rather than staff in the central delivery suite.

We saw evidence that 83% of non-medical staff had received an appraisal, 95% of junior doctors had received an appraisal and 75% of consultants had received an appraisal in June 2012. We saw that the trust monitored the rates of appraisal within the trust on a monthly basis and had an action plan in place to ensure that the levels of appraisal reached the 85% compliance level set in April 2012. The previous compliance level was 80%.

Staff we spoke with felt they were supported in their role. Although on ward 51 we were told that staff morale was low because of changes in the workforce. We discussed this with the trust and they told us about the support that was being implemented in that area to help improve morale as a result of the changes.

We saw that formal supervision processes were in place for midwives, occupational therapists and newly qualified professionals. The provider may like to note that we did not see evidence of regular formal supervision meetings for other staff with their line manager. However, most staff told us that ward managers had an open door policy and they were able to have discussions and raise concerns when necessary. We were told that supervisory sister roles were being developed in order to support nursing staff.

In the emergency department staff told us they met regularly with their team leader to discuss any learning required and discussed case studies. We were told that senior team leaders met monthly and the information from this was cascaded to the nursing teams in the department. Medical staff told us they had a similar system in place where the met with colleagues on a monthly basis. We saw evidence that team meetings occurred in other areas of the trust we reviewed but staff found it difficult to attend these as they were "too busy".

Our judgement
The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.
Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

<table>
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<tr>
<th>Our judgement</th>
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<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>We did not speak with people using the service about this outcome area.</td>
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**Other evidence**
We reviewed the systems that the trust had in place to assess and monitor the quality of the service. We reviewed the board assurance and governance framework for the trust. This demonstrated that the trust board monitors developments in the trust in line with the organisational plans and strategy.

We reviewed the trust risk register and saw that risks related to the delivery of care and the service were assessed. We saw that high level plans to mitigate those risks were included within the risk register. The areas of risk identified included: the staffing level in maternity being below that recommended in the "safer childbirth" report; risk to patients resulting from queuing to enter the emergency department; the risk of harm to patients due to acquisition of pressure ulcers and as a result of falls. Staff on the wards were aware of the plans to ensure actions were being taken. The Emergency Department had a safety brief which included the areas for improvement.

We reviewed the trust board minutes. These demonstrated that areas of risk within the trust were discussed as part of the executive board meetings and that challenge from non-executive members of the board occurred. Challenge was also received from members of the trust's membership council, who were in attendance at meetings. We also saw that the patient experience within the hospital was discussed and areas of learning from complaints received were noted.
We reviewed the minutes for the trust clinical quality group for April and May 2012. We saw that quality monitoring for the trust occurred through this group and areas of discussion included the risk register, clinical outcomes and effectiveness, National Patient Safety Agency Alerts (NPSA), patient safety (including infection control) and the quality dashboard for the trust. We saw that there was attendance of key clinical professionals within the trust at these meetings. This group reports into the trust management executive group and the non-executive led quality and outcomes committee of the trust board.

We reviewed the meetings of the quality and outcomes committee of the trust board. We saw that this committee provides oversight of the quality of the services provided within the trust.

We reviewed the audit programme for the trust for the year 2011-2012 and the year 2012-2013. We found that a large amount of clinical audit had occurred within the year 2011-2012 although some audits that were scheduled did not occur.

During our inspection of the hospital we saw evidence of audits occurring in all of the areas and wards visited. We saw that audits carried out were pertinent to practice and included audits against best practice and NICE (National Institute for Clinical Excellence) guidelines. The planned audit programme for 2012-2013 also reflected this.

We reviewed the trust “forward plan strategy document for 2012-2013”. This included plans relating to risks identified within the risk register for the trust.

We saw evidence that the trust had achieved level 2 accreditation for the NHS Litigation Authority and level 3 accreditation for CNST (Clinical Negligence Scheme for Trusts) maternity clinical risk standards.

We reviewed the incidents reported to us via the NPSA by the trust and also the analysis of incidents carried out by the trust. We saw that incidents and serious incidents were monitored by the patient safety group within the trust on a monthly basis and by the risk management group within the trust on a quarterly basis. We also saw that quarterly trends of incidents were reported on and where high levels of incidents were reported they were included in the trust wide risk register. We also saw evidence of serious incidents which had been reviewed by a serious incident panel within the trust. This provided oversight of investigations and the root causes of incidents and identified learning for the trust. The trust provided evidence of We also reviewed evidence of the trust reporting serious incidents to us by exception and the trust investigations and actions as a result of these.

We reviewed the medicine division's quality and clinical governance report for March 2012. This report was for the divisional quality and patient safety group, for which we also reviewed meeting minutes, as an example of the quality governance structure in place at divisional level within the trust. We saw that the quality dashboard for the division was reviewed by the divisional quality and patient safety group. This included the performance against key target areas for the division relating to quality. We also saw that this included discussion about serious incidents and regarding safeguarding training. We saw that pertinent items from the risk register were identified where action was required. For example, pressure ulcers.
All of the staff we spoke with in the trust said they had received feedback on any incidents they had reported. They also said that learning resulted from incidents at ward level. Staff also confirmed that they were involved in monitoring the quality of the service. This included patient feedback and clinical governance arrangements. We were shown a number of audits that had been completed on the wards, maternity department and in the emergency department that demonstrated the quality of the service was being monitored. Staff confirmed that they were given information about the audits that had been completed and any action plans that had been developed.

We saw that compliment cards and boxes were on each ward we visited. We saw some examples of the compliments made by patients and their relatives. These included "thank you for your dedication and care when I needed it most" another comment thanked staff for their compassion in supporting a patient at the end of their life.

All of the documentation and evidence we saw demonstrated that the trust had an effective system of assessing and monitoring the quality of the service.

**Our judgement**
The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of the service that people receive.
## Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

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<tr>
<th>Regulated activity</th>
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<th>Outcome</th>
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<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 13: Staffing</td>
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**How the regulation is not being met:**
There was not sufficient qualified, skilled and experienced staff to meet people’s needs.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they achieve compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
## Information for the reader

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<th>Document purpose</th>
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